2011 HOUSE EDUCATION

HB 1353

2011 HOUSE STANDING COMMITTEE MINUTES

House Education Committee
Pioneer Room, State Capitol

HB 1353
01/31/11
13696

☐ Conference Committee

Committee Clerk Signature

MINUTES:

Chairman RaeAnn Kelsch: We will open the hearing on HB 1353.

Rep. Bob Skarphol: Sponsor. Testimony attachment 1.

Chairman RaeAnn Kelsch: We will continue with Sen. Ray Holmberg.

Sen. Ray Holmberg: Sponsor. Attachment 2. You have heard and you have received messages from a lot of people that talked about honoring the vote of people. I'm sure a number of the letters you have seen, were to repeal measure number 3. Those folks are very sincere. They look to article 3 section 1 of the constitution of powers reserved to the people and it talks about how people have the right to initiate measures. I'd like to spend a few moments looking at article 8 of the constitution which gives the legislature its mandate on working on various issues that come before it. The article 8 is highlighted (refer to attachment 2). When voters look at initiatives or referrals deal with absolutes, it is yes or no. We as the legislature rightly or wrongly but by necessity have to deal with priorities. I would remind you that the legislature does this all the time because it is their legislative role to prioritize. Voters on an initiate do not prioritize because they vote yes or no. An example is measure 6 dealing with the oil tax. It passed handedly in November. It was three months later when the legislature made changes. This measure passed in 2008 and this measure before you today will make substantial changes. People will say you have 1 billion in the bank so why are you going after this program. The way the budget process works is the governor tells us how much money there is going to be and then the governor proceeds to spend it all. The argument of 1 billion in bank. Yes if you make some assumptions. If you decide that there is no good tax reduction bill that has introduced this session. You also have to agree if you want to keep that 1 billion dollars that there are no good legislative ideas that cost money. To keep that 1 billion dollars there, you would have to eliminate the rainy day fund. I think the role you have and we have in the legislature is to look at the priorities. The 32 million dollars, I'm sure you can find it in the budget somewhere but I don't know which big ticket times you want to cut. The responsible thing to do, number one, is to show and prove that the goal of the bill is a noble bill and second, to find a funding mechanism where you can pay for it. That is all.

Sen. J. Lee: Sponsor. Attachment 3. I have a few comments. I hope everyone understands that no one that will be up talking here today will think smoking is a good thing. My concern

is more about the money. The attachment gives you a detailed explanation of all the funding from a variety of sources to a variety of departments for alcohol, drug, tobacco, risk associated behavior, prevention and cessation. Not everyone who smokes drinks, or does something else that s a risky behavior but there often is a connection. I would like you to look at the attachment and the highlighted areas which give an idea of some numbers (refer to attachment 3). I think it is important for you as committee members to know what those dollars are and that we look at what other health dollars are. I have confidence you will give this a thorough review and I think the attachment offers some important information.

Dr. Wynne – Vice President, UND Health Affairs: Testimony attachment 4.

Rep. Lyle Hanson: How many resident medical students do you have in Grand Forks right now?

Dr. Wynne – Vice President, UND Health Affairs: There are 18.

Chairman RaeAnn Kelsch: Rep. Hanson are you talking about that are doing their residency or are talking about ND students?

Rep. Lyle Hanson: ND residents.

Chairman RaeAnn Kelsch: So how many medical students in the whole medical school right now are ND residents?

Dr. Wynne – Vice President, UND Health Affairs: The figures are roughly 80%. Residents has two meanings meaning either living in ND or the training a medical student goes through after graduating from medical school. The answer is 80%.

Rep. Lyle Hanson: How many out of state and that would be 20% then?

Dr. Wynne – Vice President, UND Health Affairs: That is correct.

Rep. Lyle Hanson: How many of the graduates stay in ND?

Dr. Wynne – Vice President, UND Health Affairs: Understanding these figures is critical. ND mirrors the national experience. If you go to medical school in state, there is about a 1in 3 chances you will stay to practice. ND is below the average with 31% versus 37% but it is about 1 in 3. If you do your post medical school training only in ND, it is a less than 1 in 2. If you do both, there is a 2 out of 3 chance you will stay in state. Our proposal includes the funding of the residency part because that is where you get your best return of people staying in state.

Rep. Bob Hunskor: Retention obviously is very important. Under this bill what steps would your school take to increase the retention?

Dr. Wynne – Vice President, UND Health Affairs: The retention is a key issue. There is a pipeline approach to keep that retention. One approach is to actually introduce more

youngsters to the concept of the health career. We want to do more to interest students in the field. The second approach is the admission criteria that we use to get into medical school. There are no prefect predictors that say who will stay but there are things we can use to help it. One of these is place of residence. One of the best predictors of practicing primary medicine in rural area is coming from a rural area. A second major indicator is if students when in medical school are exposed to a rural setting. We will use the best predictors we have to try and maintain them. The last part is critical because it is the most expensive part of our proposal. You work on the pipeline to get them interested, you try to select the students that are most likely to stay, you give them the experiences that encourage them to practice family medicine in a rural community, but then we you need to have attractive residencies to get them to stay in state. We are currently in the mid 60% and we think we can get it up to well of 70% for retention in the state. We want to shoot for is 3 out of 4.

Rep. Karen Rohr: Of the retention rates what percentage of those individuals go to the rural areas and how long do they stay there?

Dr. Wynne – Vice President, UND Health Affairs: Physicians are not different from the general population and the migration pattern of physicians has followed that of the general population in ND. The majority of family physicians are in the cities. It is true that there are more family physicians relative to specialists in the rural areas, but the majority of physicians still remain in the cities. 31% of family physicians are actually out in the rural areas.

Rep. Karen Rohr: So you identified 15 residents in the school? So we can count on 1 of those to go to the rural area?

Chairman RaeAnn Kelsch: Those in residency program totals 18?

Dr. Wynne – Vice President, UND Health Affairs: If we are talking about residency as the post medical school training, UND current sponsors 96 residents, the Grand Forks Family Medicine program has 18. That is 114 total residents. The length of that residency may be anywhere from 3 and 5 years. The number is if the people in the residency did their medical school here in state and then they are doing their residency here, 2 out of 3 practices here long term.

Chairman RaeAnn Kelsch: I think it would be interesting for the committee if you would tell us how many students typically apply for medical school every year, how many get in, how many slots are reserved for the in-med students and how many slots are reserved for or are part of your compact.

Dr. Wynne – Vice President, UND Health Affairs: The School of Medicine and Health Sciences currently has 55 students entering each year. There are 7 students in the federally funded Indians into Medicine program. Because it is federally funded and targeted at a population, that is a separate admission process.

Chairman RaeAnn Kelsch: That is on top of the 55?

Dr. Wynne – Vice President, UND Health Affairs: Correct which takes us to 62 but I'll talk about the ones you fund which are the 55.

Chairman RaeAnn Kelsch: Would you talk about the selection process and how they have to have the roots to ND.

Dr. Wynne – Vice President, UND Health Affairs: Of those 55 students we have higher than the national average as far as the number of applicants. We average 5 applicants for every slot. The number that get interviewed is in the 150 range. Of the people that get in, 80% are from ND, the others are just two groups: the compact group and a handful are Minnesota residents that have ties to ND. I think you can be comfortable that the selection process targets ND people and interests in practices in ND.

Chairman RaeAnn Kelsch: Does the interview committee ask every student if they are interested in staying in ND or going to a rural community?

Dr. Wynne – Vice President, UND Health Affairs: If you ask a question and you are obvious the outcome you are looking for, you will get that. We aren't looking at what they say but what they have done. People who give back to the community etc.

Rep. Phillip Mueller: We've heard from you and affirmation from your colleagues that you know you have a good sense of how we get general practitioners into rural areas of ND. What have you been doing in that regard? Are you using those studies to identify those students to fill those slots?

Dr. Wynne – Vice President, UND Health Affairs: Currently they are using the studies and when I took over as Dean and it was clear to me that increased focus on it would be important. On a national scale we are in the top half dozen of states as far our provision of providers in rural areas. Is it enough, no we are trying to do more but when you see it from the perspective of how poorly other states are doing, we aren't doing badly.

Rep. Phillip Mueller: My other question deals with CMS. Does that federal organization have any impact on how many students you have at UND in the field of medicine?

Dr. Wynne – Vice President, UND Health Affairs: The Centers for Medicare and Medicaid (CMS) is through the Medicare program the single largest provider of funds for the post medical school residency training. The problem we have in ND is that essentially the number of residency slots was frozen by the Balanced Budget Act of 1997. Even if we were to increase the size of the medical school if there were no more residency slots there would be no place for them to go. That's part of the dilemma. That is why we are proposing adding slots. If you look at the budget proposal as it is broken down. The most expensive part is for the residency slots. I wish I could have brought to you a more modest proposal. To the extent that the federal government also recognizes this, and depending on what happens with the whole health insurance reform process, it is possible and I would say hopeful that additional residencies will be forthcoming through CMS which would reduce our costs in the future.

Vice Chair Lisa Meier: How many foreign students to you currently have?

Dr. Wynne – Vice President, UND Health Affairs: As far as med students we don't have any unless a person is naturalized and a resident of ND.

Rep. John Wall: Will someone be addressing the need for a new facility?

Dr. Wynne – Vice President, UND Health Affairs: As far as the details?

Rep. John Wall: I guess the need. Can any of this be implemented in the facility you have now or do we need to address a new one?

Dr. Wynne – Vice President, UND Health Affairs: For the full implementation that we are suggesting, that is the 16 medical students, the 3 health science students, the 17 residents, with the attendant addition faculty and staff that this will incur, we will need another building. There is a multiplier effect. 16 students is the first year, the second year is 32 students so we are talking about 64 additional students if fully implemented that we have to place somewhere. For the 30 health sciences students, that program is on average 3 years so we are taking about 90 additional students. With the residents with an average 3 years we are talking about 3 times 17. When you add up additional students and faculty you are talking about an additional 200 people. Could we initiate this without a building of course, but we are land locked which causes a problem.

Rep. Lyle Hanson: If this bill passes would the number of the in-meds increase?

Dr. Wynne – Vice President, UND Health Affairs: There is nothing in here that says the in-med program would expand.

Rep. Lyle Hanson: That's federal funding and they come from anywhere in the US?

Dr. Wynne – Vice President, UND Health Affairs: They have to be an enrolled member of a tribe but they can come from any part.

Rep. Lyle Hanson: They are all Native Americans?

Dr. Wynne – Vice President, UND Health Affairs: Yes.

Rep. Lyle Hanson: So there is a potential for ND to have one or all seven?

Dr. Wynne – Vice President, UND Health Affairs: Correct

Chairman RaeAnn Kelsch: On a side note to that. Even if there were the 55 students and there were 0 in the in-med program, they cannot use those 7 slots to fill with ND students. They can only be used for the Indian students. Briefly tell the committee why the number is 16, not 10 or 7.

Dr. Wynne – Vice President, UND Health Affairs: That is roughly a 29% increase in class size. Roughly 30% is because that is what the national figures are of what is needed to meet our healthcare needs. As it turns out when we did our more detailed prediction,

roughly 30% was correct when coupled with retention. Why specifically 16? The reason is because our school has popularized and had success with small groups. We called it patient centered learning. Since we wanted to increment the class size, the way we do that is in groups in 8 students so 8 times 2 is how we came up with that figure.

Chairman RaeAnn Kelsch: Who else would like to testify in support? Rep. Bob Skarphol?

Rep. Bob Skarphol: I don't want to take up anymore time so I will yield the time to those that want to testify.

William Mann: I'm a family doctor. This summer I will be in practice 26 years after completing my residency. The statistic that probably bothers us all is the stastic of the most needed in state areas. There are variously defined as urban underserved, small rural, isolated rural, and those areas with a zip code in which there are less than 75 physicians. With exception of Grand Forks, Fargo, Bismarck and Minot, that describes all of ND. This certainly creates anxiety. The origins of physicians who come and go to rural areas are rural kids. If you want to find the people with best opportunity of returning is to find those kids. A lot of the kids lack a family that has a college degree. These kids have other strikes against them. Those kids need advocacy. The research supports it as well. You recruit them, give them early experience, and you repeat that experience. Another area you need to increase is flexibility. My own personal view is that you have a track for those kids. We have an ageing population and less people to look after them. One last thing. Research also suggests that the factors that attract are different from those that make that person move away. I see HB1353 as one part of an important process.

Chairman RaeAnn Kelsch: Questions? Support?

Larry Halverson: Attachment 5. I am a family doc. A few months ago we were asked to meet with a leadership to try to come up with some kinds of ideas to ease the present and future shortage of primary care physicians. A lot of ideas were thrown out and tossed around. None of us really grasped anything we could sink our teeth into. So why not ask the people of rural areas what kinds of things we as a health care system, a medical school, or a residency school or all combined, could do to get better odds of getting people into the rural areas. A small questionnaire was drafted. These suggestions are not coming from me personally or from any of the organizations I am affiliated with they are coming from the people from the rural areas (refer to attachment 5). Responses were complied and are on page three of the attachment (refer to attachment 5). Getting students into the rural area that want to be there is important. As they come into med school they have suggested that they should spend more time in the rural areas. I would suggest having students go back to the rural communities. I think it's clear that the need is great and the mood and timing is right.

Chairman RaeAnn Kelsch: Questions? Further support?

Bruce Levi – Executive Director, NDMA: Testimony attachment 6.

Chairman RaeAnn Kelsch: You made an interesting comment where you talk about so our state can continue our tobacco and control efforts recommended by the CDC. Are you

aware that ND is one of two states that spend more and I've been told excessively more than the recommended spending by the CVC?

Bruce Levi – Executive Director, NDMA: I think in terms of the funding levels it's best to talk to advocates on that. I think from our perspective, for over a decade the physicians through the NDMA have supported a CDC based approach to tobacco prevention and control.

Rep. Karen Karls: Could you tell us the number of physicians in ND that belong to the NDMA and what that percentage is?

Bruce Levi – Executive Director, NDMA: We have a little over 70% in ND that are members of the association which is a total of about 1400.

Chairman RaeAnn Kelsch: Questions? Support?

Jerry E. Jurena – President, NDHA: Testimony attachment 7.

Chairman RaeAnn Kelsch: We talked about that the tobacco trust funds are proven effective in smoking cessation programs. There was just a news report that says that ND spends more than the recommended CDC levels and we are only getting Cs when it comes to cessation. So where is the correlation? You throw more money at it and you don't get results? I'm just curious because you make the statement in your testimony.

Jerry E. Jurena – President, NDHA: The hospitals we have talked to said it is helping. You have acriteria that each patient that comes into the facility must receive a questionnaire on smoking and if they need help they have to provide that for smoking cessation. When I visit with them they say it is making a difference.

Chairman RaeAnn Kelsch: You don't have the statistics as to the number that receive that information and actually quit after they leave the hospital?

Jerry E. Jurena – President, NDHA: I do not.

Chairman RaeAnn Kelsch: Further support?

Rep. Bob Skarphol: As an appropriator when I look at the two scenarios, the need for dollars for tobacco cessation and the need for the expansion of the medical school, quite frankly when making the arguments in appropriations for either of those, if I were to come to my members of appropriations and ask for 106 million over 6 biennia, to fund the expansion of the medical school out of general funds, it would not happened. If there was a decision made to go forward with the expansion it would probably by a 95% chance be underfunded. I don't believe that is the best for the citizens for ND. It would encourage the medical school to be frugal in costs in order to maximize the amount of money they have on the back end to do exactly what it is they need to do to encourage doctors to stay in ND. As a side note, I had a conversation with a house member that we have another member that has a son that is a medical student in Wisconsin. He fully intended to come back but they became fond of Wisconsin. ND made an offer and Wisconsin said they would buy the

contract. For some people money is not an issue. The rural areas have a problem with getting the doctors they need. I would respectfully disagree with Dr. Wynne about the need to base the distribution of board members off population simply because that is not where the problem is. Rural ND needs better representation. If you read through the legislation and some of other policy changes, there are so many subtleties involved to accomplish what we are trying to accomplish. There needs to be more guidelines of what is expected, there needs to be more participation by stakeholders, and there needs to be some measures created and outcomes expected. We need to provide them dollars, thus the funding mechanism. There is concern whether we can withstand that expansion. In 6 years we are going to have to have some evidence of success in order to have support to cover the ongoing costs. We are talking 28 million dollars a biennium after 2011.

Rep. Corey Mock: To my understanding the tobacco settlement dollars are finite. They end and I believe there is an expiration of 2020. Is it the intention that after the revenue dries up, we will continue to fund this through the general fund or is there something else?

Rep. Bob Skarphol: We are going to have to see results, evidence of progress. The dollars being considered do run out in 2017. I'm not sure what the right policies are be them scholarships because if the hospital is willing to pay off the debt of a potential physician. I'm not sure what the best mechanism is. I believe the people involved have the wisdom to figure that out.

Rep. Phillip Mueller: I think we do need to do the UND expansion. The issue is how we fund it. I'll reference to a newspaper article on where we are at in the efforts to do a cessation program. The program in place received an A. There were two Cs. The one we got an F in was tax policy regarding cigarettes. Do you think we could move tax to 85 cents from 44 cents which would generate 34.7 million dollars on a biennium basis? Would that be enough money to do all we needed to do with the UND medical facility?

Rep. Bob Skarphol: I'm not certain that increasing tax will result in the revenues produces as you suggest.

Chairman RaeAnn Kelsch: Isn't it counter intuitive to tell people to quit smoking yet you raise the price to pay?

Rep. Bob Skarphol: All of us want people to stop smoking. It is bad for you. I think it would be much easier to convince my colleagues to fund the expansion of the medical school if we have a source of revenue that is guaranteed over the next three biennium.

Chairman RaeAnn Kelsch: We will go into opposition testimony.

Jeanie Prom – Executive Director, Center of Tobacco Prevention and Control Policy: Testimony attachment 8.

Rep. Brenda Heller: It looks like you have a lot of statistics. How much money is spent per person to prevent them from stating or to quit?

Jeanie Prom – Executive Director, Center of Tobacco Prevention and Control Policy: You could take state population and divide that by 9.3 million and you would have that. I know on the other side of that, we pay out almost a quarter of a million dollars in health care costs related to smoking alone. That is 564 dollars per family.

Rep. Brenda Heller: If you could come up with that number I would appreciate that.

Jeanie Prom – Executive Director, Center of Tobacco Prevention and Control Policy: I don't have that number.

Chairman RaeAnn Kelsch: How did you go about, do you have a calling base/data base that is utilized that you sent out notifications to people to make phone calls to people of the House Education Committee and if so how did you go about doing that?

Jeanie Prom – Executive Director, Center of Tobacco Prevention and Control Policy: We are an educational group and were not involved in that. We have made sure all our local public health units tried to connect with you.

Chairman RaeAnn Kelsch: I don't think we are hearing from the public health units themselves, we are hearing from the general public. Someone had to orchestrate it because every one of the statements on my machine was exactly the same. When I called back a couple of individuals they really didn't know what this bill was about. So I'm curious how that came about. The second question is what is your salary, how much are each of the advisory board members paid and how often do you meet?

Jeanie Prom – Executive Director, Center of Tobacco Prevention and Control Policy: Mine is about 65,000/year taken from appropriation. The board members are given 135/day stipend for the days they meet in an actual open meeting. The board meets every other month and executive committee meets every other week. I'd like to say also that we started out with no staff or no office in July of 2009, so there has been a need to meet often to set up.

Chairman RaeAnn Kelsch: If you can provide to the committee your budget and any of that information that you have that would be helpful.

Jeanie Prom – Executive Director, Center of Tobacco Prevention and Control Policy: Yes we can do that.

Rep. Mike Schatz: Has the Center for Tobacco Prevention and Control expended any public funds or resources to advocate for measure 3.

Jeanie Prom – Executive Director, Center of Tobacco Prevention and Control Policy: No. Measure 3 was passed before this organization was created.

Chairman RaeAnn Kelsch: What he is asking is, now you are an organization, have you spent any monies? Somehow you were contacting people to contact us so was there any money expended to do that?

Jeanie Prom – Executive Director, Center of Tobacco Prevention and Control Policy: No we provide education and we promote the policies. We did not spend money on lobbying.

Rep. Dennis Johnson: On page 2 you show the sale of cigarettes has gone down. Do you have charts to show sales of cigarettes on reservations?

Jeanie Prom – Executive Director, Center of Tobacco Prevention and Control Policy: I do not have a specific chart on that but I have been told that the costs of cigarettes there are about the same as off the reservation.

Rep. Dennis Johnson: You have no numbers saying if the sales are up or down?

Jeanie Prom – Executive Director, Center of Tobacco Prevention and Control Policy: No.

Vice Chair Lisa Meier: We had a bill that completely banned tobacco. Would you support that?

Jeanie Prom – Executive Director, Center of Tobacco Prevention and Control Policy: It is very complex to go with that because tobacco is a serious addiction. My short answer is that previously we have had one experience with prohibition of a substance that was legal and then became illegal that didn't go very well. It is something that needs carefully thought.

Rep. Brenda Heller: As a taxpayer in this state I am amazed on the amount of my tax dollars that go to get people to quit smoking. If tobacco was eliminated totally, which would be easier to do that than try to talk someone into quitting, I wonder how many jobs would be lost if you totally eliminated the use of tobacco? I am starting to wonder if we should criminalize smokers; if we should fine them for smoking.

Jeanie Prom – Executive Director, Center of Tobacco Prevention and Control Policy: Tobacco is an addition and we want to treat people with addictions so that has always been our public and private healthcare approach.

Rep. Brenda Heller: Do you have any idea how many jobs are directly related to tobacco prevention?

Jeanie Prom – Executive Director, Center of Tobacco Prevention and Control Policy: I don't have that exact number. It does take a certain workforce to get smokers to quit and it also takes certain workforce to educate and put in place the policies we know will help people from ever starting.

Chairman RaeAnn Kelsch: Questions? Next testimony in opposition/

Theresa Will: Testimony attachment 9.

Rep. Brenda Heller: In 2008 measure 3 was passed?

Theresa Will: Yes.

Rep. Brenda Heller: How many people in ND voted that year total of the eligible voters?

Theresa Will: I don't know the actual amount I do know 50% or more that did vote, voted in favor of measure 3.

Rep. Corey Mock: I think 65% of eligible turnout in 2008 if I'm not mistaken.

Rep. Phillip Mueller: You talked about what is happening in Barns County. If you could give the committee a sense of what is happening in other counties?

Theresa Will: The things in other counties are very similar.

Chairman RaeAnn Kelsch: Do you know where the phone calls and emails have come from? Some of the emails are not authorized emails because they are sent from school district email list serves or government list serves.

Theresa Will: I don't know exactly how that came about. I do know on my own personal time I sent some of those emails myself.

Chairman RaeAnn Kelsch: Somehow there is a list and just so you know some of those emails are not coming from appropriate places because they are coming from the government and school districts which is not allowed.

Rep. Mike Schatz: I have the attorney general's opinion here. It says thank you for your letter asking whether state agencies or entities may expend public funds or resources to advocate for or against valid measures. Consistent with the past opinions issued by this office, it is my opinion that a state agency or entity may not use state funds or resources to advocate for or against a ballot measure. That is in the constitution on statutory provision. So with that in mind you were talking earlier about the local health units using time to get people to call or email us. Is that something that you observed?

Theresa Will: I have not observed local public health units doing that on work time.

Chairman RaeAnn Kelsch: Committee members I can tell you the numbers. In 2008 there was a population of 639,715 people. Of that 496,906 people were eligible voters. The votes cast were 321,133. Of that, 53.94% were in support and 46.06% were opposed to measure 3.

Rep. Brenda Heller: I'm not sure if you can answer this but if we enact this bill as it is written now how many jobs will be lost?

Theresa Will: I don't have the total. I could give you a guess but I bet Jeanie has those numbers.

Chairman RaeAnn Kelsch: You are not opposed to adding more physicians in ND correct?

Theresa Will: Absolutely.

Javayne Oyloe: Testimony attachment 10.

Chairman RaeAnn Kelsch: Questions? Further testimony in opposition?

James Hues: Testimony attachment 11.

Chairman RaeAnn Kelsch: What is the percentage if I come from a family of smokers/smoker, what are the odds I'll become a smoker?

James Hues: There seems to be a predisposition genetically to addiction. It's very unusual to find someone that has an addiction that doesn't smoke. Nicotine washes out of the system about every 2 hours. I would say if you have 2 parents that smoke, you have smoked your whole life due to second hand smoke.

Chelsey Matter – Tobacco Cessation Coordinator, Fargo Cass Public Health: Testimony attachment 12.

Chairman RaeAnn Kelsch: Could the collaborative efforts have happened without the funding? Could have you collaborated with the hospital without funding?

Chelsey Matter – Tobacco Cessation Coordinator, Fargo Cass Public Health: No. We provide a lot of resources.

Chairman RaeAnn Kelsch: Which products?

Chelsey Matter – Tobacco Cessation Coordinator, Fargo Cass Public Health: The gum, patches and lozenges.

Chairman RaeAnn Kelsch: And you provide them free to hospitals?

Chelsey Matter – Tobacco Cessation Coordinator, Fargo Cass Public Health: Yes.

Rep. Mike Schatz: Do you do anything with the smokeless cigarettes? Do you have any research on that?

Chelsey Matter – Tobacco Cessation Coordinator, Fargo Cass Public Health: Currently that is under FDA for effectiveness. Right now and is not a recommended at this time.

Chairman RaeAnn Kelsch: Is your primary focus just the cessation? You yourself and you don't deal with any other addictions?

Chelsey Matter – Tobacco Cessation Coordinator, Fargo Cass Public Health: No.

Chairman RaeAnn Kelsch: Further testimony?

Joe DeMasi: Testimony attachment 13.

Chairman RaeAnn Kelsch: I was at a meeting last Thursday and I had smokers around me. Their comment to me was that they were not going to quit smoking no matter what. How do you feel about that?

Joe DeMasi: I don't believe everyone will quit smoking. In my lifetime we have completely changed the dynamic of smoking.

Rep. Brenda Heller: When your wife circulated the petition, how many pages was the original measure 3 and is that what she took around with her when she had it signed?

Joe DeMasi: The petition was on top and was just about a paragraph, and then signatures after that.

Rep. Brenda Heller: Did the people read all eight pages of the measure?

Joe DeMasi: In the ballot box there wasn't an eight page measure.

Chairman RaeAnn Kelsch: Thank you. Any other testimony in opposition?

Brenda Warren – Vice President of Legislation, Tobacco Free ND: Testimony attachment 14.

Chairman RaeAnn Kelsch: Questions?

Vice Chair Lisa Meier: How much does it cost to run your program per year?

Brenda Warren – Vice President of Legislation, Tobacco Free ND: I am a volunteer so I'd have to defer that to someone else.

Vice Chair Lisa Meier: If you could get us that information that would be great.

Brenda Warren – Vice President of Legislation, Tobacco Free ND: I will do that.

Chairman RaeAnn Kelsch: And it would be what you spend a year and where your monies come from. This is probably the information she would like to receive. I have one more question. Do you support the concept of more doctors in the state of ND in particular more rural doctors?

Brenda Warren – Vice President of Legislation, Tobacco Free ND: Yes.

Chairman RaeAnn Kelsch: Questions? We will close on HB 1353.

Submitted testimony: Attachments 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, and 26.

2011 HOUSE STANDING COMMITTEE MINUTES

House Education Committee
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Committee Clerk Signature

MINUTES:

Chairman RaeAnn Kelsch: We will open on HB 1353. I would like to explain the amendments. The gist of the amendments is there would be the voting member which would be two members of the senate, two members of the house, and eight individuals which must be located within the boundaries of separate human service center region. So four of the eight individuals must be located in communities having a population of fewer than 5,000, two must be located in communities having a population of at least 5,000 but having fewer than 30,000, and two of the eight individuals must be located in communities having a population of at least 30,000. Five of the eight individuals must be health care providers regularly involved with patient care. One must be a hospital or clinic administrator and one must be involved in the field of mental health. Two individuals would be appointed by the dean of the medical schools, one individual appointed by the State Board of Education, and the ex officio members would be director of the North Dakota Center for Rural Health and then the director of the Dept of Human Services. The rest of language is the language that was in the bill as originally introduced. The difference is that there is an appropriation. First of all let me say that if there was an interpretation by anyone in the audience that day that we held this hearing that people were uncivil or not kind, let me apologize for that first and foremost. Secondly what I will not apologize for is the fact that if we have a hearing and we need to get to the root of an issue we will question until we do that. Sometimes for some people that can be misconstrued as being rude rather than in a fact finding or accountability. Since there are some questions out across the state about accountability and making sure we understand exactly what the advisory committee is doing, I think some of the questioning was accountability. Perhaps it was perceived differently and if it was I will apologize as the chairman of this committee and will take full responsibility for the actions of my committee. The reason for the amendment is twofold. I had starting receiving emails from individuals who said please support measure three, but isn't there a way that you can do both. There may be a way to do both but we don't have the wherewithal in this committee to be able to figure out a way to do both in the time frames we have. We do have time to figure out how we can do both if we can send the bill to appropriations and have them continue to work on it. The point on my amendment and making sure there was an appropriation in here was that currently, and we are not sure on the numbers, I have one doc that states that the number of dollars that have been expended for the year were 3.5 million dollars, but the number I'm getting form Jeanie is different. Originally I looked at six million dollars making sure that the committee has the comfort of knowing that there is nine million there. It was a number closer to what Jeanie

thought they needed for the biennium. We all know that there are a couple things that can happen while in appropriations. Number one it gives them the time to find the full funding. Number two is it could come out with a do not pass. Number three it could come out that the medical school is funded completely and the advisory committee is funded back to the way they were originally. I was visiting a little bit with Jeanie about where some of the monies go and a great deal of that goes out in grants to the rural health districts.

Jeanie Promme – Executive Director, Center for Tobacco Prevention and Control: As far as cessation piece that is a small part of what we do. We spend about 8,000 dollars in every county. What we do with cessation is try to implement a systems change in local public health units as well as beyond local public health units so every client that uses tobacco is referred to the quit line.

Vice Chair Lisa Meier: I will move the amendment.

Rep. Mike Schatz: Second.

Chairman RaeAnn Kelsch: Discussion on the amendment?

Rep. Phillip Mueller: This bill doesn't provide money for the UND medical school facility and the operation. One of the things on page five where we take out reference to the CDC, I am wondering why we would do that. We have testimony about the makeup of the committee and it was suggested it become a bipartisan one and I see we are not doing that.

Chairman RaeAnn Kelsch: It certainly could be made bipartisan. I think when she rewrote it I was more concerned about adding some of the members back in. If that is the wishes of the committee then that could be in order. The appropriation would still be in there. Section seven is still in there.

Rep. Phillip Mueller: I agree I think the presenters about the bill did have concerns about the makeup of the committee, which it seems to me you've dealt with. Why do we not want to have the CDC reference in the language?

Chairman RaeAnn Kelsch: I didn't ask for that to be taken out. I missed that one. I'm not sure why that part was removed.

Rep. Joe Heilman: Because we are locking in the amount funded, the amount that the CDC is whatever they say and that their policy is supposed to reflect that number but we are locking in an appropriation of X. So I'm sure whoever drafted the amendment said if we are fixing the number then we can't try the CDC number anymore.

Chairman RaeAnn Kelsch: And that is what it would mean because of section seven, subsection four where it is a direct appropriation instead of the tobacco prevention and control fund. It is a direct appropriation of nine million dollars.

Rep. Phillip Mueller: The significance of July 1, 2011 to June 30, 2013, how does that compare to what is in code today? It seemed we were moving toward 2017.

Chairman RaeAnn Kelsch: What the amendment does is it appropriates the nine million dollars for this biennium. In a conversation I had it was conveyed to me that we should put twelve or fifteen million in there and put it out to 2015 so they would be guaranteed there would be a direct appropriation for two sessions. I'm not convinced we'll need that language at this point.

Rep. Phillip Mueller: How does it compare in terms of what we have in code today?

Chairman RaeAnn Kelsch: Here is what the appropriations are currently. The appropriation for 2009-2011 is 12.8 million dollars. So far they have spent 3.5 million so the balance for the biennium is 9.3 million. In talking to Jeanie she thought she would spend 80% or 10 million to be spent this biennium and they would hold 2 million to be used over the next biennium. Remember this is purely conceptual. If you'd be more comfortable putting 10 million in there then we can discuss that. We have this amendment on the table.

Rep. Bob Hunskor: If your amendment passes on this bill, the school of medicine would receive the health care funds in the state treasury and give nine million of that to the Tobacco Control and Advisory committee. Is that correct?

Chairman RaeAnn Kelsch: Yes for this biennium.

Rep. Joe Heilman: What would happen in subsequent biennia?

Chairman RaeAnn Kelsch: Here are a couple trains of thought. Number one is that this committee, because now they are a state agency, would continue to receive an annual appropriation. The other is it gets down to appropriations and it comes back with a different funding mechanism and then we are back to the way they are currently funded. Rep. Phillip Mueller did you want to add bipartisan or the language in that says one member of the minority and majority parties to the amendment?

Rep. Phillip Mueller: I would so move.

Rep. John Wall: Second.

Chairman RaeAnn Kelsch: We will try a voice vote.

Voice vote: Motion carries.

Rep. Mike Schatz: I have a question about the name. You have Tobacco Prevention and Control Executive Committee, you have center for Tobacco Prevent and Control Policy that the money go into an account for the Tobacco Prevention and Control Executive Committee or where does it go?

Chairman RaeAnn Kelsch: Yes.

Rep. Mike Schatz: What is the Center for Tobacco Prevention and Control Policy?

Chairman RaeAnn Kelsch: That will be the new committee that will work on potential policy and issues related to rural health.

Rep. Mike Schatz: Is there any way we can combine those and shorten them up?

Chairman RaeAnn Kelsch: Do you have any explanation for that Jeanie?

Jeanie Promme – Executive Director, Center for Tobacco Prevention and Control: The actual agency name is Tobacco Prevention and Control Executive Committee and that was determined by the attorney general. The actual office is a division of that committee and that is the center.

Chairman RaeAnn Kelsch: That is right. Her first statement was determined by a section of measure three. That was contained in there. We have an amended amendment before us.

Rep. Bob Hunskor: What happens for funding after 2013 for the advisory committee?

Chairman RaeAnn Kelsch: If the bill stays the way it is, it would be the recommendation of the legislature that they would continue to fund that agency. It would be a direct general fund appropriation. Is there a time when you think you will use less money?

Jeanie Promme – Executive Director, Center for Tobacco Prevention and Control: Yes when we feel we have made adequate progress.

Chairman RaeAnn Kelsch: Yes but there would always be a need for some sort of cessation program because you'll never get everyone to quit. If you got to a point where you were seeing the drops you wouldn't need as much of the monies?

Jeanie Promme – Executive Director, Center for Tobacco Prevention and Control: Yes.

Chairman RaeAnn Kelsch: At this point it would be like it was a general fund appropriation just like other state

Rep. Bob Hunskor: I thought I heard you say recommend. There is nothing guaranteed then after 2013. The way it is written now there could be nothing.

Chairman RaeAnn Kelsch: That is correct. We did talk if we should extend it out for four years. In my time that I have been on the legislature and we have started taking over appropriations for state agencies, I have never seen one not funded.

Rep. Bob Hunskor: Based on measure three again, I would have a hard time supporting this if in fact in 2013 there were no more funds.

Chairman RaeAnn Kelsch: When is the next round of settlement money coming in? 2013?

Jeanie Promme – Executive Director, Center for Tobacco Prevention and Control: Every April around the 15th.

Chairman RaeAnn Kelsch: How much is that next come coming in April?

Jeanie Promme – Executive Director, Center for Tobacco Prevention and Control: I don't have that with me.

Chairman RaeAnn Kelsch: The total settlement will be in excess of forty million. Your plan is that you would probably reserve some of the monies to hold over. Long term how many years do you expect the agency to be in operation. So if it's forty million and you're spending let's say about eight, you'd be out a little bit more than five years?

Jeanie Promme – Executive Director, Center for Tobacco Prevention and Control: Yes.

Chairman RaeAnn Kelsch: So if that was the case you'd be out a little bit?

Jeanie Promme – Executive Director, Center for Tobacco Prevention and Control: Actually we don't spend the whole eight. Some is the Department of Health and what they receive.

Chairman RaeAnn Kelsch: Rep. Bob Hunskor I probably didn't get your question answered but I have a question for you. Every session we leave here and we fund K-12 education but there is the possibility that the next session we won't fund it. We have an amendment amended adding in the bipartisan membership out of house and senate. We will try a roll call vote on the motion. Motion carries.

Voice vote: Amended amendment. Motion carries.

Rep. Corey Mock: I would like to request a roll call vote.

Roll call vote: 11 yeas, 4 nays, 0 absent. Motion carries.

Chairman RaeAnn Kelsch: Motion carries. What are the wishes of the committee?

Rep. Phillip Mueller: We have another amendment. A part of the concern with the bill is how do we fund UND medical school facility and provide operating funds. The amendment basically puts back in place the tobacco cessation and control program. The other part it does in fact raise tax on a pack of cigarettes by 44 cents to 85 cents which does supply 28.9 million dollars to handle the UND operating costs of the facility. The other question posed is we are going to tax cigarettes out of existence. That is one thing we got an F on by the CDC.

Chairman RaeAnn Kelsch: We have your amendment before us. Why all the removing?

Rep. Phillip Mueller: Basically it reinstates language that would have been part of the tobacco cessation legislation that we passed two years ago.

Chairman RaeAnn Kelsch: Questions?

Rep. Phillip Mueller: I move the amendment.

Chairman RaeAnn Kelsch: This would be a substitute motion?

Rep. Phillip Mueller: That is correct.

Rep. Corey Mock: Second.

Chairman RaeAnn Kelsch: Discussion.

Rep. Joe Heilman: Do you have any idea how much revenue that will attain?

Rep. Phillip Mueller: That in its inception will raise, for the biennium 2001-2013, 34.7 million dollars. Now that represents a 44% increase. That doesn't include the initial 41%. That will tell you it is everything the school of medicine needs.

Chairman RaeAnn Kelsch: Rep. Corey Mock did you want a roll call vote on this one as well?

Rep. Corey Mock: Yes I would appreciate a roll call vote.

Chairman RaeAnn Kelsch: This is a roll call vote on the proposed substitute amendment.

Rep. Joe Heilman: Do you know what the average price of a pack of cigarettes is?

Rep. Phillip Mueller: I'm afraid I do not. I would add that at eighty-five cents we are still below those states around us.

Rep. David Rust: I've never smoked. I see this tax as something that will probably affect those of lower income brackets. I know there are people from all kinds of economic status that do smoke but I think statistics show that it's probably with the people in the lower end of the income status that smoke. I guess I probably won't support the amendment on that because it is a tax on those who can afford it least.

Rep. Phillip Mueller: I would point out that there are all kinds of things attempting to get them to discontinue regardless of their income level. What we do know from pretty reliable statistics is it does have that affect of diminishing smoking. Maybe most importantly it has a very negative effect of young people in terms of their starting to smoke.

Vice Chair Lisa Meier: I'll call your question on the amendment.

Chairman RaeAnn Kelsch: The question has been called on Rep. Phillip Mueller's amendment. We will take a roll call vote.

Roll call vote: 5 yeas, 10 nays, 0 absent. Motion failed.

Chairman RaeAnn Kelsch: We have the bill as amended.

Rep. Corey Mock: I would like call for a minority report on the previously failed amendment.

Chairman RaeAnn Kelsch: You can ask for a minority report.

Rep. Corey Mock: My understanding is that on that amendment that failed, because there was a roll call Madame Chairman supported it, I don't know that you are technically eligible to support the minority report.

Chairman RaeAnn Kelsch: That is correct.

Rep. Mike Schatz: The amendment before that where voted one from each party in I would like a minority report on that as well.

Chairman RaeAnn Kelsch: We didn't take a roll call so I don't know if there were at least three others that voted no.

Rep. Mike Schatz: Can I make a motion to remove part of it? I believe the language says that the chairman of the legislative management will appoint. In there now we have one from a majority and minority party which I oppose. I would motion to amend to go back to original language.

Rep. Brenda Heller: Second.

Chairman RaeAnn Kelsch: Discussion?

Rep. Corey Mock: Just for clarification, a minority report is signed by at least three members of the committee who have voted against the majority report and note voted for or signed any other report. My understanding is if Rep. Mike Schatz wants a minority report.

Chairman RaeAnn Kelsch: No he is asking to amend the amendment back to the original language. He is asking to further amend. The committee doesn't need to vote on allowing you a minority report. We have the motion to go back to original language in the amendment. We will try a voice vote. The chair is in doubt. We will take a roll call vote.

Roll call vote: 6 yeas, 9 nays, 0 absent. Motion failed.

Rep. Brenda Heller: I motion do pass as amended and rerefer to appropriations.

Rep. Dennis Johnson: Second.

Chairman RaeAnn Kelsch: I want to remind you that this is not the last time you will see this bill. I do know that there is a concerted effort to look for funding. This buys some time

and gives some assurance at least right now until a source can be found or not found by the appropriations committee. If a source is not found this bill come up to the floor with a do not pass.

Rep. Dennis Johnson: That is why I seconded the bill is to move this forward and see if there is other sources of funding.

Chairman RaeAnn Kelsch: I think that certainly our constituents have a right to call us and let us know how they feel however, at this time it is a little premature to guess on what the outcome will be. I guess at this point the funding is still there for these tobacco programs and it is not in jeopardy at this point and I don't believe it will be.

Rep. Dennis Johnson: I always accept calls from constituents but I don't prefer when they are orchestrated and they say they don't really know what they were calling for.

Rep. John Wall: Unlike Rep. David Rust I want to share that I was addicted to nicotine for half of a century. I am compromised by this bill because I used quit line to quit. I don't think I would have without them. I hope in appropriations they can find a way to come up with secure funding for this. I think it is a very good program and their success rate is great.

Chairman RaeAnn Kelsch: We've sent bills out and thought I'm voting because I think the policy is good and it is an idea we need to keep alive, but we will have another chance to vote on this and if we are not satisfied at that time we will make that decision then.

Rep. David Rust: I think I'm a little torn here for a couple reasons. I think there are some very good parts of this bill but I'm also restricted with regards to the passage of measure three.

Rep. Joe Heilman: I do also support ongoing funding of the program. I think it's unfortunate that we have to choose between more med school extension and this. I'm inclined to support this just to get this up and see more constructive ways to fund this.

Rep. David Rust: I do have a question. What percentage of vote is needed in this committee on this?

Chairman RaeAnn Kelsch: We are a policy committee so it's just simple majority here. In order for these changes to happen we need a 2/3 vote on the floor. Regardless if we do it as a direct appropriation to the agency, it still would have to have a 2/3 vote. That is one of the reasons why I've asked and so have others to find a way to make sure both things happen. I trust that the appropriations are trying to find some sort of mechanism. It is keeping an idea alive. It is keeping alive the fact that we need more rural doctors; we are making sure there isn't a decrease in the funding right now, so there is money in there at least coming out of our committee.

Rep. Mark Sanford: I appreciate the advocacy in terms continuing the program. I'm going to vote for it to see what appropriations has to do with this. I think that gives the opportunity for both to happen.

Chairman RaeAnn Kelsch: Questions or comments? We will take a roll call vote on HB 1353 for a do pass as amended. The bill passes as amended and referred to appropriations. We will close on HB 1353.

10 YEAS 5 NAYS 0 ABSENT DO PASS as Amended and Rerefer to Appropriations CARRIER: Chairman RaeAnn Kelsch

2011 HOUSE STANDING COMMITTEE MINUTES

House Education Committee
Pioneer Room, State Capitol

HB 1353
02/21/11
14768

☐ Conference Committee

Committee Clerk Signature

MINUTES:

Chairman RaeAnn Kelsch: We will open the hearing on HB 1353. I'd like a motion to reconsider our actions whereby HB 1353 passed and bring it back to committee.

Rep. Dennis Johnson: Motion.

Rep. Mark Sanford: Second.

Chairman RaeAnn Kelsch: I have passed the amended version of the bill out. That is the version that we would use because it has already been amended. I'll explain the amendments to you. The amendments keep in the same revisions we had made to the advisory council. In other words the amendments keep in sections 1-6 and the rest of the bill is deleted. Could I get a motion on the amendments?

Rep. Mark Sanford: I move the amendments.

Rep. John Wall: Second.

Chairman RaeAnn Kelsch: The bill as it sits in front of you would only be sections 1-6. We will try a voice vote. Motion carries.

Voice vote: Motion carries.

Chairman RaeAnn Kelsch: We now have amended 1353 before us. What are the wishes of the committee?

Rep. Mark Sanford: I move a do pass as amended.

Rep. John Wall: Second.

Chairman RaeAnn Kelsch: Committee discussion? Seeing none we will take the roll on a do pass as amended motion on Rep. Brenda Heller 1353. We will close on HB 1353.

12 YEAS 2 NAY 1 ABSENT DO PASS as Amended
CARRIER: Chairman RaeAnn Kelsch

Date: 02-07-11
Roll Call Vote #: VOICE VOTE #1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1353

House EDUCATION Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By REP. MUELLER Seconded By REP. WALL

Representatives	Yes	No	Representatives	Yes	No
Chairman Kelsch			Rep. Hanson		
Vice Chairman Meier			Rep. Hunskor		
Rep. Heilman			Rep. Mock		
Rep. Heller			Rep. Mueller		
Rep. Johnson					
Rep. Karls					
Rep. Rohr					
Rep. Rust					
Rep. Sanford					
Rep. Schatz					
Rep. Wall					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

VOICE VOTE #1 TO AMEND THE AMENDMENT

MOTION CARRIES

11.0307.04002
Title.07000

Prepared by the Legislative Council staff for
Representative Mueller - Minority Report
January 28, 2011

√12
2/8/11
1of2

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1353

Page 1, line 1, replace "54-27-25" with "57-36-32"

Page 1, line 4, replace "the tobacco settlement trust fund" with "additional tax on the sale of cigarettes"

Page 1, line 4, remove "chapter"

Page 1, line 5, remove "23-42 and"

Page 1, line 5, remove "the tobacco"

Page 1, line 6, remove "prevention and control program and"

Page 1, line 6, after the semicolon insert "and"

Page 1, line 7, remove "; and to provide for a transfer"

Page 1, line 13, remove the overstrike over "~~educate~~"

Page 1, line 13, remove "increase the health care workforce in the state by educating"

Page 1, line 13, remove the underscored comma

Page 1, line 14, remove "with a focus on the education of primary care physicians,"

Page 1, line 14, after "professionals" insert ", increase the health care workforce in the state with a focus on the education of primary care physicians,"

Page 2, line 7, remove the overstrike over "~~(1)~~"

Page 2, line 7, remove the overstrike over "~~, one of whom must be from the majority party~~"

Page 2, remove the overstrike over line 8

Page 2, line 9, remove the overstrike over "~~of the legislative management;~~"

Page 2, line 10, remove the overstrike over "~~(2) Two~~"

Page 2, line 10, remove "two"

Page 2, line 10, remove the overstrike over "~~, one of whom must be~~"

Page 2, line 11, remove the overstrike over "~~from the majority party and one of whom must be from the minority party,~~"

Page 5, replace lines 16 through 31 with:

"**SECTION 4. AMENDMENT.** Section 57-36-32 of the North Dakota Century Code is amended and reenacted as follows:

57-36-32. Separate and additional tax on the sale of cigarettes - Collection - Allocation of revenue - Tax avoidance prohibited.

There is hereby levied and assessed and there shall be collected by the state tax commissioner and paid to the state treasurer, upon all cigarettes sold in this state,

an additional tax, separate and apart from all other taxes, of ~~seventeen~~thirty-seven and one-half mills on each cigarette, to be collected as existing taxes on cigarettes sold are, or hereafter may be, collected, by use of appropriate stamps and under similar accounting procedures. No person, firm, corporation, or limited liability company shall transport or bring or cause to be shipped into the state of North Dakota any cigarettes as provided herein, other than for delivery to wholesalers in this state, without first paying the tax thereon to the state tax commissioner. All of the moneys collected by the state treasurer under this section shall be credited to the state general fund."

Page 6, remove lines 1 through 28

Page 6, line 29, replace "Chapter 23-42 and section" with "Section"

Page 6, line 30, replace "are" with "is"

Page 7, line 2, replace "health care programs trust" with "general"

Page 7, line 8, replace "health care programs trust" with "general"

Page 7, remove lines 14 through 19

Renumber accordingly

11.0307.04006
Title.06000

Adopted by the Education Committee -
Majority Report
February 7, 2011

YR
2/8/11
10:05

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1353

Page 1, line 1, after "to" insert "create and enact three new sections to chapter 15-52 of the North Dakota Century Code, relating to the school of medicine and health sciences advisory council; to"

Page 1, line 1, after the third comma insert "23-42-01, 23-42-04, 23-42-05,"

Page 1, line 4, after the comma insert "the tobacco prevention and control program,"

Page 1, line 4, remove "to repeal chapter"

Page 1, remove line 5

Page 1, line 6, remove "prevention and control program and water development trust fund expenditures;"

Page 1, remove lines 17 through 24

Page 2, remove lines 1 through 31

Page 3, remove lines 1 through 30

Page 3, after line 30, insert:

"**SECTION 2. AMENDMENT.** Section 15-52-03 of the North Dakota Century Code is amended and reenacted as follows:

15-52-03. School of medicine and health sciences advisory council - Members~~, terms, meetings~~.

~~1.~~ To assure the proper coordination of the university of North Dakota school of medicine and health sciences with all other health activities of the state, a permanent school of medicine and health sciences advisory council is established to perform the duties in section 15-52-04.

~~2. The council consists of fifteen members:~~

~~a. (1) Two members of the senate, one of whom must be from the majority party and one of whom must be from the minority party, selected by the chairman of the legislative management; and~~

~~(2) Two members of the house of representatives, one of whom must be from the majority party and one of whom must be from the minority party, to be selected by the chairman of the legislative management;~~

~~b. One member selected by each of the following:~~

~~(1) The department of human services;~~

~~(2) The state board of higher education;~~

~~(3) The state department of health;~~

~~(4) The North Dakota medical association;~~

~~(5) The North Dakota healthcare association;~~

~~(6) The veterans administration hospital in Fargo; and~~

~~(7) The university of North Dakota center for rural health; and~~

~~c. Four members selected by the dean of the university of North Dakota school of medicine and health sciences, one from each of the four campuses of the school of medicine and health sciences with headquarters in Bismarck, Fargo, Grand Forks, and Minot.~~

~~3. The representatives named by the state agencies and boards must be selected to serve as members of the advisory council for periods of at least one year, but may not serve longer than their term of office on the public agency. The representatives from the North Dakota state medical association and the North Dakota healthcare association shall serve a term of three years or until their successors are named and qualified.~~

~~4. The council shall name its own chairman and the dean of the university of North Dakota school of medicine and health sciences shall serve as executive secretary of the council. The council shall meet not less than twice each year, and, from time to time, on its own motion or upon request of the university administration.~~ The council consists of:

1. The following voting members:

   a. (1) Two members of the senate, one of whom must be from the majority party and one of whom must be from the minority party, appointed by the chairman of the legislative management; and

   (2) Two members of the house of representatives, one of whom must be from the majority party and one of whom must be from the minority party, appointed by the chairman of the legislative management;

   b. Eight individuals appointed by the governor, provided:

   (1) Each of the eight individuals must be located within the boundaries of a separate human service center region;

   (2) (a) Four of the eight individuals must be located in communities having a population fewer than five thousand;

   (b) Two of the eight individuals must be located in communities having a population of at least five thousand but fewer than thirty thousand; and

   (c) Two of the eight individuals must be located in communities having a population of at least thirty thousand; and

   (3) (a) Five of the eight individuals must be health care providers regularly involved in patient care;

(b) One of the eight individuals must be a hospital or clinic administrator; and

(c) One of the eight individuals must be involved in the field of mental health;

c. Two individuals appointed by the dean of the university of North Dakota school of medicine and health sciences, provided each individual must represent a separate campus of the school of medicine and health sciences; and

d. One individual appointed by the state board of higher education; and

2. The following ex officio, nonvoting members:

a. The director of the university of North Dakota center for rural health; and

b. The director of the department of human services.

SECTION 3. A new section to chapter 15-52 of the North Dakota Century Code is created and enacted as follows:

Terms of office.

1. a. The term of office for each member of the legislative assembly appointed to the council is four years. A member of the legislative assembly may not serve more than two consecutive terms.

b. The term of office for each member appointed by the governor is three years, except that the terms of those members initially appointed must be staggered so that four serve for terms of two years and four serve for terms of three years. A member appointed by the governor may not serve more than two consecutive terms.

c. The term of office for each member appointed by the dean of the university of North Dakota school of medicine and health sciences is three years. A member appointed by the dean may not serve more than two consecutive terms.

2. Any member who is absent from more than three council meetings within a two-year period is precluded from further service on the council and a new member must be appointed, as provided for in section 15-52-03, to complete the term of office.

SECTION 4. A new section to chapter 15-52 of the North Dakota Century Code is created and enacted as follows:

Compensation.

1. Each member of the council, other than one who is employed by the state, is entitled to receive compensation in the amount of one hundred forty-eight dollars per day plus reimbursement for expenses as provided by law for state officers, if the member is attending meetings or participating in meetings through electronic means, or if the member is performing duties directed by the council.

2. Each member of the council who is employed by the state is entitled to receive reimbursement for expenses as provided by law for state officers, if the member is attending meetings or participating in meetings through electronic means, or if the member is performing duties directed by the council.

SECTION 5. A new section to chapter 15-52 of the North Dakota Century Code is created and enacted as follows:

Chairman - Meetings.

The council shall elect one member to serve as the chairman. The council must meet at least four times each year and may meet at its own call or at the request of university administration."

Page 5, after line 15, insert:

"**SECTION 7. 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 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.~~

SECTION 8. AMENDMENT. Section 23-42-04 of the North Dakota Century Code is amended and reenacted as follows:

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.

SECTION 9. 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 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.~~"

Page 6, line 23, after "of" insert "the comprehensive tobacco control advisory committee and the"

Page 6, remove lines 29 and 30

Page 7, after line 13, insert:

"**SECTION 13. APPROPRIATION - COMPREHENSIVE TOBACCO CONTROL ADVISORY COMMITTEE.** There is appropriated out of any moneys in the health care programs trust fund in the state treasury, not otherwise appropriated, the sum of $9,000,000, 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, for the biennium beginning July 1, 2011, and ending June 30, 2013."

Renumber accordingly

Date: 02-07-11
Roll Call Vote #: 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1353

House EDUCATION Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By VICE CHAIR MEIER Seconded By REP. SCHATZ

Representatives	Yes	No	Representatives	Yes	No
Chairman Kelsch	X		Rep. Hanson		X
Vice Chairman Meier	X		Rep. Hunskor		X
Rep. Heilman	X		Rep. Mock		X
Rep. Heller	X		Rep. Mueller		X
Rep. Johnson	X				
Rep. Karls	X				
Rep. Rohr	X				
Rep. Rust	X				
Rep. Sanford	X				
Rep. Schatz	X				
Rep. Wall	X				

Total (Yes) 11 No 4

Absent 0

Floor Assignment _____

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

ROLL CALL VOTE ON AMENDED AMENDMENT

MOTION CARRIES

Date: 02-07-11
Roll Call Vote #: 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1353

House EDUCATION Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By REP. MUELLER Seconded By REP. MOCK

Representatives	Yes	No	Representatives	Yes	No
Chairman Kelsch	X		Rep. Hanson	X	
Vice Chairman Meier		X	Rep. Hunskor	X	
Rep. Heilman		X	Rep. Mock	X	
Rep. Heller		X	Rep. Mueller	X	
Rep. Johnson		X			
Rep. Karls		X			
Rep. Rohr		X			
Rep. Rust		X			
Rep. Sanford		X			
Rep. Schatz		X			
Rep. Wall		X			

Total (Yes) 5 No 10

Absent 0

Floor Assignment _____

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

ROLL CALL VOTE ON SUBSTITUTE AMENDMENT

MOTION FAILS

Date: 02-07-11
Roll Call Vote #: 3

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1353

House EDUCATION Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By REP. SCHATZ Seconded By REP. HELLER

Representatives	Yes	No	Representatives	Yes	No
Chairman Kelsch	X		Rep. Hanson		X
Vice Chairman Meier		X	Rep. Hunskor		X
Rep. Heilman		X	Rep. Mock		X
Rep. Heller	X		Rep. Mueller		X
Rep. Johnson		X			
Rep. Karls	X				
Rep. Rohr	X				
Rep. Rust	X				
Rep. Sanford		X			
Rep. Schatz	X				
Rep. Wall		X			

Total (Yes) 6 No 9

Absent 0

Floor Assignment _____

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

MOTION TO GO BACK TO ORIGINAL LANGUAGE ON AMENDMENT.

MOTION FAILED

Date: 02-07-11
Roll Call Vote #: 4

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1353

House EDUCATION Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

☒ Rerefer to Appropriations ☐ Reconsider

Motion Made By REP. HELLER Seconded By REP. D. JOHNSON

Representatives	Yes	No	Representatives	Yes	No
Chairman Kelsch	X		Rep. Hanson		X
Vice Chairman Meier		X	Rep. Hunskor		X
Rep. Heilman	X		Rep. Mock		X
Rep. Heller	X		Rep. Mueller		X
Rep. Johnson	X				
Rep. Karls	X				
Rep. Rohr	X				
Rep. Rust	X				
Rep. Sanford	X				
Rep. Schatz	X				
Rep. Wall	X				

Total (Yes) 10 No 5

Absent 0

Floor Assignment CHAIRMAN KELSCH

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

Date: 02-21-01
Roll Call Vote #: VOICE VOTE 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1353

House EDUCATION Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By REP. D. JOHNSON Seconded By REP. SANFORD

Representatives	Yes	No	Representatives	Yes	No
Chairman Kelsch			Rep. Hanson		
Vice Chairman Meier			Rep. Hunskor		
Rep. Heilman			Rep. Mock		
Rep. Heller			Rep. Mueller		
Rep. Johnson					
Rep. Karls					
Rep. Rohr					
Rep. Rust					
Rep. Sanford					
Rep. Schatz					
Rep. Wall					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

VOICE VOTE - MOTION TO RECONSIDER HB 1353 AND BRING BACK TO COMMITTEE

MOTION CARRIES

11.0307.06002
Title.08000

Prepared by the Legislative Council staff for
Representative R. Kelsch
February 15, 2011

VR
2/21/11

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1353

Page 1, line 2, after the semicolon insert "and"

Page 1, line 3, after the second comma insert "and"

Page 1, line 3, remove ", 23-42-01, 23-42-04, 23-42-05, and"

Page 1, line 4, remove "54-27-25"

Page 1, line 4, remove "purpose of the school of medicine"

Page 1, line 5, remove "and health sciences, the"

Page 1, line 5, after the second "sciences" insert "and the school's"

Page 1, line 5, remove ", the school of"

Page 1, remove line 6

Page 1, line 7, remove "the tobacco settlement trust fund; to provide an appropriation; and to provide for a transfer"

Page 6, remove lines 21 through 30

Page 7, remove lines 1 through 31

Page 8, remove lines 1 through 31

Page 9, remove lines 1 through 30

Page 10, remove lines 1 and 2

Renumber accordingly

Date: 02-21-01
Roll Call Vote #: VOICE VOTE 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1353

House EDUCATION Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By REP. SANFORD Seconded By REP. WALL

Representatives	Yes	No	Representatives	Yes	No
Chairman Kelsch			Rep. Hanson		
Vice Chairman Meier			Rep. Hunskor		
Rep. Heilman			Rep. Mock		
Rep. Heller			Rep. Mueller		
Rep. Johnson					
Rep. Karls					
Rep. Rohr					
Rep. Rust					
Rep. Sanford					
Rep. Schatz					
Rep. Wall					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

VOICE VOTE 2 ON AMENDMENT

MOTION CARRIES

Date: 02-21-01
Roll Call Vote #:

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1353

House EDUCATION Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By REP. SANFORD Seconded By REP. WALL

Representatives	Yes	No	Representatives	Yes	No
Chairman Kelsch	X		Rep. Hanson		X
Vice Chairman Meier	X		Rep. Hunskor		X
Rep. Heilman	X		Rep. Mock		
Rep. Heller	X		Rep. Mueller	X	
Rep. Johnson	X				
Rep. Karls	X				
Rep. Rohr	X				
Rep. Rust	X				
Rep. Sanford	X				
Rep. Schatz	X				
Rep. Wall	X				

Total (Yes) 12 No 2

Absent 1 - REP. MOCK

Floor Assignment CHAIRMAN KELSCH

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

REPORT OF STANDING COMMITTEE (MAJORITY)

HB 1353: Education Committee (Rep. R. Kelsch, Chairman) A **MAJORITY** of your committee (Reps. R. Kelsch, Heller, Karls, Heilman, D. Johnson, Rohr, Rust, Sanford, Schatz, Wall) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee**.

Page 1, line 1, after "to" insert "create and enact three new sections to chapter 15-52 of the North Dakota Century Code, relating to the school of medicine and health sciences advisory council; to"

Page 1, line 1, after the third comma insert "23-42-01, 23-42-04, 23-42-05,"

Page 1, line 4, after the comma insert "the tobacco prevention and control program,"

Page 1, line 4, remove "to repeal chapter"

Page 1, remove line 5

Page 1, line 6, remove "prevention and control program and water development trust fund expenditures;"

Page 1, remove lines 17 through 24

Page 2, remove lines 1 through 31

Page 3, remove lines 1 through 30

Page 3, after line 30, insert:

"**SECTION 2. AMENDMENT.** Section 15-52-03 of the North Dakota Century Code is amended and reenacted as follows:

15-52-03. School of medicine and health sciences advisory council - Members~~, terms, meetings~~.

~~1.~~ To assure the proper coordination of the university of North Dakota school of medicine and health sciences with all other health activities of the state, a permanent school of medicine and health sciences advisory council is established to perform the duties in section 15-52-04.

~~2. The council consists of fifteen members:~~

~~a. (1) Two members of the senate, one of whom must be from the majority party and one of whom must be from the minority party, selected by the chairman of the legislative management; and~~

~~(2) Two members of the house of representatives, one of whom must be from the majority party and one of whom must be from the minority party, to be selected by the chairman of the legislative management;~~

~~b. One member selected by each of the following:~~

~~(1) The department of human services;~~

~~(2) The state board of higher education;~~

~~(3) The state department of health;~~

~~(4) The North Dakota medical association;~~

~~(5) The North Dakota healthcare association;~~

~~(6) The veterans administration hospital in Fargo; and~~

~~(7) The university of North Dakota center for rural health; and~~

~~c. Four members selected by the dean of the university of North Dakota school of medicine and health sciences, one from each of the four campuses of the school of medicine and health sciences with headquarters in Bismarck, Fargo, Grand Forks, and Minot.~~

~~3. The representatives named by the state agencies and boards must be selected to serve as members of the advisory council for periods of at least one year, but may not serve longer than their term of office on the public agency. The representatives from the North Dakota state medical association and the North Dakota healthcare association shall serve a term of three years or until their successors are named and qualified.~~

~~4. The council shall name its own chairman and the dean of the university of North Dakota school of medicine and health sciences shall serve as executive secretary of the council. The council shall meet not less than twice each year, and, from time to time, on its own motion or upon request of the university administration.~~ The council consists of:

1. The following voting members:

   a. (1) Two members of the senate, one of whom must be from the majority party and one of whom must be from the minority party, appointed by the chairman of the legislative management; and

   (2) Two members of the house of representatives, one of whom must be from the majority party and one of whom must be from the minority party, appointed by the chairman of the legislative management;

   b. Eight individuals appointed by the governor, provided:

   (1) Each of the eight individuals must be located within the boundaries of a separate human service center region;

   (2) (a) Four of the eight individuals must be located in communities having a population fewer than five thousand;

   (b) Two of the eight individuals must be located in communities having a population of at least five thousand but fewer than thirty thousand; and

   (c) Two of the eight individuals must be located in communities having a population of at least thirty thousand; and

   (3) (a) Five of the eight individuals must be health care providers regularly involved in patient care;

   (b) One of the eight individuals must be a hospital or clinic administrator; and

   (c) One of the eight individuals must be involved in the field of mental health;

   c. Two individuals appointed by the dean of the university of North Dakota school of medicine and health sciences, provided each individual must

represent a separate campus of the school of medicine and health sciences; and

d. One individual appointed by the state board of higher education; and

2. The following ex officio, nonvoting members:

a. The director of the university of North Dakota center for rural health; and

b. The director of the department of human services.

SECTION 3. A new section to chapter 15-52 of the North Dakota Century Code is created and enacted as follows:

Terms of office.

1. a. The term of office for each member of the legislative assembly appointed to the council is four years. A member of the legislative assembly may not serve more than two consecutive terms.

b. The term of office for each member appointed by the governor is three years, except that the terms of those members initially appointed must be staggered so that four serve for terms of two years and four serve for terms of three years. A member appointed by the governor may not serve more than two consecutive terms.

c. The term of office for each member appointed by the dean of the university of North Dakota school of medicine and health sciences is three years. A member appointed by the dean may not serve more than two consecutive terms.

2. Any member who is absent from more than three council meetings within a two-year period is precluded from further service on the council and a new member must be appointed, as provided for in section 15-52-03, to complete the term of office.

SECTION 4. A new section to chapter 15-52 of the North Dakota Century Code is created and enacted as follows:

Compensation.

1. Each member of the council, other than one who is employed by the state, is entitled to receive compensation in the amount of one hundred forty-eight dollars per day plus reimbursement for expenses as provided by law for state officers, if the member is attending meetings or participating in meetings through electronic means, or if the member is performing duties directed by the council.

2. Each member of the council who is employed by the state is entitled to receive reimbursement for expenses as provided by law for state officers, if the member is attending meetings or participating in meetings through electronic means, or if the member is performing duties directed by the council.

SECTION 5. A new section to chapter 15-52 of the North Dakota Century Code is created and enacted as follows:

Chairman - Meetings.

The council shall elect one member to serve as the chairman. The council must meet at least four times each year and may meet at its own call or at the request of university administration."

Page 5, after line 15, insert:

"**SECTION 7. 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 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.~~

SECTION 8. AMENDMENT. Section 23-42-04 of the North Dakota Century Code is amended and reenacted as follows:

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.

SECTION 9. 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 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.~~"

Page 6, line 23, after "of" insert "the comprehensive tobacco control advisory committee and the"

Page 6, remove lines 29 and 30

Page 7, after line 13, insert:

"**SECTION 13. APPROPRIATION - COMPREHENSIVE TOBACCO CONTROL ADVISORY COMMITTEE.** There is appropriated out of any moneys in the health care programs trust fund in the state treasury, not otherwise appropriated, the sum of $9,000,000, 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, for the biennium beginning July 1, 2011, and ending June 30, 2013."

Renumber accordingly

REPORT OF STANDING COMMITTEE (MINORITY)

HB 1353: Education Committee (Rep. R. Kelsch, Chairman) A **MINORITY** of your committee (Reps. Hanson, Hunskor, L. Meier, Mock, Mueller) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee**.

Page 1, line 1, replace "54-27-25" with "57-36-32"

Page 1, line 4, replace "the tobacco settlement trust fund" with "additional tax on the sale of cigarettes"

Page 1, line 4, remove "chapter"

Page 1, line 5, remove "23-42 and"

Page 1, line 5, remove "the tobacco"

Page 1, line 6, remove "prevention and control program and"

Page 1, line 6, after the semicolon insert "and"

Page 1, line 7, remove "; and to provide for a transfer"

Page 1, line 13, remove the overstrike over "~~educate~~"

Page 1, line 13, remove "increase the health care workforce in the state by educating"

Page 1, line 13, remove the underscored comma

Page 1, line 14, remove "with a focus on the education of primary care physicians,"

Page 1, line 14, after "professionals" insert ", increase the health care workforce in the state with a focus on the education of primary care physicians,"

Page 2, line 7, remove the overstrike over "~~(1)~~"

Page 2, line 7, remove the overstrike over "~~, one of whom must be from the majority party~~"

Page 2, remove the overstrike over line 8

Page 2, line 9, remove the overstrike over "~~of the legislative management;~~"

Page 2, line 10, remove the overstrike over "~~(2) Two~~"

Page 2, line 10, remove "two"

Page 2, line 10, remove the overstrike over "~~, one of whom must be~~"

Page 2, line 11, remove the overstrike over "~~from the majority party and one of whom must be from the minority party,~~"

Page 5, replace lines 16 through 31 with:

"**SECTION 4. AMENDMENT.** Section 57-36-32 of the North Dakota Century Code is amended and reenacted as follows:

57-36-32. Separate and additional tax on the sale of cigarettes - Collection - Allocation of revenue - Tax avoidance prohibited.

There is hereby levied and assessed and there shall be collected by the state tax commissioner and paid to the state treasurer, upon all cigarettes sold in this state,

an additional tax, separate and apart from all other taxes, of ~~seventeen~~thirty-seven and one-half mills on each cigarette, to be collected as existing taxes on cigarettes sold are, or hereafter may be, collected, by use of appropriate stamps and under similar accounting procedures. No person, firm, corporation, or limited liability company shall transport or bring or cause to be shipped into the state of North Dakota any cigarettes as provided herein, other than for delivery to wholesalers in this state, without first paying the tax thereon to the state tax commissioner. All of the moneys collected by the state treasurer under this section shall be credited to the state general fund."

Page 6, remove lines 1 through 28

Page 6, line 29, replace "Chapter 23-42 and section" with "Section"

Page 6, line 30, replace "are" with "is"

Page 7, line 2, replace "health care programs trust" with "general"

Page 7, line 8, replace "health care programs trust" with "general"

Page 7, remove lines 14 through 19

Renumber accordingly

The reports of the majority and the minority were placed on the Seventh order of business on the calendar for the succeeding legislative day.

REPORT OF STANDING COMMITTEE

HB 1353, as engrossed: Education Committee (Rep. R. Kelsch, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (12 YEAS, 2 NAYS, 1 ABSENT AND NOT VOTING). Engrossed HB 1353 was placed on the Sixth order on the calendar.

Page 1, line 2, after the semicolon insert "and"

Page 1, line 3, after the second comma insert "and"

Page 1, line 3, remove ", 23-42-01, 23-42-04, 23-42-05, and"

Page 1, line 4, remove "54-27-25"

Page 1, line 4, remove "purpose of the school of medicine"

Page 1, line 5, remove "and health sciences, the"

Page 1, line 5, after the second "sciences" insert "and the school's"

Page 1, line 5, remove ", the school of"

Page 1, remove line 6

Page 1, line 7, remove "the tobacco settlement trust fund; to provide an appropriation; and to provide for a transfer"

Page 6, remove lines 21 through 30

Page 7, remove lines 1 through 31

Page 8, remove lines 1 through 31

Page 9, remove lines 1 through 30

Page 10, remove lines 1 and 2

Renumber accordingly

2011 SENATE HUMAN SERVICES

HB 1353

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1353
March 14, 2011
15384

☐ Conference Committee

Explanation or reason for introduction of bill/resolution:

Relating to the school of medicine and health sciences advisory council

Minutes: *No written testimony*

Chairman Senator Lee opened the hearing for early testimony on HB 1353.

Representative Skarphol, District 32 thanked the committee and told them that he appreciated their willingness to take his early testimony. He said that Reengrossed HB 1353 is less controversial then the original bill because all the tobacco implications have been removed. He said the bill is simply a policy change with regard to the University of North Dakota School of medicine and health sciences. He explained the changes being made in HB 1358. He stated that Section 1, emphasizes the need for health care workforce in the state by educating physicians with a focus on the education of primary care physicians. The second page of the bill is a deletion of the existing membership advisory board and page three of the bill is the recommendation of the makeup of the new membership advisory board. The only concern in Dr. Winn's testimony in the House was the amount of representation of rural hospitals. The concern was too much emphasis on small and thought there should be more representation of larger hospitals. Representative Skarphol said that he understood the concern but disagreed because it is the rural part of North Dakota that needs to get more involved. He said page 4 of HB 1353 deals with member absentees and how they will be dealt with and compensation. Representative Skarphol said that the real substance of the bill is on pages 5 and 6 where it puts in place more recommendations for implementing strategies. He added that this is an effort to get the advisory board to become more innovative and to try some different things. He said that in section 6 they are asking annual reports go to the budget section, the legislative management and in addition, the reports go to the appropriations committees of the house and senate during each legislative session. This is an attempt to get more specificity into indicating what type of outcomes we have.

Senator Mathern said that a number of things that are promoted in this bill, he has already promoted as a member of the present advisory council. He asked Representative Skarphol if he ever attempted to be on the council and why he wasn't.

Representative Skarphol said that Leadership feels they have given him enough responsibility in other areas. He said that if Leadership asked he would consider it.

Discussion followed on appropriations and what we can do and can't do without appropriations.

Senator Lee suggested extending the emphasis beyond primary care physicians to include other health professionals.

Representative Skarphol didn't see a problem with extending the language in the bill to include physician assistance and other health professionals that they feel need to be there.

Senator Lee adjourned the hearing and stated that the hearing for HB 1353 will continue, March 15, 2011.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1353
March 15, 2011
15490

☐ Conference Committee

Explanation or reason for introduction of bill/resolution:

Minutes: *Committee Work/Action*

Vice Chairman Senator Uglem reopened the hearing on HB 1353 relating to the school of medicine and health sciences advisory council. He told those present that the prime sponsor, Representative Skarphol had given early testimony in support of HB 1353.

Senator Uglem asked for any additional testimony in support of HB 1353.

Senator Uglem asked for any opposing testimony.

Senator Mathern rose in opposition to HB 1353. He stated that he was on the advisory council for School of Medicine and Health Sciences for the University of North Dakota. He said the School of Medicine and Health Sciences is an agency of the entire state. He stated that now the legislature wants to change that mission. His hope is that the committee doesn't permit the legislature to micromanage an institution that has been responsive to the legislature. His second concern is how the board is chosen and how the appointments of board members are made.

Senator Dever asked if he was in opposition of increasing the number of physicians in the state, particularly in rural areas. He asked if he was in total opposition of the bill.

Senator Mathern replied that his concerns were with the changes in the mission statement and the advisory board makeup.

Senator Berry asked if he felt amendments could be added or if he thought the bill was lost. He commented on his perspective of the front page that it expanded instead of narrowing the focus. He said that it talked about the primary purpose is increasing health care workers and it does mention an emphasis on primary care physicians but it leaves in the wording, "other health professionals to enhance the quality of life in North Dakota".

Senator Mathern commented on his need to memorize the mission statement in any organization he has been a part of. He believes that by adding more words, the additional

words only become part of the detail. He added that yes, he said amendments could address his concerns. He stated that if the bill is about these issues and we have concerns, we should amend this bill in committee.

Senator Uglem asked if nurse practitioners get education at the school of medicine and health science.

Senator Mathern said yes, a wide range of courses are offered in the school of medicine and health sciences.

Senator Lee added that it would include medical technology, physical therapy, and a variety of other health sciences.

There was some discussion on restoring the original bill.

Senator Erbele, District 28 and a member of the advisory council said that he feels the advisory committee is excellent the way it is. If the makeup of the advisory committee is the only thing left in this bill, he feels it is currently working very well. He thinks there is good engagement by all members of the current committee. He also said that a mission statement should be something we can recite. Representative Erbele stated that he would stand against the bill in its current form.

Senator Lee said the only thing in the bill besides the advisory committee makeup is compensation and reports. The heart of the bill is the advisory council.

Senator Lee closed the public hearing on HB 1353.

Senator Lee opened discussion on HB 1352. (2:30 pm)

Discussion followed on if there was a need to try to salvage the bill.

Senator Dever moved a **Do Not Pass.**

Senator Uglem seconded the motion.

Roll call vote: 4-1-0. **Motion carried**.

Senator Uglem moved to reconsider.

Senator Mathern seconded.

Roll call vote: 5-0-0. **Reconsider action passed**.

Senator Dever moved a **Do Not Pass**.

Senator Uglem seconded the motion.

Roll call vote: 5-0-0. **Motion carried**. **Carrier is Senator Tim Mathern**.

Date: 3-15-11

Roll Call Vote # 1

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1353

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☒ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Sen. Dever Seconded By Sen. Uglem

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		Sen. Tim Mathern	✓	
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry		✓			

Total (Yes) 4 No 1

Absent 0

Floor Assignment Mathern

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

reconsidered

Date: 3-15-11

Roll Call Vote # 2

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1353

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☒ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☒ Reconsider

Motion Made By Sen. Uglem Seconded By Sen. Mathern

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		Sen. Tim Mathern	✓	
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment _____

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

Date: 3-15-11

Roll Call Vote # 3

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1353

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☑ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By **Sen.** Dever Seconded By **Sen.** Uglem

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		Sen. Tim Mathern	✓	
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment Senator Mathern

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

REPORT OF STANDING COMMITTEE

HB 1353, as reengrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO NOT PASS** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Reengrossed HB 1353 was placed on the Fourteenth order on the calendar.

2011 TESTIMONY

HB 1353

TESTIMONY ATTACHMENT 1

Madam Chair, House Education Committee members, for the record, my name is Rep. Bob Skarphol, District 2, Tioga and I am here in support of HB 1353.

Madam Chair and committee members, there are three primary issues in this proposal.

- The first issue is support of the UNDSMHS plan to produce a sufficient supply of graduates to address the Healthcare Workforce needs of our citizen over the long term. The UND School of Medicine and Health Sciences is proposing to increase the Medical School class size by 16 students, the Health sciences by 30 students, and the residency program by 17 slots. There is a substantial cost associated with that expansion. Dr. Josh Wynne , Dean of the UNDSMHS is here today to give you more specifics with regard to the background and the recommendation he has made to the State Board of Higher Education and to the Education and Environment Sub-section of House Appropriations.
- The second issue for this committee to consider is the changes being proposed with regard to how we

might enable this expansion to move forward and succeed. In HB 1353, there is a substantial change to the makeup and the responsibilities of the UNDSMHS Advisory Council. I, and the people who have worked with me on this proposal, sincerely believe this type of significant change is necessary to get the outcomes the citizens of North Dakota deserve over the long term. These structural and strategic changes are not out of any lack of respect for the current composition or the individuals involved. Nor is it the result of any distrust or lack of leadership on the part of the current Dean of UNDSMHS. It is about creating a system where the stakeholders are involved in setting the strategic priorities of the UNDSMHS and measuring the implementation to ensure the short and long term objectives are achieved and adaptations are made when necessary. Madam Chair, and committee members, I have spent upwards of four years educating myself in order to understand *this dilemma and it is truly disturbing to visit with* some the very people we expect to volunteer to educate our future Doctors and Healthcare Workforce. Some

are convinced that we cannot succeed because of the mistakes of the past. Others are so discouraged that it will be difficult to re-invigorate their enthusiasm to step forward again and help re-ignite the process needed to ensure an adequate Healthcare Workforce for North Dakota and especially rural North Dakota for the long term. Madam Chair, discussions of the last few days have convinced me that the Department of Human Services and the Department of Health need to be part of the Advisory Council. A discussion with one of these entities about the membership on the council suggests they are amenable to being ex-officio members. It would be my recommendation to your committee to make that addition to membership with the same provisions that apply to all other members.

- The third issue Madam Chair is the funding mechanism chosen to support the initiatives of the UNDSMHS which is designed to address the long term health service needs of our citizens. Examples would include the expansion of the class size, the opportunity to build the new building, and to

provide the needed and proper funding of scholarships and incentives to optimize and maximize the opportunity to be successful. The approximate cost of the additional operating expense over three biennia is $45 million. The suggested cost of the new building is $28 million. The total tobacco settlement dollars projected by Legislative Council through 2017 amount to $105.6 million. Madam Chair, quick math would tell you that this proposal would leave roughly $32 million available for other purposes. Madam Chair, we are recommending to the House Appropriations committee that the funding mechanism leave $1.5 million per year to the Community Health Trust Fund for the Department of Health to contract with an entity, or entities, for the purpose of advancing the effort on tobacco cessation. That would be $9 million in addition to the current efforts of state government. I believe Senator Lee is prepared to discuss current state efforts and I will leave the specifics on that issue to Senator Lee. That would leave approximately $23 million "excess" revenue for innovation and attempting to ensure the success

of this proposal. Our vision and recommendation to House Appropriations will be for a $15 million scholarship fund which would require a dollar for dollar match from outside sources before it could be utilized. If the match is not forthcoming, the money could not be used in that fashion, but must be carried forward to cover future on-going costs of operation to reduce future costs to the taxpayers of North Dakota. The remaining $8 million will also be given guidance as to utilization, but it will be flexible enough to allow for innovative ideas from the UNDSMHS Advisory Council to be attempted and reported as to results. Without risk there is often no reward.

Madam Chair, I would like to now yield the podium to Dr. Wynne to enable the committee to hear the specifics as to the necessity for and the reasoning behind the recommended expansion of the Medical School.

I would ask Madam Chair, that following Dr. Wynne's presentation, that I be allowed to discuss the recommended policy changes is HB 1353.

ATTACHMENT 2

HB 1353

North Dakota Constitution

ARTICLE III

POWERS RESERVED TO THE PEOPLE

Section 1. While the legislative power of this state shall be vested in a legislative assembly consisting of a senate and a house of representatives, the people reserve the power to propose and enact laws by the initiative, including the call for a constitutional convention; to approve or reject legislative Acts, or parts thereof, by the referendum; to propose and adopt constitutional amendments by the initiative; and to recall certain elected officials. This article is self-executing and all of its provisions are mandatory. Laws may be enacted to facilitate and safeguard, but not to hamper, restrict, or impair these powers.

Section 8. If a majority of votes cast upon an initiated or a referred measure are affirmative, it shall be deemed enacted. An initiated or referred measure which is approved shall become law thirty days after the election, and a referred measure which is rejected shall be void immediately. If conflicting measures are approved, the one receiving the highest number of affirmative votes shall be law. **A measure approved by the electors may not be repealed or amended by the legislative assembly for seven years from its effective date, except by a two-thirds vote of the members elected to each house.**

Prepared by the North Dakota Legislative Council staff

January 2011

ATTACHMENT 3

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 reviewed.

Since the original survey in the 2001-02 interim, similar surveys have been conducted each interim.

In January 2011 state agencies were requested to update the information for the 2009-11 biennium and to provide information for the 2011-13 biennium based on the executive recommendation. The table below summarizes 2009-11 biennium and 2011-13 biennium programs and related funding.

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2009-11 Biennium Amount and Funding Source for Each Program			2011-13 Executive Budget Amount and Funding Source for Each Program			Detail of 2011-13 Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
	General Fund	Federal And Special Funds	Total Funds	General Fund	Federal and Special Funds	Total Funds			
State Department of Health Statewide tobacco cessation for primary prevention, including city/county/state programs and the quitline/quitnet and tobacco surveillance		$3,510,495	$3,510,495		$3,510,495	$3,510,495	Community health trust fund	Funds support a statewide toll-free telephone and web-based counseling and tobacco surveillance.	One hundred percent of funds will support the tobacco cessation statewide and tobacco surveillance.
Tobacco prevention and control for disease control and prevention		2,678,616	2,678,616		2,651,900	2,651,900	Centers for Disease Control and Prevention (CDC)	Restricted to tobacco control, cannot be used for direct services or cessation services	One hundred percent for tobacco control
Rape prevention and education		231,452	231,452		231,500	231,500	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.
Enhancing and Making Programs and Outcomes Work to End Rape (EMPOWER)		200,000	200,000		200,000	200,000	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 youth prevention	$250,000	465,000	715,000	$991,493		991,493	Substance Abuse and Mental Health Services Administration (SAMHSA)	Federal 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		474,315	474,315		440,727	440,727	CDC	Funds to be used for the provision of family planning, medical, laboratory, and counseling services	All family planning clients provide a health history which includes tobacco, alcohol, and drug use, along with other risky behaviors, such as unprotected sex, etc. Counseling and referral is provided as appropriate. The total identified represents the funding for risky behavior which is 15 percent of funds received.
Abstinence education		172,990	172,990		172,995	172,995	Health Resources and Services Administration (HRSA)	Funds are used to target youth and young adults aged 12 to 29.	Funds are used for curriculum and program development that focus on abstinence, which includes other risk reduction topics, including tobacco, alcohol, and other drugs.

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2009-11 Biennium Amount and Funding Source for Each Program			2011-13 Executive Budget Amount and Funding Source for Each Program			Detail of 2011-13 Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
	General Fund	Federal And Special Funds	Total Funds	General Fund	Federal and Special Funds	Total Funds			
Child passenger safety	41,280	457,220	498,500	47,472	464,428	511,900	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
Comprehensive sexually transmitted disease prevention systems and human immunodeficiency virus (AIDS) prevention programs		2,050,395	2,050,395		1,966,583	1,966,583	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 percent to 5 percent of total funds are directed to risky behavior, recognition, reduction. Funding is generally used for disease intervention.
Total - State Department of Health	$291,280	$10,240,483	[redacted]	$1,038,965	$9,638,628	$10,677,593			
Attorney General									
Residential substance abuse treatment for state prisoners grant program - A passthrough grant for addiction treatment of state prisoners		$93,500	$93,500		$320,000	$320,000	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	$2,900,000		2,900,000	$3,207,565		3,207,565			Ninety-five percent of the funds are used for operations. Five percent of the funds are used for equipment.
Midwest high-intensity drug trafficking area - Federal cooperative agreement aimed at the growing methamphetamine problem in this region		1,064,184	1,064,184		1,253,939	1,253,939	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)		1,656,378	1,656,378		1,652,213	1,652,213	Justice assistance grant program - United States Department of Justice	A certain percentage of the funds must be provided to local jurisdictions. There are six legislative purpose areas for which the funds can be used.	Administrative funds (approximately 10 percent) are used to manage grant contracts to ensure compliance with federal regulations. Grant funds (approximately 90 percent) are awarded to local units of government, state agencies, and Indian tribes for criminal justice purposes.

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2009-11 Biennium Amount and Funding Source for Each Program			2011-13 Executive Budget Amount and Funding Source for Each Program			Detail of 2011-13 Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
	General Fund	Federal And Special Funds	Total Funds	General Fund	Federal and Special Funds	Total Funds			
Justice assistance grant (American Recovery and Reinvestment Act of 2009)		1,581,168	1,581,168		1,413,189	1,413,189	Justice assistance grant program - American Recovery and Reinvestment Act of 2009) United States Department of Justice	A certain percentage of the funds must be provided to local jurisdictions. There are six legislative purpose areas for which the funds can be used.	Administrative funds (approximately 10 percent) are used to manage grant contracts to ensure compliance with federal regulations. Grant funds (approximately 90 percent) are awarded to local units of government, state agencies, and Indian tribes for criminal justice purposes.
Community Oriented Policing Services methamphetamine initiative		831,328	831,328		795,000	795,000	Office of Community Oriented Policing Services, 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.
24/7 sobriety program	329,826		329,826	329,826		329,826			Support efforts to remove intoxicated drivers from the road and improve their ability to succeed in their treatment choices
Total - Attorney General	$3,229,826	$5,226,558	[illegible]	$3,537,391	$5,434,341	$8,971,732			
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.	$5,039,555		$5,039,555	$5,480,256		$5,480,256			Contract for transitional services and staff to manage the program
Tompkins Rehabilitation and Correction Center - The center 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.	4,764,035		4,764,035	5,409,447		5,409,447			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.	1,151,476		1,151,476	2,585,047		2,585,047			Contract for transitional services

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2009-11 Biennium Amount and Funding Source for Each Program			2011-13 Executive Budget Amount and Funding Source for Each Program			Detail of 2011-13 Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
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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.	1,625,813		1,625,813	1,677,723		1,677,723			Contract for treatment services
Male inmate transition - This program provides transitional services to male inmates located in Fargo.	1,842,362		1,842,362	1,049,185		1,049,185			Contract for transitional services
Alternatives to incarceration - Programs providing alternatives to incarceration, including halfway houses, treatment, detention, and other correctional programming	3,292,535		3,292,535	2,454,034		2,454,034			Contract for services
Faith-based programming	760,475		760,475	843,150		843,150			Contract for housing
Institutional treatment - Adult - Conduct assessments and provide treatment for inmates with addiction and mental health issues	4,549,114		4,549,114	5,098,686		5,098,686			Salaries - Approximately $4.8 million Operating expenses - Approximately $200,000
Institutional treatment - Juvenile - Conduct assessments and provide treatment for inmates with addiction and mental health issues	1,286,151	$519,375	1,805,526	2,329,763		2,329,763			Salaries - Approximately $2.2 million Operating expenses - Approximately $100,000
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.	1,487,039	2,548,561	4,035,600	1,511,900	$2,483,609	3,995,509	Federal funds OJJDP - $1.25 million Title IV-E/XIX reimbursements - $630,000 Title V - $100,000 JAIBG - $500,000	Majority of funding must be provided to local units of government.	Grants and contracts
Total - Department of Corrections and Rehabilitation	$25,798,555	$3,067,936	[redacted]	$28,439,191	$2,483,609	$30,922,800			

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2009-11 Biennium Amount and Funding Source for Each Program			2011-13 Executive Budget Amount and Funding Source for Each Program			Detail of 2011-13 Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
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Department of Human Services									
Treatment services provided at the human service centers	$13,606,437	$11,457,677	$25,064,114	$16,041,611	$10,532,646	$26,574,257	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.
							Social Service block grant - $486,249	None	
							Medical assistance - $1,506,091	None	
							Collections - $1,528,739	None	
Treatment services provided at the State Hospital	2,739,315	6,245,121	8,984,436	2,358,068	7,555,204	9,913,272	Insurance collections and payments from the Department of Corrections and Rehabilitation - $7,555,204	Payments from the Department of Corrections and Rehabilitation need to be spent toward the population placed by the Department of Corrections and Rehabilitation.	To provide inpatient treatment of substance abuse, including alcohol and other drugs Program operations - $9,913,272/100 percent
Prevention related to substance abuse	194,445	2,290,124	2,484,569	181,899	6,912,413	7,094,312	SAPT block grant - $2,495,702	Funds are limited to primary prevention activities only. See additional restrictions for the SAPT grant under the first item listed for the Department of Human Services	Four tribal contracted prevention coordinators and six role-based prevention specialists to provide prevention efforts throughout the state and tribal areas. This framework for the substance abuse prevention program provides strategic consultation, training, and research-based tools. The Prevention Resource and Media Center (PRMC) provides free materials and resources regarding substance use prevention, provides clearinghouse materials, and designs media kits and messaging support for prevention efforts across the state. Program operations - $1,782,201/25 percent Grants/contracts - $5,312,111/75 percent
							Strategic prevention framework state incentive grant (SPFSIG) - $4,416,711	Funds are limited to primary prevention activities only.	

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2009-11 Biennium Amount and Funding Source for Each Program			2011-13 Executive Budget Amount and Funding Source for Each Program			Detail of 2011-13 Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
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Methamphetamine and other substance abuse residential treatment services	1,481,573		1,481,573	1,594,025		1,594,025			To provide residential treatment for methamphetamine and other substance users Grants/contracts - $1,594,025/100 percent
Program and policy related to substance abuse	474,392	849,397	1,323,789	454,220	939,424	1,393,644	SAPT block grant - $939,424	See additional restrictions for the SAPT grant under the first item listed for the Department of Human Services.	To provide technical assistance, training, regulatory oversight and outcome management policy to treatment and prevention fields Program operations - $1,393,644/100 percent
Data information systems		250,000	250,000		387,542	387,542	Drug and alcohol services information system - $387,542	Must be used to develop and implement substance abuse data management	Contracts - $387,542/100 percent
Governor's fund for safe and drug-free schools and communities - Funding is provided as grants to high-risk areas for enforcement and education. (This funding source will end when the current grant is expended.)		596,340	596,340		240,000	240,000	Safe and drug-free schools and communities grant - $240,000	At least 10 percent of this amount shall be used for law enforcement education partnerships. No more than 5 percent of this amount can be used for administrative costs.	Baseline community readiness surveys completed in regions and in the process of completion in tribal areas of the state. Community-focused best practices using community readiness survey results are being implemented. Prevention conference held in collaboration with the Department of Public Instruction and the State Department of Health. Grants/contracts - $240,000/100 percent
State Epidemiological Outcomes Workgroup (SEOW)		250,261	250,261		221,572	221,572	SEOW - $221,572	Must be used for prevention strategies	Utilizing the principles of outcome-based prevention, the SEOW is designed to create and oversee the strategic use of data to inform and guide substance abuse prevention policy and program development in North Dakota. Through ongoing and integrated data analyses, the SEOW will implement SAMHSA's strategic prevention framework. The five-step process includes: • Assessment of population needs, resources, and readiness; • Mobilization and capacity building to address needs; • Prevention planning and funding decisions; • Implementation of evidence-based prevention programs; and • Evaluation of key outcomes and plan adjustments. State- and county-level epidemiological profiles are being produced that summarize alcohol, tobacco, and other drug consumption patterns and associated consequences across the lifespan. Grants/contracts - $221,572/100 percent

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2009-11 Biennium Amount and Funding Source for Each Program			2011-13 Executive Budget Amount and Funding Source for Each Program			Detail of 2011-13 Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
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United States Department of Justice underage drinking grant - Funding is used for underage drinking prevention programs.		696,644	696,644		712,872	712,872	Enforcing underage drinking laws grant. This program is funded by the United States Department of Justice - $712,872.	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.	Alcohol beverage server campaign in collaboration with Attorney General's office; in collaboration with Highway Patrol, compliance checks, shoulder taps, point-of-purchase operations, and party patrols are implemented; overtime hours for officers in order to provide the enforcement activities listed; Youth Advisory Board activities; and safety and educational messaging and media involvement Operating expenses - $65,072/9 percent Grants/contracts - $647,800/91 percent
Total - Department of Human Services	$18,496,162	$22,635,564	[redacted]	$20,629,823	$27,501,673	$48,131,496			
Department of Transportation Impaired driving prevention program							National Highway Traffic Safety Administration (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.	
SCRAM units for Attorney General's 24/7 sobriety program					$100,000	$100,000	NHTSA Section 410		Funds to the Attorney General's Office to purchase SCRAM units for continuous alcohol monitoring of driving under the influence (DUI) offenders participating in the Attorney General's 24/7 sobriety program
Parents listen, educate, and discuss (LEAD)		$150,000	$150,000		150,000	150,000	NHTSA Section 410		Parents LEAD educates parents to talk about alcohol with their children. The North Dakota Department of Transportation Traffic Safety Office, the Department of Human Services Division of Mental Health and Substance Abuse, and the North Dakota Higher Education Consortium for Substance Abuse are program partners for program expansion and outreach.
Impaired driving enforcement programs		700,000	700,000		1,000,000	1,000,000	NHTSA Section 410		Conduct saturation patrols, sobriety checkpoints, alcohol sales compliance checkers, and server training

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2009-11 Biennium Amount and Funding Source for Each Program			2011-13 Executive Budget Amount and Funding Source for Each Program			Detail of 2011-13 Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
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Digital surveillance equipment to law enforcement		400,000	400,000		500,000	500,000	NHTSA Section 410		Funds for law enforcement to purchase digital surveillance cameras to facilitate DUI arrests and adjudication
Alcohol content testing equipment		400,000	400,000		400,000	400,000	NHTSA Section 410		Funds to the Attorney General's state toxicology office to purchase alcohol testing equipment for use by law enforcement and in the laboratory
Traffic safety resource prosecutor		200,000	200,000		400,000	400,000	NHTSA Section 410		Funds to contract with an attorney to provide training, technical assistance, and resources to prosecutors and other court personnel to facilitate the prosecution of DUIs
Media/public information and education		750,000	750,000		900,000	900,000	NHSTA Section 410		Paid media and coordination of earned media for impaired driving prevention. Includes electronic (television and radio) and print (billboard, indoor ads, etc.) media, editorials, public service announcements, appearances on news shows, etc., to promote various enforcement and social norms messages.
Community traffic safety program (formerly safe communities)		900,000	900,000		500,000	500,000	NHTSA Section 402		Community traffic safety programs are community programs that address data-driven traffic safety issues (primarily seatbelt use and impaired driving) through various public information and education programs. This amount reflects about half of total program funding. Community traffic safety programs allocate about half of their time to impaired driving prevention and seatbelt use respectively.
Total - Department of Transportation		$3,500,000	[redacted]		$3,950,000	$3,950,000			
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		$2,277,356	$2,277,356				Department of Education	For prevention- and education-related activities in kindergarten through grade 12 in the areas of drugs, alcohol, tobacco, weapons, violence, bullying, school climate, and crisis management Not to be used for treatment or entertainment	Ninety-three percent of funds are allocated to local education agencies based on a formula of poverty and enrollment. The remaining 7 percent is for the state education agency to use for technical assistance (4 percent) and administration (3 percent).
21st century community learning centers provide funds for out-of-school programs, including academics, enhanced academic programming, arts, and recreation		11,085,426	11,085,426		$11,879,992	$11,879,992	Department of Education	Must serve students attending school with 40 percent or greater free and reduced lunches, must have a community-based partner, and must occur when school is not in session	Ninety-five percent to local education agencies and community-based organizations Three percent for technical assistance Two percent for administration
Total - Department of Public Instruction		$13,362,782	[redacted]		$11,879,992	$11,879,992			

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2009-11 Biennium Amount and Funding Source for Each Program			2011-13 Executive Budget Amount and Funding Source for Each Program			Detail of 2011-13 Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
	General Fund	Federal And Special Funds	Total Funds	General Fund	Federal and Special Funds	Total Funds			
Judicial branch Juvenile drug court	$780,000		$780,000	$780,000		$780,000		N/A	Ninety percent of the funds are used for alcohol and drug testing and analysis and monitoring. Ten percent of the funds are used for education and training.
Total - Judicial branch	$780,000		$780,000	$780,000		$780,000			
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		$600,000	$600,000		$2,000,000	$2,000,000	Department of Defense through the National Guard Bureau	To be used only for drug interdiction and substance abuse	Will be used for working with law enforcement and community based organizations. Will also be used for drug testing, prevention, and awareness for members of the North Dakota National Guard.
Total - National Guard		$600,000	$600,000		$2,000,000	$2,000,000			
North Dakota Higher Education Consortium for Substance Abuse Prevention Coordinates and supports the prevention efforts and programs of each North Dakota University System campus	$222,487		$222,487	$233,310		$233,310	N/A	N/A	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	$222,487		$222,487	$233,310		$233,310			
Tobacco Prevention and Control Executive Committee Tobacco prevention and control		$12,882,000	$12,882,000		$12,922,614	$12,922,614	Special funds - Tobacco Master Settlement Agreement strategic contribution funds	Funds must be used for evidence-based programs according to the CDC *Best Practices for Comprehensive Tobacco Control Programs*	Funds will be used to support state and community tobacco prevention and control interventions, cessation interventions, health communications, surveillance and evaluation, and administration and management of the programs. Grants and contracts will be awarded to local public health units, special population groups with disparities in tobacco use, and partner groups that can advance the goals of the state plan.
Total - Tobacco Prevention and Control Executive Committee		$12,882,000	$12,882,000		$12,922,614	$12,922,614			

Alcohol, Drug, Tobacco, and Other Risk-Associated Behavior Programs	2009-11 Biennium Amount and Funding Source for Each Program			2011-13 Executive Budget Amount and Funding Source for Each Program			Detail of 2011-13 Sources of Federal and Special Funds	Restrictions on Uses of Funds	Anticipated Uses of Funds
	General Fund	Federal And Special Funds	Total Funds	General Fund	Federal and Special Funds	Total Funds			
Indian Affairs Council									
Indian youth leadership program	$40,000		$40,000	$60,000		$60,000			Facilitate a camp for Indian youth, meeting academic requisites, to learn and enhance leadership skills and provide opportunities that will advance spiritual, intellectual, emotional, and physical attributes
Suicide prevention and education				$100,000		$100,000			Suicide prevention and education for Indian youth through the development of a crisis team to react to suicide threats and coordination with tribal agencies currently assisting with crisis
Total - Indian Affairs Council	$40,000		$40,000	$160,000		$160,000			

Funding Summary By Agency

	2009-11 Biennium Legislative Appropriations			2011-13 Biennium Executive Budget			2011-13 Executive Budget Increase (Decrease) to 2009-11 Legislative Appropriations		
	General Fund	Federal and Special Funds	Total Funds	General Fund	Federal or Special Funds	Total Funds	General Fund	Federal or Special Funds	Total Funds
State Department of Health	$291,280	$10,240,483	$10,531,763	$1,038,965	$9,638,628	$10,677,593	$747,685	($601,855)	$145,830
Attorney General's office	3,229,826	5,226,558	8,456,384	3,537,391	5,434,341	8,971,732	307,565	207,783	515,348
Department of Corrections and Rehabilitation	25,798,555	3,067,936	28,866,491	28,439,191	2,483,809	30,922,800	2,640,636	(584,327)	2,056,309
Department of Human Services	18,496,162	22,635,564	41,131,726	20,629,823	27,501,673	48,131,496	2,133,661	4,866,109	6,999,770
Department of Transportation		3,500,000	3,500,000		3,950,000	3,950,000		450,000	450,000
Department of Public Instruction		13,362,782	13,362,782		11,879,992	11,879,992		(1,482,790)	(1,482,790)
Judicial branch	780,000		780,000	780,000		780,000			
National Guard		600,000	600,000		2,000,000	2,000,000		1,400,000	1,400,000
North Dakota Higher Education Consortium for Substance Abuse Prevention	222,487		222,487	233,310		233,310	10,823		10,823
Tobacco Prevention and Control Executive Committee		12,882,000	12,882,000		12,922,614	12,922,614		40,614	40,614
Indian Affairs Commission	40,000		40,000	160,000		160,000	120,000		120,000
Total - All agencies	$48,858,310	$71,515,323	$120,373,633	$54,818,680	$75,810,857	$130,629,537	$5,960,370	$4,295,534	$10,255,904

ANALYSIS OF THE TOBACCO PREVE ON AND CONTROL TRUST FUND FOR THE 2009-11 AND 11-13 BIENNIUMS (REFLECTING THE 2011-13 BIENNIUM EXECUTIVE BUDGET RECOMMENDATION)

	2009-11 Biennium		2011-13 Biennium	
Beginning balance		$14,107,486		$25,901,527
Add estimated revenues				
Tobacco settlement revenues collected to date	$12,274,393[1]		$0	
Projected tobacco settlement revenues	12,274,393[2]		24,548,786[2]	
Investment income	127,255		213,616	
Total estimated revenues		24,676,041[3]		24,762,402[3]
Total available		$38,783,527		$50,663,929
Less estimated expenditures and transfers				
Tobacco Prevention and Control Executive Committee expenditures	$12,882,000[4]		$12,922,614[4]	
Total estimated expenditures and transfers		12,882,000		12,922,614
Estimated ending balance		$25,901,527		$37,741,315

[1]As of November 2010, the state has received two tobacco settlement payments totaling $33,091,258 for the 2009-11 biennium, of which $20,816,865 was deposited in the tobacco settlement trust fund and $12,274,393 was deposited in the tobacco prevention and control trust fund. To date, the state has received total tobacco settlement collections of $305,399,942, including $265,189,809 under subsection IX(c)(1) of the Master Settlement Agreement and $40,210,133 under subsection IX(c)(2) of the Master Settlement Agreement. Of the $305,399,942, $278,987,538 has been deposited into the tobacco settlement trust fund and $26,412,404 has been deposited into the tobacco prevention and control trust fund.

[2]Estimated payments for the remainder of the 2009-11 biennium and the 2011-13 biennium are based on the amount received in 2010.

[3]Initiated measure No. 3 approved in the November 2008 general election provides that 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. The 2009 Legislative Assembly in Section 39 of House Bill No. 1015 provided that any money deposited in the water development trust fund under North Dakota Century Code Section 54-27-25 may only be spent pursuant to legislative appropriation.

The measure will result in the following estimated allocation of the revised estimated collections of the tobacco settlement payments through 2025:

	Actual and Estimated Total Tobacco Settlement Proceeds	Actual and Estimated Payments Under Master Settlement Agreement Subsection IX(c)(2) Deposited in the Tobacco Prevention and Control Trust Fund	Allocation of Actual and Estimated Payments Under Master Settlement Agreement Subsection IX(c)(1)		
			Common Schools Trust Fund	Water Development Trust Fund	Community Health Trust Fund
Actual payment April 2008	$36.4 million	N/A	$16.4 million	$16.4 million	$3.6 million
Actual payment April 2009	39.2 million	$14.1 million	11.3 million	11.3 million	2.5 million
Estimated 2009-11 biennium	68.3 million	24.5 million	19.7 million	19.7 million	4.4 million
Estimated 2011-13 biennium	70.3 million	24.5 million	20.6 million	20.6 million	4.6 million
Estimated 2013-15 biennium	73.7 million	27.6 million	20.8 million	20.8 million	4.5 million
Estimated 2015-17 biennium	73.7 million	27.6 million	20.8 million	20.8 million	4.5 million
Estimated 2017-19 biennium	52.5 million	N/A	23.6 million	23.6 million	5.3 million
Estimated 2019-21 biennium	52.5 million	N/A	23.6 million	23.6 million	5.3 million
Estimated 2021-23 biennium	52.5 million	N/A	23.6 million	23.6 million	5.3 million
Estimated 2023-25 biennium	52.5 million	N/A	23.6 million	23.6 million	5.3 million
Total	$571.6 million	$118.3 million	$204.0 million	$204.0 million	$45.3 million

TESTIMONY ATTACHMENT 4

Good morning, Madame Chair Kelsch, members of the Committee, and guests. My name is Dr. Joshua Wynne, and I am proud to be the Vice President for Health Affairs at the University of North Dakota, and Dean of *your* School of Medicine and Health Sciences. I come before you today representing not only UND's School of Medicine and Health Sciences, but also the School's Advisory Council. The School of Medicine and Health Sciences Advisory Council is a legislatively mandated board of 15 individuals composed of a broad array of health care representatives from across the state. The current membership of the Council is shown on the front page of our handout. The Council met last Thursday and discussed House Bill 1353. My testimony today reflects that discussion and the Advisory Council's attendant recommendations. Because the major focus of the bill deals with funding the proposed expansion of the School of Medicine and Health Sciences, I'd like to begin by outlining that pressing issue.

Currently and especially in the future, addressing the imbalance between an increasing demand for health services and an inadequate supply of providers will require a coordinated approach to moderate demand (that is, reduce the need for acute and chronic care services), increase the supply of providers, and improve the efficiency of the healthcare delivery system within the state.

There are five factors that challenge North Dakota's healthcare delivery system now and especially in the future. Together, they will necessitate more physician and health science providers in North Dakota, and better healthcare delivery systems. The first of these is rural depopulation, with movement of North Dakotans from the prairie to the cities. The second is out-migration, with loss of mainly the young from North Dakota to elsewhere in the country. The third is partially the result of rural depopulation and out-migration, which results in an increasingly elderly and often rural population. In fact, we are and will continue to be one of the oldest states in the country, second only to Florida in the percentage of people 85 and older. Fourth is low population density, with about 10 people per square mile, but thankfully a far cry from the 10,000 people per square mile in the District of Columbia! But such a low population density engenders unique challenges for healthcare delivery in the state. The last factor involved in North Dakota's healthcare work force shortage is localized population growth that is occurring mainly in the cities, and in the counties around the oil patch.

North Dakota currently has a paradox regarding its healthcare work force—shortages in the midst of plenty. The size of the current physician work force in North Dakota is at or better than national norms for most specialties, including all of the primary care disciplines, although some of this apparent adequacy is distorted by an inflow of additional patients from surrounding states. But there is a significant physician distribution problem, with the predominance of providers located in the urban areas, and a shortage especially of primary care providers in the rural areas.

The current shortage of physicians is only going to increase as the population ages and grows modestly in the future. Based on highly conservative estimates, North Dakota will need an additional 210 physicians at a minimum over the next 15 years.

The shortage of healthcare workers will not be limited to physicians. An entire cadre of additional healthcare providers including nurses, physical and occupational therapists, physician assistants and

others, will be needed to ensure that effective, efficient, and appropriate healthcare is available to all North Dakotans.

To address the widening gap between the need for healthcare and the supply of providers, the School of Medicine and Health Sciences Advisory Council, in conjunction with the School, has developed a comprehensive healthcare plan for North Dakota. The plan has been reviewed, vetted, and approved by multiple stakeholders. The plan calls for reducing disease through the initiation of a master of public health degree program as a combined undertaking by UND and NDSU, and the institution of a geriatrics training program. The plan provides for an expanded healthcare workforce through two approaches: most importantly, greater retention of our graduates, but coupled with an expansion of the medical school, health sciences, and residency classes. To accommodate the attendant growth, a new building also will be required. The proposed budget required for full implementation of the healthcare plan is shown on the reverse side of our handout.

This plan has a high likelihood of success, although it does not come with a guarantee. But enhanced efforts at increased retention of graduating students will cost little and should provide about 40% of the anticipated physician shortfall. Increased class size will provide another 40%. The remaining 20% of needed providers will be recruited as new physician and health sciences faculty members who will not only teach the expanded student and resident classes but also provide direct patient care.

House Bill 1353 provides critically needed support to get this workforce plan up and running soon. Because the bill amends and re-enacts various sections of the North Dakota Century Code, I would like to address in sequence each of the major changes or additions contained within the bill. The bill contains four major issues related to the School of Medicine and Health Sciences and its Advisory Council, and proposes a funding mechanism for implementation of the class size expansion.

The first issue relates to the purpose of the School. Last legislative session, this very same purpose statement was redefined as a consequence of a performance audit that was begun in 2007. The redefinition ensured proper alignment between legislative intent and the stated mission of the School. This amendment serves to further redefine the primary purpose of the School, with an increased emphasis on expanding the healthcare workforce in the state, especially with primary care providers. Because this is the cornerstone of our healthcare workforce plan, the School and Advisory Council are supportive of this amendment. As was discussed last week when the School's budget proposal was considered by the House Appropriations Education and Environment Division, the School and Advisory Council have advanced a plan to deal with the looming healthcare workforce shortage that we are already experiencing. And as I just commented, the healthcare workforce plan calls for increased retention of our medical and health science graduates, along with an expansion of class size. The expansion of the class size is to be focused on providing more primary care providers for the state, so the proposed amendment re-defining the primary purpose of the School is congruent with the aspirations of the School.

The second major amendment relates to the composition of the School's Advisory Council. The membership of the Advisory Council is defined by the Century Code. Currently, the Council is composed

of 15 members, with four legislators, four members selected by the Dean of the School of Medicine and Health Sciences with one from each of the four campuses of the School, and the remaining seven members selected by a variety of organizations, including the Center for Rural Health, the State Board of Higher Education and others. The proposed change would increase the membership to 16, change the selection process of the legislators, and substitute individuals representing small, medium and large sized communities for the representation from state organizations. We are strongly supportive of the goal of achieving a better balance on the Advisory Council with more grass roots representation, and more representation from the rural areas of the state. I believe that the current composition of the Council *is* skewed toward organizational representation, with insufficient direct community input. Thus, the proposed change is a welcome one, and a good starting point. Here are the adjustments that we'd suggest: First, our experience on the Advisory Council is that the current legislative representation is ideal. We have two members from the majority party, and two from the minority, with two from the House and two from the Senate. This has ensured that the deliberations of the Council are as apolitical as possible, and encourage practical problem-solving. We would propose, therefore, that *no* change be made in the current method of selection of the legislators on the Council. Second, we would propose that the community representative selection reflect the population demographics of the state. As an aside, I don't believe that the definition of small, medium, and large-sized communities contained in Section 15-52-03 (2) of House Bill 1353 reflects current terminology and metrics. Be that as it may, the proposed language stipulates that six of eight community member representatives come from small or medium-sized communities, but those communities, depending on how they are defined, made up only a little over half of the population of the state. We would suggest that the community representation mirror and reflect the population in the various communities around the state. Last, we believe that there is merit in having *some* representation from healthcare organizations that represent the *entire* state. Representation from the State Department of Health, the State Department of Human Services, the North Dakota Medical Association, and the North Dakota Hospital Association would be highly desirable. We would propose that representatives from these four organizations be added to the list. In order to keep the Council size from becoming overly large, we would also propose that those additions are balanced by limiting the community-based representatives to four, and allocating them based solely in proportion to population.

The third major change amends the duties of the Council to expand the list of recipients of the report that the Council is required to submit. We welcome that change, and, in fact, have already complied with this proposed amendment. The first iteration of the Council's report, entitled *Health Issues for the State of North Dakota*, has already been distributed to all members of the House and Senate. House Bill 1353 also expands the scope of the required elements in the report to include workforce issues, and changes the frequency of reporting to annually. Suffice it to say that we are strongly supportive of these amendments as well.

The fourth major amendment authorizes the expansion of the School of Medicine and Health Sciences class size, and the construction of a health sciences building needed to accommodate the attendant increase in students, faculty, and staff. The School is strongly supportive of the effort to increase the number of graduates as part of an approach to mitigate the present and future healthcare workforce

storages in the state. Increasing the class size is one of four components of our plan to optimize the delivery of healthcare in North Dakota, along with efforts to reduce disease burden, increase retention of graduates for practice in North Dakota, and improve the efficiency, inclusiveness, and scope of our healthcare delivery system. We feel that all four components—reducing disease burden, increasing retention, increasing class size, and improving health system efficiency—will be needed to evolve a truly optimal healthcare delivery system for North Dakota.

Part of reducing disease burden involves reducing preventable diseases, and part involves better management of chronic diseases. Our plan supports this approach, with the initiation of a master of public health degree program in conjunction with NDSU, and a geriatrics training program for North Dakota. Further, the School supports efforts to mitigate those modifiable behaviors that lead to disease, disability, and death. The School is actively involved in prevention efforts, especially our Center for Health Promotion and Prevention Research or CHPPR, which was was originally established in 2001. The mission of the Center is to assist public health and other community partners in reducing and preventing chronic diseases caused by unhealthy behaviors. It has been estimated that around 40 percent of deaths are potentially preventable through changes in behavior. Cigarette smoking, obesity, inadequately treated high blood pressure, improper diet, and sedentary lifestyle are major contributors to premature mortality. We are supportive of approaches to mitigate these various risk factors that have been demonstrated to be effective and productive. For some, like obesity, the demonstrated benefits of most approaches unfortunately are of at best modest benefit when viewed over the long-term. Thus, we need to develop even more effective and useful interventions to help motivated patients modify these risky behaviors, and the School is ready and able to contribute to those efforts.

The last issue regarding House Bill 1353 relates to the funding source, and that, in our view, clearly is a legislative issue. One challenge for the legislature is to identify the appropriate source of funding for meritorious projects such as ours. The second—and more difficult—task is to prioritize spending priorities when there are multiple competing meritorious projects. I would assume that the final arbiter in those situations is the return on investment of the various projects—that is, which project returns the most value to the people of North Dakota for a given investment. But those value judgments are best left to the legislative deliberative process.

In summary, the School of Medicine and Health Sciences and its Advisory Council are supportive of the four elements of House Bill 1353 as I've outlined, with a request for consideration of the modifications that we've proposed. We defer to the legislature as to the most appropriate method for funding the necessary expansion of the School class size and the attendant additional building, but urge the legislature to find a way.

Thank you.

SCHOOL OF MEDICINE & HEALTH SCIENCES
ADVISORY COUNCIL

The University of North Dakota
School of Medicine
& Health Sciences

Mr. David Molmen, Chair
Northeast Campus Representative

Dr. Tom Arnold
Southwest Campus Representative

Dr. John Baird
Southeast Campus Representative

Representative Stacey Dahl
ND House of Representatives

Dr. Terry Dwelle
State Health Department Representative

Senator Robert Erbele
ND Senate

Dr. J. Brian Hancock
Veterans Affairs Medical Center

Dr. Gary Hart
UND Center for Rural Health

Mr. John Kutch
Northwest Campus Representative

Senator Tim Mathern
ND Senate

Representative Ralph Metcalf
North Dakota House of Representatives

Ms. Carol Olson
State Department of Human Services

Dr. Shari Orser
ND Medical Association Representative

Mr. Grant Shaft
State Board of Higher Education Representative

Vacant
State Healthcare Association Representative

Dr. Joshua Wynne
Executive Secretary

UND School of Medicine & Health Sciences
HEALTHCARE WORKFORCE INITIATIVE
(Original Proposal)

RECURRING COSTS

- Offer new Master's degree in Public Health in conjunction with NDSU (3.0 faculty, two staff and operating costs).
Cost: $1,215,219 (IN the Executive Budget)

- Expanded training in Geriatrics (2 faculty positions and related operating costs).
Cost: $1,151,810 (IN the Executive Budget)

- Increase the number of medical students per year by 16 for four years starting 7/1/12.
Cost: $857,600 (NOT IN the Executive Budget)

- Increase the number of resident positions per year by 17 for three years starting 7/1/12.
Cost: $2,170,806 (NOT IN the Executive Budget)

- Increase the number of health sciences students per year by 30 for three years starting 7/1/12.
Cost: $402,000 (NOT IN the Executive Budget)

Total: $5,797,435 ($3,430,406 ADD to Executive Budget)

ONE TIME COST

- Construct a new Health Science facility addition for program expansion. (132,000 sq.Ft., four stories)
Cost: $28.89 million (NOT IN the Executive Budget)

The University of North Dakota
School of Medicine & Health Sciences
www.med.und.edu

ATTACHMENT 5

Altru Health System

The University of North Dakota
School of Medicine & Health Sciences

Grand Forks Family Medicine Residency
A part of Altru Health System

CEO's and Providers of Critical Access Hospitals in North Dakota

It is clear to all of us that access to medical care in rural states like North Dakota is approaching a state of crisis, if not already there. The recruitment of health care providers to our state has always been a challenge, and is becoming more difficult even in the larger cities. The reasons for these difficulties are multi-factorial and therefore the problem cannot be solved by any one entity. It will require the concerted concentrated effort of many entities working together. Altru Health System, University of North Dakota School of Medicine and Health Sciences and the Grand Forks Family Medicine Residency all realize that to ensure access to health care in our state, it is absolutely critical to maintain the viability of our critical access hospitals. If ever there was a time to think outside the box, it is now. We are asking you, the CEOs and providers at these hospitals, for suggestions of additional things that we might do together, as we train future physicians, which may benefit the rural community, increase the viability of the rural hospitals, and enhance the recruitment and retention of physicians in North Dakota. Suggestions regarding anything, from admission policies to residency training, will be welcomed.

Will you please take a few moments to write down three to five suggestions on the enclosed sheet that we might do that you feel might increase the likelihood of attaining the above goals? Thank you for your input and time.

Casey Ryan, MD
President
Altru Health System

Joshua Wynne, MD, MBA, MPH
Vice President for Health Affairs & Dean
School of Medicine & Health Sciences

Greg Greek, MD
Program Director
GF Family Medicine Residency

Dave Molmen
Chief Executive Officer
Altru Health System

Gwen Halaas, MD, MBA
Senior Associate Dean
Academic and Faculty Affairs
School of Medicine & Health Sciences

Larry Halvorson, MD
Assistant Program Director
GF Family Medicine Residency

Please comment:

1.

2.

3.

4.

5.

Name _____ *(optional)*

Please return comments in the enclosed postage-paid envelope.

Thank you.

Rural Resident Rotations (14)

- Allow residents to rotate into rural areas for training
- Increase rural rotations
- Mandatory clinic rotations at critical access hospitals could be implemented
- Require rural rotations (possibly supported through grants too? Or state monies) in residency in addition to continuing medical school required rural rotation. (Rapid City residency has required rural rotation in residency)
- More time by medical students and residents in rural facilities
- Educate residents about critical access requirements
- Make a rural rotation mandatory at the end of second and third years
- Offer (mandatory?) rural rotations during each year of residency
- Rural rotations for FM residents in all programs. One month in first year, one month in second year
- Mandate a rural rotation at a critical access hospital site
- Residents should spend two to four week rotations at rural sites, under guidance from local physicians. The residency clinics should have a mechanism for covering for those gone a few weeks. Work with those communities to perhaps offer some "moonlighting"/financial reward
- Encourage residents to choose rural rotations for a month, 2nd and 3rd year in order to expose residents to rural practices
- Develop a rural fellowship program
- Rural Rotations: The residencies headquartered in the larger communities are most necessary. I am sure it would be very difficult to have a residency program in a small rural community. However, the use of rural rotations and ROME placements should be increased if possible. We don't want a student that has intentions of being a cardiologist having to rotate through our medical system as such would only increase your and our cost. But, if we could encourage more students to pick primary care occupations, we would be most pleased to host these students

Scholarships with Obligation (14)

- Scholarships for medical students that will obligate them to accept time committed placements to practice in rural ND
- Inducement on the back end of training like loan repayment subsidies if they stay in the state. State funded?
- Scholarships/stipends for medical students who commit to rural primary care; individual towns/counties could sponsor them
- Loan forgiveness or model similar to public health model to have students sign up for loan forgiveness if practices in ND in primary care
- More National Health Service Corporation loan repayment money to the state
- Full scholarship for medical school with stipend in family medicine residency to stay in state/rural location (7 year commitment)
- Aggressive state loan repayment/recruitment bones for new MD's to state
- Increase legislative support for medical student retention recruitment to state of ND

- Increase legislative support of loan forgiveness or payback to those serving in rural setting
- Tuition forgiveness to those who go into family practice and serve two-three years in a rural setting
- Seek an income tax break or property tax break for a short period of time for newly recruited providers
- Academic loan program with forgiveness of debt if person returns to work her for set period of time
- Student loan forgiveness with graduated amounts based on population/remote setting i.e., not 15 miles from Fargo or Grand Forks
- Continue work with state legislature to provide increased incentives to MD's, DO's, FNP and PA's to practice in a rural setting

Practice/Educational Networking (7)

- Foster educational days where a hospital will plan a day of education dedicated to rural topics
- Develop a support system such as continued grand rounds where through the BTWAN rural physicians can present difficult cases for review
- Develop a rural-urban voluntary mentoring system for new physicians
- Tertiary and rural facilities must increase collaborative efforts to ensure the availability of primary care services in the rural areas
- Recognize a trauma unit (state) with capacity to handle any trauma case from any center
- Central radiology link where x-rays can be easily transferred digitally among all the centers, easy access
- Promote medical home concept so all patients, esp. those with ANY chronic medical condition will identify their primary care provider. This will promote coordination of care among specialists and overall reduce cost of medical care

Dedicated Class Slots with Commitment (7)

- Set aside slots for practitioners willing to commit to rural communities
- More medical students in the first approach. There are thousands of qualified young men and women who are turned away each year. Many of them are interested in Family Medicine, but may not be of the same (MCAT, GPA, and other criteria relied on so heavily by US Medical Schools). Medical schools could be looking at a primary care or family medicine tracking program at the time of admission or shortly after admission for a percentage of students. Those programs would have the advantage of utilizing programs within the state and could conceivably retain more of these students. There could be other incentives, particularly with regards to loan repayments, etc. Other medical schools such as the University of Minnesota Duluth has some of these programs in place and are working on others.
- Allotting five spots to "track" into residencies offered in ND – surgery, medicine, family practice. The idea is to select students committed to ND residency

- Give preference to pre-med students a) from towns less than 15,000 population; b) who indicate a preference to enter primary care
- Fund 10 spots for each medical school class for rural medicine – if they get spot they go to rural place. Accept only person from ND with city population <5000
- Talk to medical school admission committee as they continue to admit most commonly from large cities with students from cities most likely go back to cities. We have not been able to recruit physicians from ND medical school. Students raised in small town are more likely to return there and the Admissions Committee is doing a poor job of accepting students predisposed to small town life
- Recruit people who want to live in a rural environment so they are more likely to stay. Begging or using each incentives may work short term but not long range

Reimbursement Equity (7)

- Use a base plus incentive for pay to FP's. While the recent cms RVU values changed to try to up family practice pay - all that happened was each clinic's "conversion factor" changed to keep everyone the same
- Support conditions (and salary) so that single specialities can be converted to at least minimum of two specialist groupings
- I have been screaming this for over 10 years from my small family practice in Harvey. Since it is now affecting the larger cities, it is getting some notice and concern. The problem has been critical for years and it will still take many years to start rectifying the deficit of family physicians and primary care physicians. I am speaking not of the Urgent Care, Walk-in or Shopping Center physicians, but of those who work in critical access hospitals in rural communities. Those physicians who provide hospital care, ER coverage along with full clinic duties. They work the longest hours and receive the least pay and reimbursement. I have been recruiting for over two years. Now that the larger cities are feeling the shortage, I have a difficult time competing with the large salaries and signing bonuses that are offered. I will not belabor the point, only to say that the critical access hospital and practices are becoming endangered. So what are the answers?
- Student debt burden real and perceived entices students to specialize; therefore pay equity would go a long way towards rebalancing primary vs specialty care choices
- There is a very large inequity of reimbursement for family physicians. I don't know how to approach this, but the Federal government (i.e., Medicare) bears some responsibility as do insurance companies
- Work with federal government, state, insurance companies to increase salary/income for primary care providers. This would also involve reduced payment for specialty care providers
- Reasonable payment: I realize this is out of your direct control but it is such a major element in the retention of physicians to ND that it must be championed. (a) overpaid sub-specialty procedures: The high side of unreasonable payment is for procedures performed by sub-specialty physicians. Doing such procedures, they can be paid $20,000 per hour while family physicians are paid

less than 10% of that amount. This results in most new grads wanting to become sub-specialty physicians make the "really big bucks". The overpayment has to be reduced/eliminated. (b) under-reimbursed frontier areas: CMS and other payers need to recognize that frontier areas with their very low population density just cannot produce the same volumes of work as higher population areas. There has to be payment mechanisms that reward providers for providing patient access in remote areas. The federal government does this for Alaska but we have some areas nearly as remote in the lower 48 states, particularly in the upper Midwest.

Rural Student Rotations (6)

- Increase rural rotations
- Mandatory clinic rotations at critical access hospitals could be implemented
- More time by medical students and residents in rural facilities
- Consider putting the Family Medicine rotation back at the beginning of 4th year. The experience of having completed all of the 3rd year rotations makes a huge difference. At a minimum, start the FP rotations January of 3rd year at the earliest
- Our best recruiting tool has been the ROME program – having 3rd year med students train her from July – Feb. Exposure to opportunities in rural medicine while students are still deciding their futures is key
- Establish teaching tracks in rural locations

Social Networking (5)

- Do a dinner or meeting with rural physicians from around the state of residents to mingle
- Annual Christmas party in rural area with rural docs/residents
- For residents that like outdoors - fishing, hunting, etc. setup trips for some clinic time and then "fun" - in rural areas
- Allow rural provider, C-suite hospital employees to present to medical students on the joys of rural practice in North Dakota
- Each residency should offer a "homecoming" once or twice a year, so we could network with the current residents. Something fun, like a weekend UND hockey series, for anyone interested, even if we had to buy our own tickets and meals – it would also be nice to reconnect with our residency peers and preceptors

Coverage (5)

- Develop relationships with rural hospitals to help provide coverage for hospitals/ER/clinic hospitals/ER/clinic with residents (2nd and 3rd years) i.e., moonlighting
- People are looking for quality of life – thus, the physician who lives a 1:1 or 1;2 call is being relatively non-existent. But population cannot support a large medical staff; need to look into job sharing/rotation as viable option
- Issues for single specialist or small specialty group; ER department must be able to manage minor emergencies so that your nights are not as often compromised (i.e., midnight to 8 am)

- Reduce some of the competition between different groups to work together, share specialty expertise among the hospitals in the system-facilitate specialty clinics
- Models for hospitalist program for smaller facilities. We in Williston have a hard time recruiting now dues to call related issues and new FP grads often choose practices were there is internal medicine hospitalist programs

Residency Curriculum (4)

- A standardized curriculum in FP and rural IM residencies, more than the Board requirements, so that residents and employers have a realistic picture of what they can expect a residency training FP or IM physician to be able to do (the first question at one job interview I went on was "How many hip fractures did you pin last year?"
- While doing my FP rotations @ UNC-Chapel Hill, my preceptor was British-trained. He was trained in spine manipulation. Needless to say, hew was in much demand by the patients. Why not train FP's in spinal manipulation? I don't know of any other FP programs that does that, neither does UNC-CH. That would be a draw for students.
- Concern regarding post-opcare of patients; bed management: there should be designated surgical beds with surgical nurse training on the combined unit to facilitate confidence in post-op management
- I would consider emphasizing more nutritional education in the curriculum. From the standpoint of prevention, this is a critical element. I believe if we do not get on top of this obesity epidemic, diabetes, metabolic syndrome, etc. that is will be impossible to meet the medical needs of ND

Promote North Dakota (3)

- More aggressive ad campaigns to attract medical students interested in practicing in rural ND
- ND has the second lowest malpractice cases in the US behind Alaska. We have the lowest unemployment rate in the nation. Our economy is growing and we have a state surplus of $$. Do we brag about this when recruiting students, faculty and practitioners?
- Find a way to show students that ND really DOES have great care. I trained in Wisconsin for awhile, and actually transferred back to finish FP residency in GF, because I couldn't accept the way healthcare was delivered in that community in Wisconsin
- Incentives: We need to champion incentives for physicians to accept employment in North Dakota and particularly for true rural (non-suburb or bedroom) communities. We should reward students who fill physician shortages in both rural and urban areas. One of the incentives could even relate to whether they get into the program or not.

Other (3)

- AHEC's must work to enhance exposure to health career opportunities and be the catalyst for increasing opportunities within the education sector and health delivery system
- Midlevels are not a solution. I have two of them. They are wonderful providers and very capable, and do extend the physicians ability to take care of more patients, but they are not able to function as a physician and do not give physicians actual time off

Less paperwork/regulatory hassles for small clinics and hospitals

Improve Image of Family Medicine (2)

- The image of family physicians has been downgraded over the years. Often times they are perceived as a convenience physician. OB has nearly gone by the wayside, hospitalists have taken over their hospital care and even though they are well trained in residency, their skills are lost due to inability to get privileges for them or just choosing not to do the things they were training to do. The image of family practice needs to be improved as the vital link to a health family.

Promote Family Medicine at the Medical School (2)

- Incentives to the Instructors: I have heard from quite a few students who are told by instructors, "they have too much potential to be a family physician", or "rural communities are dying, you don't want to go there" or other negative comments. To combat this I would suggest that funding for these instructors programs be based upon the percent of their students that are placed in North Dakota. They should be working for both the state's and student's benefit rather than using our tax dollars to build the medical staffs of other states.
- Motivational Examples: I was at a POND (Practice Opportunities in North Dakota) event some years ago where one of our physicians addressed the students. He explained why he got into medicine, why he chose family medicine and why he though that being a family physician was "the best job in the world". He had the students rapt attention, they were all hanging on his every word. We need more physician champions of family medicine to talk to the students and raise their interest and excitement in the profession. There is more to life than money.

Fargo Residency (1)

- Start (restart) residency for family practice in Fargo. The "concern" that the residents stayed in the larger town is invalid, as FP's in the larger towns is now critical as well

Increase Class Size (1)

- Increase the capacity of the medical college to accept larger amounts of students

Flexibility for Critical Access Hospitals (1)

- Allow flexibility of admission beds – (Example) Med/Surg has 10 beds for inpatients, 3 are full but labor and delivery's 5 inpatient beds are full so a post partum mom has to go to a different floor away from her baby and to less experienced nursing care

Ease Immigration (1)

- Improve visa availability and east of getting green care for providers of rural community

Student Survey (1)

- Survey the Students: On a confidential basis, done by an independent company, do some surveys of the students as to why they are in medicine, what are their objectives and goals, their interest in staying in the state, and what kind of practice would draw them to a rural area. I realize that some are in it for the money but I know that there are quite a few motivated by other reasons. It would be good to quantify this.

Physicians Dedicated to the Health of North Dakota

TESTIMONY ATTACHMENT 6

NORTH DAKOTA MEDICAL ASSOCIATION

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Testimony on HB 1353
House Education Committee
January 31, 2011

Madam Chairman Kelsch and Committee Members, I'm Bruce Levi and I serve as 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.

HB 1353 places the medical community in a quandary – setting at odds the important future healthcare workforce challenges we face in North Dakota against our successful state efforts to reduce tobacco use and the incidence of tobacco-related disease.

NDMA agrees with the previous testimony of UNDSMHS Dean Joshua Wynne with respect to the issues raised in HB 1353 regarding 1) the statutory purpose of the UND School of Medicine & Health Sciences (UNDSMHS), 2) the proposed changes to the composition of the UNDSMHS Advisory Council, 3) the duties of the UNDSMHS Advisory Council, and 4) the proposed medical school programs expansion and health sciences facility project.

NDMA supports the medical school programs expansion and health sciences facility project as proposed in the *First Biennial Report* of the UNDSMHS Advisory Council [UNDSMHS Advisory Council, *First Biennial Report, Health Issues for the State of North Dakota*, 2011].

NDMA opposes the proposed funding mechanism in HB 1353 that would dismantle the state's Tobacco Prevention and Control Program and Fund in NDCC Chapter 23-42.

Several physicians serve on the UNDSMHS Advisory Council and participated in the development of the UNDSMHS Advisory Council *First Biennial Report*. The recommendations of that report identify a four-pronged approach to ensure effective, efficient, timely, and affordable healthcare for all North Dakotans:

- Reduction of disease burden, thus reducing the demand for healthcare services and the related costs
- Augmentation of the physician and other healthcare provider workforce through increased retention of graduates
- Augmentation of the physician and other healthcare provider workforce by increasing the medical, health science student, and resident class size
- Improvement of the healthcare delivery system in North Dakota

The *First Biennial Report* sets the appropriate context for discussion of HB 1353. We face an increasingly large gap between the demand for healthcare services which is projected to grow substantially over the next 15 years, and the supply of physicians and other healthcare providers.

NDMA believes it is critical that the state prepare adequately for our future healthcare workforce needs – on the supply side, we must increase the retention of our UNDSMHS graduates and increase the class sizes of our medical students, health science students and residents; and we must continue to maintain a practice environment in our state that facilitates recruitment of physicians to both rural and urban areas and encourages those physicians who practice here now to stay.

On the demand side, NDMA believes it is imperative that the state continue in its efforts to reduce the burden of tobacco-related disease in our state which would reduce the demand for healthcare services and their costs.

The *First Biennial Report* recognizes, in addition to the critical need to prepare a healthcare workforce for the future, that the best way to treat disease is to "prevent it in the first place," and recognizes the efforts undertaken in the state to positively impact the health-related behaviors of North Dakotans in eating, smoking, physical activity, and other self-care. As stated in the *Report*, successful improvement of health-related behaviors can not only avoid an enormous toll of suffering and death, but can be accomplished at far less expense than treating the diseases it prevents.

The *First Biennial Report* stresses the importance of efforts to reduce tobacco use as the number one preventable cause of death and disease in North Dakota. North Dakota

physicians through NDMA for many years have strongly supported and been an integral part of the efforts to reduce tobacco use in North Dakota.

For over a decade, NDMA worked with public health advocates and many other organizations and individuals in this state to encourage the creation of a Centers for Disease Control (CDC)-based tobacco prevention and cessation program which is an effective, science-based approach to reduce tobacco use and impact health outcomes. In 2009, NDMA supported the comprehensive tobacco plan developed by the ND Tobacco Prevention and Control Advisory Committee [*Saving Lives, Saving Money: North Dakota's Comprehensive State Plan to Prevent and Reduce Tobacco Use*, July 2009] and the essential goals of decreasing the number of people who start using tobacco products, increasing the number of tobacco users who quit, and eliminating exposure to secondhand smoke; and supporting the ongoing tobacco prevention and control efforts and funding of Measure 3, which NDMA fully supported in 2008.

The need to reduce tobacco use and the steps taken in North Dakota to do so are recognized as priorities in the *First Biennial Report* [pp. 56-57]. HB 1353 would result in an unfortunate paradox in that what the bill on one hand would create in terms of a better health workforce capacity in our state to diagnose and treat disease would, on the other hand, serve to eliminate the very proven efforts we have taken to reduce the number one preventable cause of disease and death in our state – tobacco use.

NDMA urges the Committee to consider the recommendations of the UNDSMHS Advisory Council, both as set forth in the *First Biennial Report* and in the testimony of Dean Wynne with respect to the provisions of HB 1353. NDMA also urges the Committee to reconsider the proposed funding mechanism in HB 1353 so that as a state we can continue our tobacco prevention and control efforts at the level recommended by the Centers for Disease Control, and instead consider other funding options for the work that must be done to address our future health workforce needs.

Thank you Madam Chairman and Committee members for this opportunity to comment on HB 1353 on behalf of North Dakota's physicians.

TESTIMONY ATTACHMENT 7

North Dakota Hospital Association

Vision
The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission
The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

Testimony on HB 1353
House Education Committee
January 31, 2011

Good morning Madam Chairman Kelsch and Members of the House Education Committee.

I am Jerry Jurena, President of the North Dakota Hospital Association. I am here to provide testimony on HB 1353.

In regards to HB 1353 we are in support of expanding the UND School of Medicine for Medical students as there is a need for primary care physicians across the state of North Dakota.

However, we cannot support the transfer of voter-passed funds from the Tobacco Settlement Trust Fund for the expansion of UND Medical School. The Tobacco Trust Funds have proven effective in smoking cessation programs; i.e. "Quitline", nicotine replacement products and counseling.

Again we are in favor of expanding the UND School of Medicine, and we are opposed to transferring the Tobacco Settlement Trust Fund money to accomplish the expansion.

I
Jerry E. Jurena, President
North Dakota Hospital Association

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BreatheND
Saving Lives, Saving Money with Measure 3.

TESTIMONY ATTACHMENT 8

Testimony
House Bill 1353
House Education Committee
9:00 a.m., Monday, January 31, 2011
North Dakota Center for Tobacco Prevention and Control Policy
North Dakota Tobacco Prevention and Control Advisory/Executive Committee

Good morning, Madame Chair and members of the Education Committee. I am Jeanne Prom, executive director of the Center for Tobacco Prevention and Control Policy. The Center is the office created with funding from the North Dakota Tobacco Prevention and Control Executive Committee. The creation of this office is part of the 9-member North Dakota Tobacco Prevention and Control Advisory Committee's comprehensive statewide plan, required by law. I am here today to testify in opposition to House Bill 1353, sections 4 and 5. The Center supports the School of Medicine and its programs, but does not support the funding mechanism for the school as provided in this bill.

The Center is opposing HB 1353 because it repeals Statewide Initiated Measure 3, which North Dakota voters passed in November 2008. Measure 3 set aside a small, time-limited portion of the tobacco settlement money, called the Strategic Contribution Fund, for tobacco prevention. Please see the attachment which shows that while the annual tobacco settlement payments continue in perpetuity, the deposits into the Measure 3 fund – the Tobacco Prevention and Control Trust Fund -- end in 2017. (Tobacco Prevention and Control Trust Fund – Projected Revenues, ND Legislative Council, October 2010)

My comments begin with details of how HB 1353 repeals Measure 3. Next, I will highlight how, as Measure 3 funded-tobacco prevention efforts increased, smoking decreased. Finally, I'll explain how Measure 3 affects everyone, young and old, in every county, by providing all counties much-needed funding for prevention and cessation to reach people where they live. This will include the widespread health improvements we can expect by continuing Measure 3, and conversely, the erosion of these health improvements if we repeal Measure 3.

HB 1353 repeals Measure 3

Section 4 (beginning on pages 5, line 16 and continuing through page 6, line 28) of HB 1353 eliminates any requirement that tobacco settlement dollars be spent on tobacco prevention programs by:

1) repealing the commitment that any of the tobacco settlement annual payments (of which just 10% are directed to health) be used for tobacco prevention (page 6, lines 2-3), and
2) repealing the requirement that 9 of 10 payments of the tobacco settlement's separate Strategic Contribution Funds be deposited in a Tobacco Prevention and Control Trust Fund (page 6, lines,11-28).

The Tobacco Prevention and Control Trust Fund is a legacy fund for comprehensive tobacco prevention. This legacy fund provides support over adequate time to

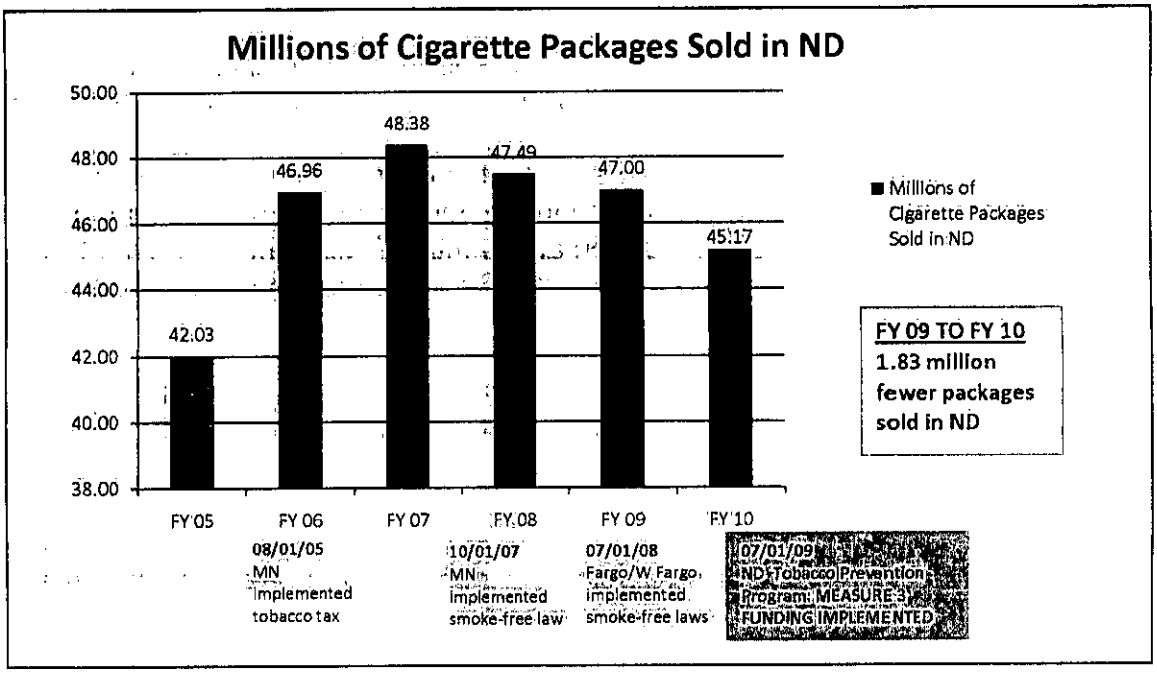
significantly reduce tobacco use in our state. HB 1353 replaces the Tobacco Prevention and Control Trust Fund with a new trust fund with a different purpose. HB 1353 transfers all monies to this new trust fund. Section 4 thus eliminates the guarantee that any tobacco settlement dollars will be used for their intended purpose: tobacco use prevention.

Section 5 (page 6, lines 29-30) repeals the remaining provisions of Measure 3 law (NDCC §23.42.01 through §23.42.08) that provide for the Tobacco Prevention and Control Advisory and Executive Committee, and a comprehensive statewide plan to prevent and reduce tobacco use.

Measure 3-funded tobacco prevention efforts are working, repealing Measure 3 will erode health improvements

The following chart shows that fewer packs of cigarettes were sold in the first year of Measure 3 tobacco prevention efforts than in any of the previous five years. In the first year of Measure 3 funding, the decrease in packs sold from the previous year was larger than in any recent two-year comparison. In Fiscal Year 2010, 1.8 million fewer packs of cigarettes were sold in North Dakota.

In first year of Measure 3 funding, largest drop in cigarette sales occurs



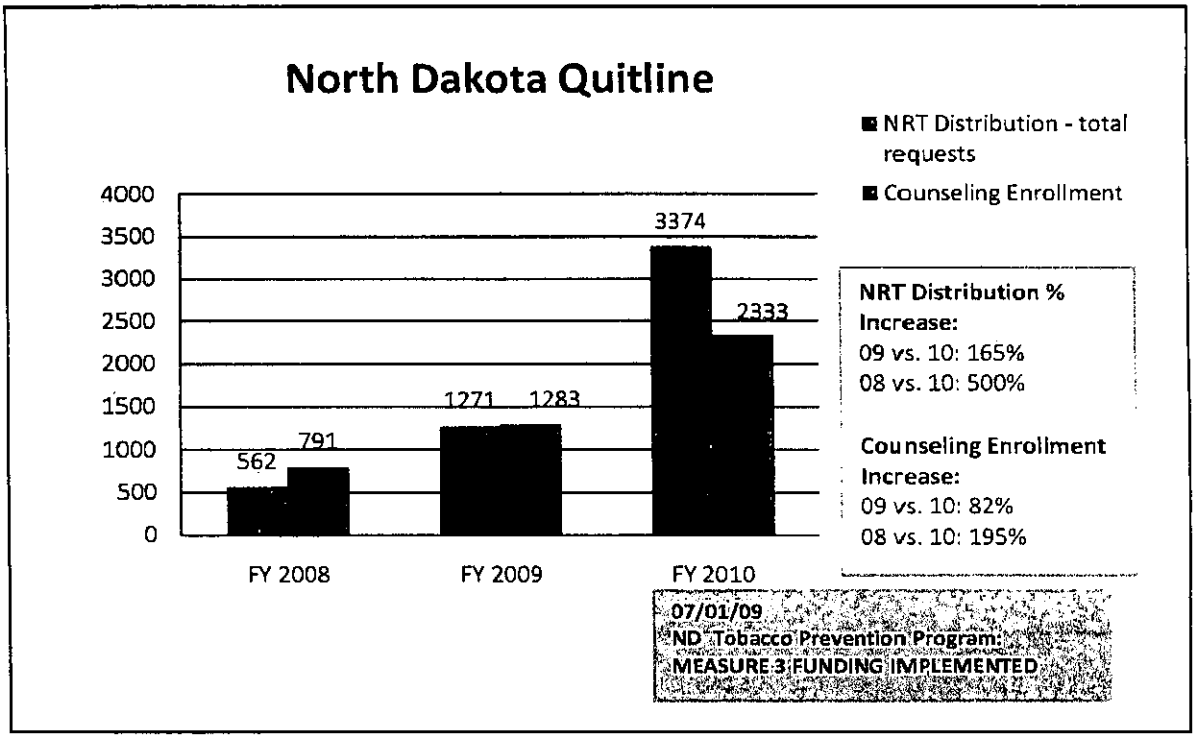
The chart above illustrates how smoke-free laws in Fargo, West Fargo and in Minnesota coincide with reduction in packs of cigarettes sold in North Dakota in the years prior to Measure 3 funding. The Measure 3-funded tobacco prevention program has continued to promote 100% smoke-free laws with success. The most significant drop in cigarette sales occurred in the first year of Measure 3 funding during Fiscal Year 2010 – 1.8 million fewer packs sold. The chart also illustrates how a tobacco tax increase in Minnesota coincides with an increase in N.D. cigarette tax sales. To significantly decrease tobacco use in North Dakota without decreasing tobacco tax revenue, we must increase N.D. tobacco taxes. Sales/tax collection amounts by county are not available.
Source: N.D. Tax Department, tobaccosales tax data

Without Measure 3 funding, North Dakota may experience what occurred in Massachusetts. There, during the program's peak funding (1993-2003) cigarette use

was declining at more than double the rate in the rest of the country. Then in 2003, the program was cut by 90% and use increased in 2005-2006, while in the rest of the country it continued to decline.

During the first year of Measure 3-funded efforts, use of our statewide quitline increased dramatically. Measure 3 grants totaling $940,000 provided to local public health units in every county made it possible for public healthcare systems improvements. This included system upgrades to enable public health providers to systematically refer their clients using tobacco to the free/affordable quitline services. These systems changes can further advance with electronic medical records, and expansion into additional private healthcare systems. This will result in more people connecting with the quitline. However, without Measure 3 funding, these advancements likely won't occur or be sustained. Cost efficiency of the quitline is only enhanced by more users, applying economies of scale.

In first year of Measure 3 funding, dramatic increase in quitline use occurs



This chart illustrates how Measure 3-funded efforts to increase referrals to the quitline from local public health units contributed to significant increases in distribution of nicotine replacement therapy (NRT) and in enrollment for counseling from the statewide quitline. Measure 3 grants to local public health units require that health units ask all clients about their tobacco use and refer tobacco users to the quitline. *Source: N.D. Department of Health, quitline reports.*

This biennium, Measure 3 funds provided $5.9 million in grants reaching all counties. These county prevention programs have resulted in:

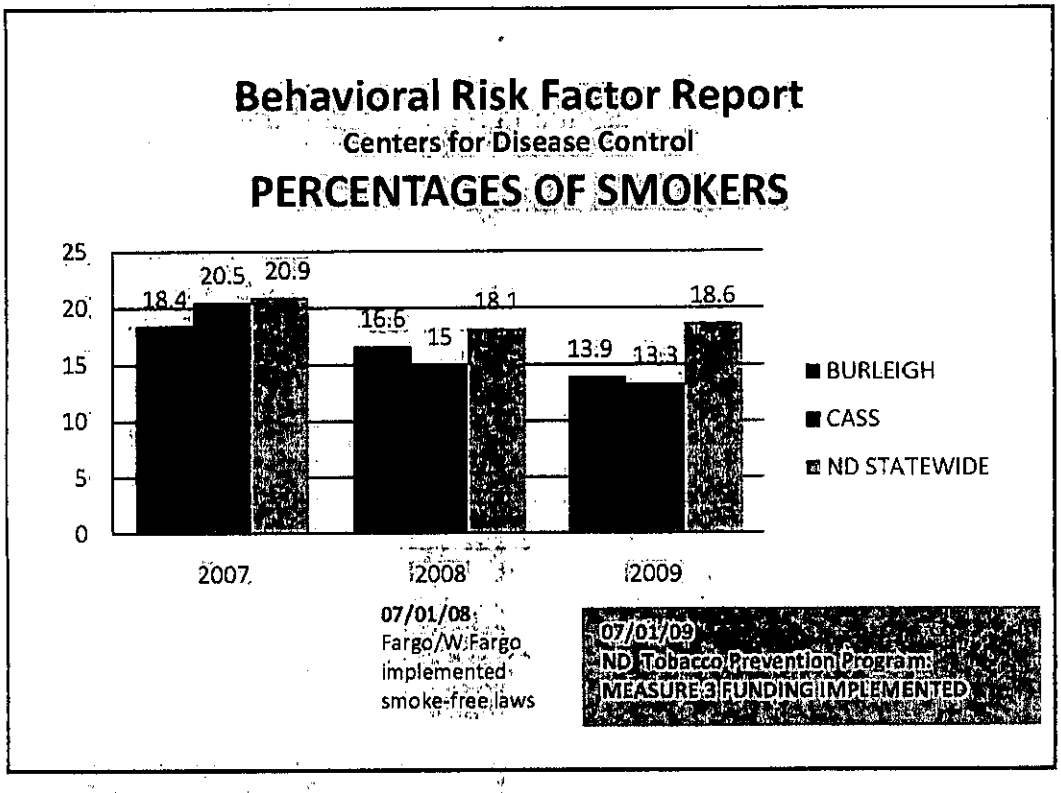
- 37 new tobacco-free K-12 school district campus policies,
- 2 new tobacco-free college campus policies, plus 1 phased-in campus policy,
- 3 new cities becoming smoke-free (9% more of the population),
- 28 new local public health unit policies referring all tobacco users to the quitline,
- 3 policies in large private healthcare main campus settings referring all tobacco users to the quitline, and

- expansion of the local public health workforce by 11.29 FTEs, at least half of whom work in cities of fewer than 5,000 people.

Measure 3 provides the only support for local tobacco prevention programs in each county. Without Measure 3 funding, these kinds of public health improvements would not occur in our counties, especially not in our rural areas.

We have already seen smoking decrease in two counties where data are available. This illustrates how important it is to fund all counties at a level where tobacco prevention education and services can reach everyone.

Adequate funds for local tobacco prevention cuts smoking in Burleigh, Cass



This chart illustrates how Burleigh and Cass counties have reported lower tobacco use rates while state tobacco use rates are relatively unchanged. This coincides with Burleigh and Cass counties receiving the highest levels of single-county funding for tobacco control in the state, and with smoke-free laws in Fargo and West Fargo. Bismarck also enacted a local smoke-free law in 2005 that is stronger than the state law. Both health units have undertaken significant public education campaigns on the health consequences of tobacco use, and have active citizen coalitions. *Source: U.S. Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System.*

Healthcare costs impact

Savings Per Percentage Point Declines in Smoking Rates

With each one percentage point decline in North Dakota's smoking rate, it is estimated that the following benefits and savings will be obtained:

BENEFITS & SAVINGS FROM EACH 1% POINT DECLINE IN ND SMOKING RATES

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.

Excerpted from: Measure 3: Comprehensive tobacco prevention and cessation for North Dakota: A win-win solution for North Dakota's health and economy. A special report by the Campaign for Tobacco-Free Kids. (September 22, 2008)

For North Dakota to experience the significant reduction in heathcare costs associated with comprehensive programs, there are four key points to bear in mind:

1. When adequately funded, comprehensive statewide tobacco prevention programs quickly and substantially reduce tobacco use, save lives, and cut smoking-caused costs.
2. State tobacco prevention programs must be insulated against the inevitable attempts by the tobacco industry to reduce program funding and otherwise interfere with the programs' successful operation.
3. The statewide funding must be sustained over time both to maintain initial tobacco use reductions and to achieve further cuts.
4. When program funding is cut, progress in reducing tobacco use erodes, and the state suffers from higher levels of smoking and more smoking-caused deaths, disease, and costs.

I have heard comments that our state spends up to $70 to $100 million on tobacco prevention. Currently, the state spends about $9.3 million each year on tobacco prevention and cessation. According to the Survey of Agency Alcohol, Drug, Tobacco and Risk-Associated Behavior Prevention Programs (prepared by the North Dakota Legislative Council staff for Representative Carlisle, January 2008), seven state agencies planned to spend $63.5 million on a variety of programs the previous biennium. Only $7.4 million from one agency was spent solely on tobacco prevention, and only one other agency's programs listed tobacco prevention or treatment as a possible use of prevention funds. (The 2008 report was the most recent posted on the Legislative Council website.)

I have also heard comments about the oversight of the agency. Governmental checks and balances are in place ensuring it is a transparent state agency held accountable in all the ways that any other state agency is held accountable. The agency:

- operates under the same Office of Management and Budget fiscal policies and procedures as every other state agency;
- is subject to the same audit regulations as every state agency;
- has an organizational structure like many of the other 140-plus boards and commissions currently operating under North Dakota Century Code, and which function under the Governor in the Executive Branch;
- has all 9 members appointed by the Governor; (By law, seven are nominated from a group of names forwarded by different health organizations – physicians, nurses, respiratory therapists and public health. Two members the Governor can pick at large, with one being a youth or young adult.)
- spends only funds appropriated by the N.D. Legislature;
- has an Executive Committee of three members of the Advisory Committee; (They have the statutory authority to spend the money. So, unlike another agency with only one leader who may be appointed -- or in other cases, elected -- we have three people appointed who are the agency heads and make the spending decisions.)
- benefits from board members who are experts in tobacco prevention and public health; (For example, agriculture commissions have farmers, ranchers and agricultural businesses on their boards. This is good government because it

allows those with expertise in a specialized area to make decisions, while not politicizing the process.) and

- is protected from the political influence of the tobacco industry. (The board, like other specialized boards, is made up of subject-matter experts.)

In addition, this state agency:

- reports to the interim Budget Section every three months on expenditures and progress, unlike most other agencies;
- allows for elected officials to serve on the board;
- must, by law, evaluate the effectiveness and implementation of the state plan each year; and
- must, by law, once a biennium, provide for an independent audit of the state plan to ensure it is consistent with CDC Best Practices and report the results to the Governor and State Health Officer.

To summarize:

- The Center opposes Sections 4 and 5 of House Bill 1353.
- The Center supports the School of Medicine and its programs, but not the funding mechanism provided in this bill.
- Measure 3 funds are improving the health of North Dakotans through tobacco prevention and cessation programs in every county.
- Eliminating funding for tobacco prevention and cessation would cause tobacco use rates to increase, placing an even greater burden on families, the healthcare system and providers, and the taxpayers.

Thank you for your time. I am happy to answer any questions.

Prepared by the North Dakota Legislative Council staff for the Budget Section
October 2010

TOBACCO PREVENTION AND CONTROL TRUST FUND - PROJECTED REVENUES

This memorandum provides information on the tobacco prevention and control trust fund, including estimated revenue from tobacco settlement strategic contribution payments to be received by the state under the Master Settlement Agreement.

BACKGROUND

The tobacco prevention and control trust fund was created as a result of voter approval of initiated measure No. 3 in the November 2008 general election. The measure added seven new sections to the North Dakota Century Code and amended Section 54-27-25 to establish the 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. The measure provides for the advisory committee, appointed by the Governor, to develop the initial comprehensive plan and select an executive committee responsible for the implementation and administration of the comprehensive plan. The initiated measure became effective 30 days after the election (December 4, 2008).

Tobacco settlement payments received by the state under the Master Settlement Agreement are derived from two subsections of the agreement. Subsection IX(c)(1) of the agreement provides payments on April 15, 2000, and on April 15 of each year thereafter in perpetuity, while subsection IX(c)(2) of the agreement provides for additional strategic contribution payments that begin on April 15, 2008, and continue each April 15 thereafter through 2017. Section 54-27-25, created by 1999 House Bill No. 1475, did not distinguish between payments received under the separate subsections of the agreement and provided for the deposit of all tobacco settlement money received by the state into the tobacco settlement trust fund. Money in the fund, including interest, is transferred within 30 days of deposit in the fund as follows:

- Ten percent to the community health trust fund.
- Forty-five percent to the common schools trust fund.
- Forty-five percent to the water development trust fund.

The measure provided for a portion of tobacco settlement dollars received by the state to be deposited in the newly created tobacco prevention and control trust fund rather than the entire amount in the tobacco settlement trust fund. Tobacco settlement money received under subsection IX(c)(1) of the agreement continues to be deposited in the tobacco settlement trust fund and allocated 10 percent to the community health trust fund (with 80 percent used for tobacco prevention and control), 45 percent to the common schools trust fund, and 45 percent to the water development trust fund. Tobacco settlement money received under subsection IX(c)(2) of the agreement is deposited into the tobacco prevention and control trust fund. Interest earned on the balance in this fund is deposited in the fund. The fund is administered by the executive committee created by the measure for the purpose of creating and implementing the comprehensive plan.

The measure also provides that 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. The 2009 Legislative Assembly in Section 39 of House Bill No. 1015 provided that any money deposited in the water development trust fund under Section 54-27-25 may only be spent pursuant to legislative appropriation.

REVENUES

The tobacco settlement payment received by the state in April 2008 was the first payment that included funds relating to subsection IX(c)(2) of the agreement. This payment was received prior to the approval of the measure and was deposited in the tobacco settlement trust fund and disbursed as provided for in Section 54-27-25 prior to amendment by the measure. In 2009 tobacco settlement payments began to be deposited in the tobacco settlement trust fund and the tobacco prevention and control trust fund pursuant to Section 54-27-25 as amended by the measure.

The following chart provides the allocation of the estimated collections of the tobacco settlement payments for the period 2008 through 2025:

	Actual and Estimated Total Tobacco Settlement Proceeds (Amounts Shown in Millions)	Estimated Payments Under Master Settlement Agreement Subsection IX(c)(2) Deposited in the Tobacco Prevention and Control Trust Fund (Amounts Shown in Millions)	Allocation of Actual and Estimated Payments Under Master Settlement Agreement Subsection IX(c)(1)		
			Common Schools Trust Fund (Amounts Shown in Millions)	Water Development Trust Fund (Amounts Shown in Millions)	Community Health Trust Fund (Amounts Shown in Millions)
Actual payment April 2008	$36.4	N/A	$16.4	$16.4	$3.6
Actual payment April 2009	39.2	$14.1	11.3	11.3	2.5
Estimated 2009-11 biennium	68.8	26.1	19.2	19.2	4.3
Estimated 2011-13 biennium	73.7	27.6	20.8	20.8	4.5
Estimated 2013-15 biennium	73.7	27.6	20.8	20.8	4.5
Estimated 2015-17 biennium	73.7	27.6	20.8	20.8	4.5
Estimated 2017-19 biennium	52.5	N/A	23.6	23.6	5.3
Estimated 2019-21 biennium	52.5	N/A	23.6	23.6	5.3
Estimated 2021-23 biennium	52.5	N/A	23.6	23.6	5.3
Estimated 2023-25 biennium	52.5	N/A	23.6	23.6	5.3
Total	$575.5	$123.0	$203.7	$203.7	$45.1

Interest earned on the balance in the tobacco prevention and control trust fund is deposited in the fund. Investment income deposited in the tobacco prevention and control trust fund during the 2007-09 biennium totaled $8,290, and investment income to be deposited in the tobacco prevention and control trust fund during the 2009-11 biennium is estimated to total $345,000.

EXPENDITURES

Actual expenditures of the Tobacco Prevention and Control Executive Committee for the 2007-09 biennium totaled $38,815. Section 35 of 2009 House Bill No. 1015 appropriated $12,882,000 from the tobacco prevention and control trust fund to the Tobacco Prevention and Control Executive Committee 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 2009-11 biennium. The Tobacco Prevention and Control Executive Committee is requesting the same level of funding--$12,882,000--for the 2011-13 biennium.

TESTIMONY ATTACHMENT 9

Testimony
House Bill 1353
House Education Committee
Theresa Will, RN, Executive Director, City-County Health District

Good Morning Madame Chair and members of the House Education Committee. I am Theresa Will from Valley City. I have been a Registered Nurse for 26 years, working in public health for 22 years and as the executive director of the City-County Health District for the past 7 years. I currently also have the privilege and responsibility to serve as a local public health member and chair of the Executive Committee charged with implementing the comprehensive tobacco prevention program spelled out in the Measure 3 Law. I am pleased to be here this morning to provide testimony in opposition to Sections 4 and 5 of HB 1353 which would repeal the voter initiative and eliminate the comprehensive statewide tobacco prevention and control program.

The Executive Committee-Local Public Health partnership is clearly the proper mechanism for providing tobacco prevention and control in North Dakota. It is a natural and indispensable collaboration. For many years, public health professionals have known that significantly reducing tobacco addiction in North Dakota –both now and in future years—is by far the single most important thing we could do to improve the health of, and reduce the economic burden on, the entire North Dakota population. But not until the people adopted Measure 3 did we in public health have access to the powerful resources that are necessary for us to, finally, vigorously confront our state's largest cause of preventable disease, death, and taxpayer' expenditures for tobacco-related healthcare.

All of your statewide Local Public Health team who promote a higher level of health among all North Dakotans are grateful for and dedicated to the Measure 3 tobacco prevention program. That's because Measure 3 is precisely what has enabled us to begin achieving the highest calling in our overall public health mandate.

Public health professionals are the people with the training, positioning and mission needed to put the state plan, "Saving Lives—Saving Money," into action. At the same time, the Measure 3 resources are also helping in small but significant ways to alleviate the long term sustainability issues that have often plagued local public health in North Dakota.

If the ND Legislature repeals Measure 3 (through HB 1353 or through any other avenue), a severe blow will be dealt to the strength, effectiveness and integrity of all of Public Health in the State of North Dakota.

Madame Chair and members of the House Education Committee , in the 2008 General Election, North Dakota voters passed Initiated Measure # 3 for a very good reason –to allocate the amount of Tobacco Settlement dollars actually needed to substantially reduce both the current and future harms that tobacco addiction imposes on ALL North Dakotans.

Your constituents directed Tobacco-Settlement dollars for this specific program because it will improve health and their personal economics. North Dakota taxpayers are tired of paying the enormous costs of tobacco addiction. Your constituents directed this specific investment because

they know that the model CDC comprehensive program has already reduced tobacco diseases and expenses in other states. This same program will reduce tobacco-caused physical suffering across North Dakota. And it will benefit 100% of the citizens by cutting the tobacco-caused healthcare costs that we ALL pay. Now, the tax burden that each-and-every household is forced to pay for tobacco-related healthcare amounts to $574 every year.

Due to time constraints this morning, I can enumerate only some of the accomplishments that we have already made:

- Measure 3 resources have enabled an increased focus on implementing Comprehensive Tobacco Free School Policies. As a result, nearly 1/3 of the K-12 students in North Dakota (33,000 students) are now protected with a healthy, tobacco-free norm. In Barnes County, we now protect about 83% of our students in this manner.
- Both locally and statewide, during Measure 3's first year, the volume of citizens using the Tobacco Quitline skyrocketed. Intake calls increased by 62%--up to 2145 callers in FY 2009-2010, from 1325 callers in FY 2008-2009. Locally, with Measure 3 funding, we were able to approximately TRIPLE the number of Barnes County citizens who completed the ND Tobacco Quitline's intake call during FY 2009-10.
- The ND Quitline can now offer a free 2-month supply of nicotine patches, gum or lozenges to all enrollees who do not have cessation medication coverage through a health plan. Locally, CCHD can now provide any additional quit medications needed.
- Prior to Measure 3 implementation, only 17.6% of the state's population was protected by a comprehensive smoke-free law. Now, about 232,993 citizens (36% of the state's population) are protected from toxic secondhand smoke at work and in public places.

As an administrator, I have been extremely impressed with the accountability that is required by the Executive Committee. The members are very cautious and require scrupulous details. (I honestly receive more financial details from the Measure 3 funding than I receive in my own health unit.) All spending decisions are well thought out and clearly support the goal of our state plan.

As you can see and have just heard, the Comprehensive Tobacco Prevention and Control Program that the voters put into place with Measure 3 funding is already working in Barnes County and throughout the entire state. Please maintain funding in its current form and oppose HB 1353. Supporting this bill in its present form would be ignoring our leading cause of death; and it would be ignoring the people's wishes and votes. Thank you for receiving my testimony. I'd be happy to answer any questions that you may have.

Resolution in Opposition to Overturning Measure # 3

WHEREAS tobacco addiction, the state's **leading preventable cause of death,** is a severe problem harming all North Dakotans: Each year, 910 North Dakotans die from tobacco-related diseases and $247 million is spent to treat tobacco-related diseases;

WHEREAS with overwhelming evidence that fully-funded, comprehensive tobacco prevention programs substantially reduce tobacco addiction (thus preventing disease and saving both lives and taxpayer dollars), ND residents in 2008 voted to approve Measure 3 in order to allocate the "Strategic Contribution" portion of the state's Tobacco Settlement to fund precisely such a program at the level recommended by the U.S. Centers for Disease Control and Prevention;

WHEREAS the voter-initiated tobacco prevention program required by Measure 3 **is working!** While much more remains to be accomplished, major positive outcomes have already been seen during its first 1.5 years of existence, including:

- 1.8 million fewer packs of cigarettes were sold in FY 2010 in North Dakota
- Counseling enrollments in the North Dakota Tobacco Quitline and Quitnet increased by 195% since 2008
- Number of school districts fully protecting kids from secondhand smoke increased from 21% to 34%
- Targets were exceeded in implementing US Public Health Service guidelines for facilitating cessation in all 28 local public health units and the state's 3 largest healthcare systems

WHEREAS a 2010 public opinion survey showed that 82% of North Dakota adults support spending Tobacco Settlement funds on tobacco prevention efforts, thus reaffirming the 2008 General Election vote for Initiated Measure 3;

NOW THEREFORE BE IT RESOLVED that, to continue reducing the harms that tobacco addiction imposes on all North Dakotans, the City-County Health Board opposes legislation, including HB 1353, that would transfer away any of the funds that North Dakota voters specifically allocated for comprehensive tobacco prevention and control when they adopted Initiated Measure # 3 on November 4, 2008.

Signed:

Sharon E Buhr Date: 1-28-11

CHAIR, CITY-COUNTY HEALTH BOARD

Sharon E Buhr
613 Chautauqua Blvd
Valley City, ND 58072
701-845-5197

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NOW THEREFORE BE IT RESOLVED that, to continue reducing the harms that tobacco addiction imposes on all North Dakotans, I oppose legislation, including HB 1353, that would transfer away any of the funds that North Dakota voters specifically allocated for comprehensive tobacco prevention and control when they adopted Initiated Measure # 3 on November 4, 2008.

Date: January 28 2011

Signed: Dean Koppelman

Dean Koppelman
Superintendent of Valley City Public Schools
460 Central Avenue North
Valley City, ND 58072

TESTIMONY ATTACHMENT 10

WRITTEN TESTIMONY ON THE EVIDENCE BASE FOR COMPREHENSIVE STATE TOBACCO CONTROL PROGRAMS

TERRY PECHACEK, PhD
ASSOCIATE DIRECTOR FOR SCIENCE
OFFICE ON SMOKING AND HEALTH
NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION
AND HEALTH PROMOTION
U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

JANUARY 31, 2011
North Dakota House of Representatives, Education Committee

Introduction

Thank you for the opportunity to provide information on the dramatic health gains and economic savings that can be achieved with adequate funding and evidence-based interventions for tobacco control. I am Dr. Terry Pechacek with the Office on Smoking and Health, Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia. I am an author of the original and updated versions of the CDC guidance document *Best Practices for Comprehensive Tobacco Control Programs* and have been involved in the writing or scientific review of all U.S. Surgeon General's Reports on the health consequences of tobacco use since 1979. In addition, I have provided senior technical advice on the planning, implementation, and evaluation of comprehensive tobacco control programs in Arizona, Arkansas, California, Florida, Georgia, Indiana, Iowa, Kentucky, Maine, Massachusetts, Minnesota, Mississippi, New Jersey, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee, Texas, Vermont, Virginia, Washington, and West Virginia.

For the record, I have submitted this written testimony at the request of Jeanne Prom, the Executive Director of the Center for Tobacco Prevention & Control Policy, to summarize the scientific evidence regarding best practices in comprehensive tobacco prevention and control and the effectiveness of comprehensive state tobacco control programs. Also for the record, this written testimony is not for or against any specific legislative proposal.

Effects of State Tobacco Control Programs

Tobacco use is the leading preventable cause of illness and death in the United States. From 2000 to 2004, an average of 900 North Dakota residents died per year from smoking-related diseases; and North Dakota ranks 4th highest among states in its smoking-related death rate with 225.6 of every 100,000 people over age 35 dying due to tobacco use. In addition, studies have shown that, for every person who dies of a smoking-related disease, another 20 persons are living with a serious chronic disease caused by smoking.

The good news is that we know what works and how to reduce tobacco use. If North Dakota were to continue to fully fund tobacco control programs and implement proven tobacco control strategies, including full implementation of smoke-free environments in all workplaces and public places, increases in tobacco product prices, hardhitting media campaigns, ensuring tobacco users can get help quitting, and youth empowerment initiatives that counteract tobacco industry marketing, North Dakota could make significant progress in reducing the staggering toll that tobacco use takes on its families and communities.

State tobacco control programs coordinate these and other proven tobacco control approaches to ensure maximum impact. States that have made large and sustained investments in tobacco control programs have seen cigarette sales drop more than twice as much as in the United States as a whole. Smoking prevalence among youth and adults declines faster as spending for tobacco control programs increases. States such as Maine, New York and Washington, have achieved 45 to 60 percent reductions in youth smoking through sustained implementation of coordinated

tobacco control programs. As another example, between 1998 and 2002, a comprehensive tobacco control program in Florida that included an aggressive youth-oriented media campaign reduced smoking rates by 50 percent among middle school students and by 35 percent among high school students.

State tobacco control programs that are sustained over time also generate a high return on investment. For example, a study of California's tobacco control program found that the state realized a 50-to-1 return on the monies invested in the program during its first 15 years – saving $86 billion in health care costs from 1989 to 2004, while investing $1.8 billion in the program. These findings provide further evidence that investments in tobacco control not only prevent disease and save lives, but also dramatically reduce health care costs.

States can achieve substantial reductions in tobacco use and tobacco-related disease and death by sustaining support for comprehensive, evidence-based tobacco control programs over time. In combination with other evidence-based tobacco control interventions – including enacting 100 percent smoke-free laws, increasing the price of tobacco products, implementing media campaigns, and making cessation services available to all populations – adequately funded comprehensive state tobacco control can bring an end to the tobacco use epidemic.

Effects of Reducing State Funding for Tobacco Control Programs

The experiences of a number of states show that reducing funding for state tobacco control programs leads to rapid reversals of previous progress in reducing tobacco use. For example, after funding for the Massachusetts program was cut by 95 percent in Fiscal Year 2004, cigarette sales to minors increased, declines in youth smoking stalled, and the state's per capita cigarette consumption rose. Similarly, after funding for Florida's highly successful youth-oriented "truth" campaign was drastically reduced, youth smoking rates, which had been falling sharply, stabilized and then began creeping up again. Finally, within six months of the elimination of the youth-oriented Target Market media campaign in Minnesota, awareness of the campaign among youth fell sharply and youth susceptibility to initiating smoking increased.

Conclusion

The tobacco use epidemic can be stopped. We know what works. If we were to fully implement proven strategies, we could prevent the staggering toll that tobacco takes on our families and our communities. With sustained implementation of state tobacco control programs and policies, the Institute of Medicine report's best-case scenario of reducing adult tobacco prevalence to 10 percent by 2025 would be attainable.

Tobacco use will remain the leading cause of preventable illness and death in the United States until our efforts to address this problem are on a par with the harm it causes. We look forward to working with you to address this urgent public health issue. Thank you.

TESTIMONY ATTACHMENT 11

Monday, January 31st, 2011

Chairman Kelsch and members of the House Education Committee,

This bill presents the concerned citizen with a tragic dilemma. We can choose to keep in place a successful preventative medicine program to manage tobacco use, and the inevitable addiction and disease caused by tobacco use, or we redirect the funding to benefit the medical school. If we do not stay the course and deal with the issue of tobacco, we will certainly need more doctors in the future. If a car is heading into an accident the solution is to stop the car, not build repair shops. We have a responsibility to strike at the heart of the largest avoidable adversary to health in North Dakota, now, at this moment.

Tobacco kills indiscriminately, but predictably, affecting every age group, smokers and never-smokers. Second-hand smoke is a grim reaper that sows genetic injury to cells with such effectiveness that there is no safe level of exposure. We know this. The true cost to society of a pack of cigarettes is $10.48, which means that society is subsidizing about 60% of the cost of each pack sold. Most of the cost is consumed by the cost of health care, including Medicaid and Medicare, as well as reduced productivity, and early death.

Most tobacco products are purchased by someone who acquired their addiction before the legal age of 18. The tobacco industry has been successfully growing a replacement generation of dependent consumers in the cultural environment of tolerance. Effective application of CDC guidelines for tobacco control promises to succeed where government and existing medical practice has failed. We need to change our culture of failure. We need to recognize that lives are being consumed today in North Dakota which can be saved cheaply by prevention funded by tobacco settlement dollars instead of being lost expensively in the future. Every year 700 North Dakota children become addicted to tobacco. I hope that we do not tolerate this tragic statistic so that we can profit from tobacco. There is a great deal of money to be made from tobacco, by the merchants that sell it, the government that taxes it, and the special interests, including lobbyists and elected officials. The tobacco industry spends over $86,000 a day promoting their products in this state. That is 32 million dollars per year. Certainly there is money outside the tobacco settlement funds that can be used for health promotion and the UND medical school.

When dealing with the cause of so much suffering among our family members, friends and fellow citizens, we need to keep our perspective and the moral high ground. We should not profit from addiction. Rather, we should defeat it. This tragic dilemma-fully funding tobacco control or the medical school- should not exist. Currently, North Dakota has a successful science –based tobacco control program in place at the will of the people. There are better ways to fund the medical school than to kill an effective tobacco control program. Remember, the reason we have this money is because of the tobacco -induced injury and suffering of North Dakota Medicaid patients.

TESTIMONY ATTACHMENT 12

North Dakota House Bill 1353 Testimony
House Education Committee

9am Monday, January 31, 2011
State Capitol Pioneer Room

Good morning Chairman Kelsch and Members of the Committee.

My name is Chelsey Matter. I am the Tobacco Cessation Coordinator for Fargo Cass Public Health. I am here today to share with you the progress my local public health unit has made as a result of Measure 3 funding.

Since Measure 3 funding became available, new partnerships have been developed in a community-wide effort to reduce tobacco use. Fargo Cass Public Health has developed new partnerships with Sanford and Essentia to ensure those health systems have resources not only to effectively address patient tobacco use but to also provide cessation resources.

Both Sanford and Essentia have received support for this policy change system wide. Implementation of a system called Ask.Advise.Refer will provide a channel for patients to access tobacco cessation services. This will be true regardless of where patients access services within that health system.

This initiative is still in the beginning stages at both of these large health systems. As we move forward in these partnerships, we will continue to build support and evaluate the program so that it can be used as a model and replicated statewide.

Another new initiative is the nicotine replacement therapy (NRT) pilot project. NRT includes nicotine patch, gum, and lozenge. This is a partnership that Fargo Cass Public Health has initiated with Sanford, Essentia, Family Healthcare Center, and NDSU Student Health Services.

Often times in a hospital or clinic setting people begin to contemplate behavior change. This is what we refer to as a teachable moment. If a person is considering quitting tobacco use, this program immediately provides them with the resources and tools they need. At these 4 agencies, patients are given 2 weeks of NRT products so they can start the quitting process right away. The Quitline then follows up with additional resources, including ongoing counseling and NRT.

In 2010, 615 ND residents took advantage of this program. This small pilot project shows potential for enormous statewide success in terms of reducing tobacco use by encouraging people to quit and utilizing the resources available.

Both of these programs and many others like them are available because of Measure 3 funding. These programs will not be able to provide immediate cessation resources or positively impact the health of North Dakota residents without continued funding.

Our health department operates under the advisement of the Fargo Cass Board of Health. This board recognizes the value and importance of maintaining tobacco prevention funding at a level recommended by the Centers for Disease Control and Prevention. You have all received correspondence regarding their opposition to this bill.

Thank you for your time and I would be happy to answer any questions you have.

Monday, January 31st, 2011

Chairman Kelsch and members of the House Education Committee,

This bill presents the concerned citizen with a tragic dilemma. We can choose to keep in place a successful preventative medicine program to manage tobacco use, and the inevitable addiction and disease caused by tobacco use, or we redirect the funding to benefit the medical school. If we do not stay the course and deal with the issue of tobacco, we will certainly need more doctors in the future. If a car is heading into an accident the solution is to stop the car, not build repair shops. We have a responsibility to strike at the heart of the largest avoidable adversary to health in North Dakota, now, at this moment.

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TESTIMONY ATTACHMENT 13

Testimony from Michelle Grebel, Valley City, North Dakota

Presented To: **North Dakota House Education Committee**
Re: **House Bill 1353**
Date: **January 31, 2011**
Presented by: **Joe DeMasi**

Hello, Chair Kelsch and members of the House Education Committee. I am Joe DeMasi from Valley City. My wife, Michelle Grebel, could not be here today so she asked me to present this testimony in opposition to House Bill 1353 on her behalf.

While I do not look at all like Michelle, I will be reading in her voice.

FROM MICHELLE GREBEL:

In the summer of 2008, when I learned that, out of the $25 million per year in Tobacco Settlement payments that North Dakota had been receiving for about 10 years, only a tiny fraction of this huge sum had actually been allowed for tobacco prevention work, I was appalled. Along with thousands of other voters, I had assumed during all those years that the Legislature was responsibly investing an adequate amount of TOBACCO Lawsuit Settlement funds to reduce future TOBACCO-caused harms in the state!

So, when a friend of mine in Valley City invited me to help educate folks about Initiated Measure # 3, she didn't have to ask twice. I was happy to help because I knew Measure 3 was for the right thing – specifically dedicating enough Tobacco Settlement money to proven tobacco prevention work to make some serious progress.

I want to help you to realize that it was ordinary people like myself who donated a big chunk of their 2008 summer to work on Measure 3, and none of us will be very happy if our own elected legislators undo all our work. I enjoyed explaining Measure 3 to the people and without realizing it, I had soon collected a pretty good number of signatures on the required petitions.

The people who kept track of our progress in the Barnes County area notified me that by the end of the summer, I had collected 224 signatures. In making all of those contacts, I encountered only ONE PERSON who declined to sign in support of "Measure 3 Tobacco Prevention." I think that tells you a lot about how strong public support is for rejecting HB 1353. In Barnes County alone, a total of 53 public-spirited citizens collected Measure 3 signatures, got their petitions notarized and turned them in. This was a genuine project in participatory democracy. I think actively participating in our democratic system is one of the most important things that a citizen can do.

You are sitting as a committee today to hear testimony on this bill only because the people of North Dakota who happen to reside in your districts entrusted you to represent their best interests in the democratic process. If you support HB 1353, you will be doing the exact opposite of that: You will be overturning the decision of those same voters as they expressed their wishes at the ballot box. If you support HB 1353, you will be further destroying the already-shaky faith that many citizens have in the integrity of state government. And you will be undoing all the work I did in the summer of 2008. **Please do not do that.**

Thank you.

TESTIMONY ATTACHMENT 14

Testimony on House Bill 1353

House Education Committee -- Monday, January 31, 2011

Brenda Warren, Vice-President of Legislation, Tobacco Free North Dakota

Good Morning Madame Chair Kelsch and members of the House Education Committee. My name is Brenda Warren and I am the ~~president-elect~~ of Tobacco Free North Dakota, a statewide coalition of voluntary individuals. organizations and agencies working to promote a healthy society that chooses not to use tobacco; and a state free from death, disease, disability and excess taxes caused by tobacco use.

Tobacco Free North Dakota is a grassroots people's coalition, and I am here today to testify in opposition to House Bill 1353 from a citizen's viewpoint.

The people know that even if none of our own family members use tobacco, ALL North Dakotans pay the huge price of tobacco addiction in our state. For 100% of your constituents, the economic burden from tobacco addiction includes significant additional taxes and higher costs for healthcare. Just for starters, every tax-paying family in the state forfeits $564 to pay for tobacco-related costs every single year!

The people know that for around a decade, North Dakota has received about $25 million every year as our share of the Tobacco Settlement, which we were told was negotiated for the purpose of aggressively reducing FUTURE human and economic harms from tobacco addiction.

The people know that OTHER states that have faithfully funded evidence-based, comprehensive programs have already greatly reduced their own tobacco burdens. For instance, we know that because California DID diligently invest in state-of-the-art tobacco prevention, California's smoking rate is now one-half that of the rest of the country. More importantly, they have hit the ultimate pay-back: Their program has now has resulted in lung cancer rates in California that are nearly 25 percent lower than other states.

The people want to see that same dramatic reduction in lung cancer in North Dakota, too!

Sadly, the people also know that, for more than a decade, North Dakota has failed to invest enough Tobacco Settlement dollars to get that done. That is why, when still-more Tobacco Settlement dollars became available, the citizens in 2008 initiated and ultimately voted-in Measure # 3 by a comfortable margin. Since then, citizen enthusiasm for sustaining this program has only increased. An August 2010 survey of North Dakota adults showed more than 80 percent of North Dakotans support using tobacco settlement money for precisely this purpose.

You have received ample documentation that, even though it is still in its infancy, the state program made possible by Measure 3 is already working. If you scorn the voice of the people by destroying that program, the initial gains will be reversed, and the pernicious "Tobacco Industry Virus" will run unchecked and untreated in North Dakota.

Please do not tell 162,793 North Dakotans that their vote doesn't matter.

Thank you.

The amendment I am proposing increases tobacco product taxes to fund the proposed increases for the medical school programs. For example, cigarette taxes are increased from 44 cents per pack to $2.00 per pack. Increases for other tobacco products are commensurate with the increase for cigarettes. I note that the increased tax will not only fund the new medical school programs proposed by this bill, but similar increases in other states have also resulted in a decrease in tobacco use.

While funding is provided for the new medical school programs, the general fund is held harmless because no funding is provided until the twenty-two million seven hundred and fourteen thousand dollars ($22,714,000) expected in tobacco tax collections each year of the 2009-2011 biennium, has been deposited into the general fund. Any tobacco product taxes collected above that amount in any fiscal year will be deposited at the beginning of the next fiscal year into the Rural Health Care Trust Fund to be used for the benefit of the new medical school programs. It is estimated that increase in the cigarette tax will raise $33.4 million annually and that the additional revenue from the increase in the tax on other tobacco products will raise $3.2 million annually.

The amendment removes all language in HB 1353 that references the original Measure #3 language. In short, if this amendment passes Measure #3 and the will of the people will remain intact, there will be a funding source for these new medical school programs, and tobacco use will also decline.

PROPOSED AMENDMENT TO HOUSE BILL NO. 1353

Page 1, line 1, after "Act" insert "to create and enact a new section to the century code establishing the rural health care trust fund,"

Page 1, line, 1, after "15-52-04," insert: "subsections 1 and 2 of sections 57-36-25, subsections 1 and 2 of section 57-36-26, subsection 1 of section 57-36-27,"

Page 1, line 1, after the second "and" replace "54-27-25" with "57-36-32"

Page 1, line 4, after the second "and" replace "the tobacco settlement trust fund" with "rates of taxation on tobacco products"

Page 1, line 4, remove "to repeal chapter"

Page 1, remove line 5

Page 1, line 6, remove ""prevention and control program and water development trust fund expenditures;"

Page 5, line 16 remove "Section 54-27-25 of the North Dakota Century Code is"

Page 5, remove lines 17 through 31

Page 6, replace lines 1 through 30 with

"Subsections 1 and 2 of section 57-36-25 of the North Dakota Century Code are amended and reenacted as follows:

1. There is hereby levied and assessed upon all cigars and pipe tobacco sold in this state an excise tax at the rate of ~~twenty-eight~~ one hundred twenty seven and one-third percent of the wholesale purchase price at which such cigars and pipe tobacco are purchased by distributors. For the purposes of this section, the term "wholesale purchase price" shall mean the established price for which a manufacturer sells cigars or pipe tobacco to a distributor exclusive of any discount or other reduction.
2. There is levied and assessed upon all other tobacco products sold in this state an excise tax at the following rates:
   a. Upon each can or package of snuff, ~~sixty cents~~ two dollars and seventy two cents per ounce and a proportionate tax at the like rate on all fractional parts of an ounce.
   b. On chewing tobacco, ~~sixteen~~ seventy-three cents per ounce and a proportionate tax at the like rate on all fractional parts of an ounce.

   For purposes of this subsection, the tax on other tobacco products is computed based on the net weight as listed by the manufacturer.

SECTION 5. AMENDMENT. Subsections 1 and 2 of section 57-36-26 of the North Dakota Century Code are amended and reenacted as follows:

1. There is levied and assessed, upon all cigars and pipe tobacco purchased in another state and brought into this state by a dealer for the purpose of sale at retail, an excise tax at the rate of ~~twenty-eight~~ one hundred and twenty eight percent of the wholesale purchase price and, upon all other tobacco products purchased in another state and brought into this state by a dealer for the purpose of sale at retail, an excise tax at the rates indicated in section 57-36-25, at the time the products were brought into this state. For the purposes of this section, the term "wholesale purchase price" means the established price for which a manufacturer sells cigars or pipe tobacco to a distributor exclusive of any discount or other reduction. However, the dealer may elect to report and remit the tax on the cost price of the products to the dealer rather than on the wholesale purchase price. The proceeds of the tax, together with the forms of return and in accordance with any rules and regulations the tax commissioner may prescribe, must be remitted to the tax commissioner by the dealer on a monthly basis on or before the fifteenth day of the month following the monthly period for which it is paid. The tax commissioner shall have the authority to place any dealer on an annual remittance basis when in the judgment of the tax commissioner the operations of the dealer merit that remittance period. In addition, the tax commissioner shall have the authority to permit the consolidation of the filing of a dealer's return when the dealer has more than one location and thereby would be required to file more than one return.

2. If cigars, pipe tobacco, or other tobacco products have been subjected already to a tax by any other state in respect to their sale in an amount less than the tax imposed by this section, the provisions of this section apply, but at a rate measured by the difference only between the rate fixed in this section and the rate by which the previous tax upon the sale was computed. If the tax imposed in the other state is ~~twenty percent of~~ equal to or greater than the ~~wholesale purchase price or more~~ rates in section 57-36-25, then no tax is due on the article. The provisions of this subsection apply only if the other state allows a tax credit with respect to the excise tax on cigars, pipe tobacco, or other tobacco products imposed by this state which is substantially similar in effect to the credit allowed by this subsection.

SECTION 6. AMENDMENT. Subsection 1 of section 57-36-27 of the North Dakota Century Code is amended and reenacted as follows:

1. A tax is hereby imposed upon the use or storage by consumers of cigarettes in this state, and upon ~~such~~ those consumers, at the ~~following~~ rates:

~~a. On cigarettes weighing not more than three pounds [1360.78 grams] per thousand, five mills on each such cigarette.~~

~~b. On cigarettes weighing more than three pounds [1360.78 grams] per thousand, five and one-half mills on each such cigarette~~ in sections 57-36-06 and 57-36-32.

SECTION 7. AMENDMENT. Section 57-36-32 of the North Dakota Century Code is amended and reenacted as follows:

57-36-32. Separate and additional tax on the sale of cigarettes - Collection - Allocation of revenue - Tax avoidance prohibited. There is hereby levied and assessed and there shall be collected by the state tax commissioner and paid to the state treasurer, upon all cigarettes sold in this state, an additional tax, separate and apart from all other taxes, of ~~seventeen~~ one-hundred mills on each cigarette, to be collected as existing taxes on cigarettes sold are, or hereafter may be, collected, by use of appropriate stamps and under similar accounting procedures. No person, firm, corporation, or limited liability company shall transport or bring or cause to be shipped into the state of North Dakota any cigarettes as provided herein, other than for delivery to wholesalers in this state, without first paying the tax thereon to the state tax commissioner. All of the moneys collected by the state treasurer under this section shall be credited to the state general fund.

SECTION 8. A new section to the North Dakota Century Code is hereby created:

Rural health care trust fund - Interest on fund - Uses. There is created in the state treasury a rural health care trust fund. At the end of each fiscal year, the state treasurer shall transfer to the rural health care trust fund all revenues derived from taxes on tobacco products that are in excess of twenty-two million seven hundred and fourteen thousand dollars during the fiscal year. Interest earned on the rural health care trust fund must be credited to the fund and deposited in the fund. The principal and interest of the rural health care trust fund may only be used to defray the expenses of the university of North Dakota school of medicine and health sciences projects and programs related to increasing the health care workforce in the state, with a focus on the education of primary care physicians."

Page 7, line 1 replace "6" with "9"

Page 7, line 2, replace "health care programs" with "rural health care"

Page 7, line 7, replace "7" with "10"

Page 7, line 8, replace "health care programs" with "rural health care"

Page 7, line 14, replace "8" with "11"

Page 7, line 14, replace "**TOBACCO PREVENTION AND CONTROL TRUST**" with "**GENERAL**"

Page 7, line 15, replace "**HEALTH CARE PROGRAMS**" with "**RURAL HEALTH CARE**"

Page 7, line 16, replace "any balance remaining in the tobacco prevention and control trust fund" with " the sum of $34,700,000, from the general fund"

Page 7, line 17, replace "health care programs" with "rural health care"

Page 7, line 17, remove "For purposes of this section, "at the"

Page 7, remove lines 18 and 19.

Renumber accordingly

NEW REVENUES, PUBLIC HEALTH BENEFITS & COST SAVINGS FROM A $1.56 CIGARETTE TAX INCREASE IN NORTH DAKOTA

Current state cigarette tax: 44 cents per pack (46th among all states)
Smoking-caused costs in North Dakota: $10.48 per pack

Annual healthcare expenditures in North Dakota directly caused by tobacco use: $247 million
Smoking-caused state Medicaid program spending each year: $47.0 million

New Annual Revenue from Increasing the Cigarette Tax Rate by $1.56 Per Pack: $33.4 million
Additional Revenue from Raising Other Tobacco Product Rates to Parallel New Levels: $3.2 million

New Annual Revenue is the amount of additional new revenue over the first full year after the effective date. The state will collect less new revenue if it fails to apply the rate increase to all cigarettes and other tobacco products held in wholesaler and retailer inventories on the effective date.

Projected Public Health Benefits from the Cigarette Tax Rate Increase	
Percent decrease in youth smoking:	**25.7%**
Kids in North Dakota kept from becoming addicted adult smokers:	**7,900**
Current adult smokers in the state who would quit:	**5,300**
Smoking-affected births avoided over next five years:	**1,800**
North Dakota residents saved from premature smoking-caused death:	**3,900**
5-year health savings from fewer smoking-affected pregnancies & births:	**$3.1 million**
5-year health savings from fewer smoking-caused heart attacks & strokes:	**$2.4 million**
Long-term health savings in the state from adult & youth smoking declines:	**$188.6 million**

- Tax increases of less than roughly 25 cents per pack or 10% of the average state pack price do not produce significant public health benefits or cost savings because the cigarette companies can easily offset the beneficial impact of such small increases with temporary price cuts, coupons, and other promotional discounting. Splitting a tax rate increase into separate, smaller increases in successive years will similarly diminish or eliminate the public health benefits and related cost savings (as well as reduce the amount of new revenues).
- Raising state tax rates on other tobacco products (OTPs) to parallel the increased cigarette tax rate will bring the state more revenues, public health benefits, and cost savings (and promote tax equity). With unequal rates, the state loses revenue each time a cigarette smoker switches to cigars, RYO, or smokeless. To parallel the new $2.00 per pack cigarette tax, the state's new OTP tax rate should be at least 65% of wholesale price with minimum tax rates for each major OTP category linked to the state cigarette tax rate on a per-package or per-dose basis.

Needed State Efforts to Protect State Tobacco Tax Revenues

Having each of the following measures in place will maintain and increase state tobacco tax revenues by closing loopholes, blocking contraband trafficking, and preventing tax evasion.

State tax rate on RYO cigarettes equals the state tax rate on regular cigarettes	Yes
State tax rates on other tobacco products match the state cigarette tax rate	Yes
State definitions of "cigarette" block cigarettes from wrongfully qualifying as "cigars"	No
State definitions of "tobacco product" reach all tobacco products	No
Loopholes for the new generation of smokeless products (snus, tablets, etc.) closed	No
Minimum taxes on all tobacco products to block tax evasion and promote tax equity	No
"High-tech" tax stamps to stop counterfeiting and other smuggling and tax evasion	No
Retailers lose license if convicted of contraband trafficking	Yes
Street sales and mobile sales of cigarettes and other tobacco products prohibited	Yes
Non-Tobacco nicotine products without FDA approval banned	No

More information available at http://tobaccofreekids.org/research/factsheets/index.php?CategoryID=18

Campaign for Tobacco-Free Kids 10.07.10 / Ann Boonn & Eric Lindblom, December 13, 2010

1400 I Street NW - Suite 1200 - Washington, DC 20005
Phone (202) 296-5469 · Fax (202) 296-5427 · www.tobaccofreekids.org

Explanations & Notes

Projections are based on research findings that each 10% cigarette price increase reduces youth smoking by 6.5%, adult rates by 2%, and total consumption by 4% (adjusted down to account for tax evasion effects). Revenues still increase because the higher tax rate per pack will bring in more new revenue than is lost from the tax-related drop in total pack sales.

The projections incorporate the effect of both ongoing background smoking declines and the continued impact of the 61.66-cent federal cigarette tax increase (effective April 1, 2009) on prices, smoking levels and pack sales.

These projections are fiscally conservative because they include a generous adjustment for lost state pack sales (and lower net new revenues) from possible new smuggling and tax evasion after the rate increase and from fewer sales to smokers or smugglers from other states. For ways that the state can protect and increase its tobacco tax revenues and prevent and reduce contraband trafficking and other tobacco tax evasion, see the Campaign for Tobacco-Free Kids factsheet, *State Options to Prevent and Reduce Cigarette Smuggling and to Block Other Illegal State Tobacco Tax Evasion*, http://tobaccofreekids.org/research/factsheets/pdf/0274.pdf.

Kids stopped from smoking and dying are from all kids alive today. Long-term savings accrue over the lifetimes of persons who stop smoking or never start because of the rate increase. All cost and savings in 2004 dollars. Projections will be updated when new relevant data or research becomes available.

Ongoing reductions in state smoking levels will, over time, gradually erode state cigarette tax revenues (in the absence of any new rate increases). But those declines are more predictable and less volatile than many other state revenue sources, such as state income tax or corporate tax revenues (which can drop sharply during recessions). In addition, the smoking declines that reduce tobacco tax revenues will simultaneously produce much larger reductions in government and private sector smoking-caused costs. See the Campaign for Tobacco-Free Kids factsheet, *Tobacco Tax Increases are a Reliable Source of Substantial New State Revenue*, http://tobaccofreekids.org/research/factsheets/pdf/0303.pdf.

For other ways states can increase revenues (and promote public health) other than just raising its cigarette tax, see the Campaign factsheet, *The Many Ways States Can Raise Revenue While Also Reducing Tobacco Use and Its Many Harms & Costs*, http://tobaccofreekids.org/research/factsheets/pdf/0357.pdf.

For more on sources and calculations, see
http://www.tobaccofreekids.org/research/factsheets/pdf/0281.pdf

Additional Information on Tobacco Product Tax Increases

Raising State Cigarette Taxes Always Increases State Revenues and Always Reduces Smoking, http://tobaccofreekids.org/research/factsheets/pdf/0098.pdf.

Responses to Misleading and Inaccurate Cigarette Company Arguments Against State Tobacco Tax Increases, http://tobaccofreekids.org/research/factsheets/pdf/0227.pdf.

State Cigarette Excise Tax Rates & Rankings, http://tobaccofreekids.org/research/factsheets/pdf/0097.pdf.

Top Combined State-Local Cigarette Tax Rates (State plus County plus City), http://tobaccofreekids.org/research/factsheets/pdf/0267.pdf.

State Cigarette Tax Increases Benefit Lower-Income Smokers and Families, http://tobaccofreekids.org/research/factsheets/pdf/0147.pdf.

The Best Way to Tax Smokeless Tobacco, http://tobaccofreekids.org/research/factsheets/pdf/0282.pdf.

The Problem with Roll-Your-Own (RYO) Tobacco, http://tobaccofreekids.org/research/factsheets/pdf/0336.pdf.

How to Make State Cigar Tax Rates Fair and Effective, http://tobaccofreekids.org/research/factsheets/pdf/0335.pdf.

State Benefits from Increasing Smokeless Tobacco Tax Rates, http://tobaccofreekids.org/research/factsheets/pdf/0180.pdf.

The Case for High-Tech Cigarette Tax Stamps, http://tobaccofreekids.org/research/factsheets/pdf/0310.pdf.

State Options to Prevent and Reduce Cigarette Smuggling and to Block Other Illegal State Tobacco Tax Evasion, http://tobaccofreekids.org/research/factsheets/pdf/0274.pdf.

The Many Ways States Can Raise Revenue While Also Reducing Tobacco Use and Its Many Harms & Costs, http://tobaccofreekids.org/research/factsheets/pdf/0357.pdf

For questions or model legislation, please contact factsheets@tobaccofreekids.org.

SUBMITTED TESTIMONY ATTACHMENT 15

Sanford Roger Maris Cancer Center
820 4th St N
Fargo, ND 58122
(701) 234-6161
www.sanfordhealth.org

SANFORD HEALTH

January 31st, 2011

Education Committee
600 East Blvd Ave.
Bismarck, ND 58505-0200

820 4th Street North
Fargo, ND 58122

To Whom It May Concern:

It has come to my attention that the Education Committee is hearing bill 1353 on January 31st. As Medical Director of the Sanford Roger Maris Cancer Center, I support tobacco education and cessation programs at CDC funding levels.

Tobacco cessation will decrease cancer deaths across the state. Tobacco is linked to more causes of cancer deaths than any other carcinogen.

I thank you for your consideration in this matter and look forward to hearing the results of this legislative session.

Sincerely,

John Leitch, MD
Medical Director
Sanford Roger Maris Cancer Center

Our Mission:
Dedicated to the work of health and healing

SUBMITTED TESTIMONY
ATTACHMENT 16

Essentia Health
Here with you

North Dakota House Bill 1353 Testimony
House Education Committee
9am Monday, January 31, 2011
State Capitol Pioneer Room

Good morning Chairman Kelsch and Members of the Committee.

My name is Cheri Thomson I am a Tobacco Treatment Specialist for Essentia Health in Fargo. Essentia Health supports expanding funding for the UND Medical School – however, we strongly oppose re-directing the voter-approved Measure 3 tobacco funds as the major funding source for this expansion.

Essentia Health is committed to helping our patients and their families lead active and fulfilling lives. Our partnership with Fargo Cass Public Health, made possible by Measure 3 funding, ensures our patients have the necessary resources to quit tobacco use and lead healthier lives.

Thank you for your time and I would be happy to answer any questions you have.

3000 32nd Avenue South

Fargo, ND 58103

SUBMITTED TESTIMONY ATTACHMENT 17

Public Health
Prevent. Promote. Protect.
Fargo Cass Public Health

401 Third Avenue North
Fargo, ND 58102
701-241-1360

January 19, 2011

Dear Education Committee Members:

This letter is regarding House Bill 1353, related to the transferring of funds away from a voter-initiated tobacco prevention program, Measure 3. This measure works to reduce death and disease related to tobacco use in North Dakota. House Bill 1353 transfers all funds for tobacco prevention and control in ND to the UND School of Medicine, to support primary care physician programs.

In 2008, ND residents voted to approve Measure 3, which allocated funding for tobacco prevention and control at minimum levels recommended by the U.S. Centers for Disease Control and Prevention. This amount is $9.3 million annually. Measure 3 funding became available in 2009 and as a result, each of the 28 local public health units in ND have been able to work toward implementing comprehensive tobacco prevention and control programs in their respective service areas. Measure 3 requires that the comprehensive program must be what is described in the CDC's *Best Practices for Comprehensive Tobacco Control Programs*. The CDC Best Practices are strategies that are proven to reduce tobacco use significantly across the population in the most cost-effective way.

Measure 3 allowed for the creation of a state-wide plan to reduce tobacco use, 'Saving Lives-Saving Money: North Dakota's Comprehensive State Plan to Prevent and Reduce Tobacco Use 2009-2014". This plan includes four goals: 1) Prevent initiation of tobacco use among youth and young adults, 2) Eliminate exposure to secondhand smoke, 3) Promote quitting tobacco use, and 4) Build capacity and infrastructure to implement a comprehensive evidence-based tobacco prevention and control program.

The appropriation of funds for Measure 3 meant that North Dakota was one of only 2 states to fully fund comprehensive tobacco prevention and control program. Research indicates that without fully funding a comprehensive tobacco prevention and control program, adequate progress will not be made in terms of reducing death and disease from tobacco use. Should House Bill 1353 pass, the resulting action would effectively eliminate all funding for comprehensive tobacco prevention and control programs in North Dakota. Measure 3 successes in the first year of implementation include:

- ✓ Seven additional K-12 schools have adopted a comprehensive school tobacco policy, meaning more ND kids are protected from secondhand smoke.
- ✓ More ND residents are accessing the ND Quitline as well as Quitnet.
- ✓ Three communities, Grand Forks, Napoleon and Pembina, have adopted and implemented comprehensive smoke-free public workplace laws for their communities. Bismarck is also actively working toward the same goal and will hold a public vote in April.
- ✓ New partnerships, in addition to other on-going projects, have been established with Essentia (formerly Innovis) and Sanford Health (formerly MeritCare) to implement the Public Health Service guidelines, which help facilitate tobacco cessation services for patients in these facilities.

The work of Measure 3 is nowhere near complete. If HB 1353 passes, Measure 3 will no longer have the resources or ability to serve the residents of ND.

We, as the Board of Health for Fargo Cass Public Health, ask as this issue is brought before the Education Committee, that you seriously consider the negative consequences for North Dakota residents if HB 1353 is passed.

Respectfully submitted,

Michelle M. Donarski

Michelle M. Donarski, JD
Chair – Board of Health

SUBMITTED TESTIMONY ATTACHMENT 18

North Dakota House Bill 1353 Testimony
House Education Committee
9am Monday, January 31, 2011
State Capitol Pioneer Room

Good morning Chairman Kelsch and Members of the Committee.

My name is Brandon Carmichael and I live in West Fargo.

I am living proof of the deadly effects of tobacco. I've lost my limbs from tobacco use, but I haven't lost my voice. I voted to pass Measure 3 in 2008 and today I urge you to oppose House Bill 1353.

TESTIMONY OPPOSING OF HB1353

SUBMITTED TESTIMONY
ATTACHMENT 19

K.C. Chatwood
7500 University Dr
Bismarck, ND
1- 406-855.1194

Chairman Kelsch and Representatives,

My name is KC Chatwood, I am speaking on the behalf Health Pro (Peers Reaching Out) from the University of Mary. Health Pro are student leaders who provide health and wellness education programs to University of Mary students on a peer-to-peer level. We are fortunate enough to received professional training and technical support from Measure 3 funds through Bismarck Burleigh, Tobacco Prevention and Control program to work on strengthening our tobacco free policy to include the entire campus.

Measure 3 funding provided the opportunity this past summer, for Health Pro students along with other North Dakota universities and colleges to attend a statewide Bacchus Network training on tobacco-free college campus policies. By attending this training we were able to move forward on advancing tobacco free policy at the University of Mary. We have learned that a tobacco-free policy provides an environment that reinforces healthy behavior. As the policy removes the immediate threat of exposure to secondhand smoke, it also decreases the use of tobacco and the number of people who start smoking in college. It provides a healthy learning environment.

Measure 3 funding also gave us the available resources for technical support in development of educational materials to educate our peers and administration about the benefits of tobacco free campus to assist with reducing tobacco use rates.

We oppose HB 1353 because it removes funding from Measure 3, and we would not have been able to accomplish the work we have done at the University of Mary without it.

Thank you

SUBMITTED TESTIMONY
ATTACHMENT 20

NDNA

P.O. Box 292 Mandan, ND 58554

701-223-1385

Testimony on HB 1353

January 31, 2011

Wanda Rose PhD, RN, BC

North Dakota Nurses Association

My name is Wanda Rose, I am a Registered Nurse and the President of the North Dakota Nurses Association, and today I am representing the ND Nurses Association. The North Dakota Nurses Association is opposed to HB1353 and the elimination of statewide Best Practice tobacco prevention programs that are working.

If there was an H1N1 epidemic in the state and 900 people died each year from it, our residents would be up in arms that such a thing would be allowed and that more was not being done to protect health and save lives. The epidemic is tobacco use and it is killing more than 900 North Dakotans each year. This is truly an epidemic that cannot be ignored and must be given the resources to effectively decrease the personal tragedies and suffering.

Tobacco use is the leading cause of preventable death and disability in ND. The costs to North Dakota are staggering. The U.S. Centers for Disease Control and Prevention (CDC) reports that in North Dakota, smoking costs $247 million per year in healthcare expenses. Of this, $47 million are Medicaid costs. The CDC estimates that smoking-caused healthcare costs and lost productivity losses in North Dakota total $10.48 per pack sold in the state. In addition, North Dakota households pay on average of about $564 per year in federal and state taxes to cover government expenditures caused by tobacco use.

In reviewing North Dakota Medicare data, hospital costs associated with one person experiencing an acute myocardial infarction (heart attack) and one person seeking treatment for COPD (chronic obstructive pulmonary disease), a respiratory illness that can be caused, by smoking, were available. The median Medicare payment made to Altru Hospital of Grand Forks, Medcenter One and St. Alexius here in Bismarck, Sanford and Innovis in Fargo and Trinity in Minot, ranges from $ 4,338 to $11,956 per person to treat. Similarly, for COPD, the median Medicare payments the same hospitals range from $3,618 to $8,029 with per person to treat. (USDHHS, 2010, Hospital Compare).

A specific Medicaid expenditure is births, with state Medicaid programs covering well over half of all births in the United States. Research studies estimate that the direct

additional healthcare costs associated just with the birth complications caused by pregnant women smoking or being exposed to secondhand smoke could be as high as an average of $1,142 to $1,358 per birth. In North Dakota smoking in pregnancy is higher than the national average: 18% vs. 11%.

Additionally, in North Dakota, 10% of all smoking-caused healthcare expenditures are paid for by the state's Medicaid program.

Tobacco kills people who never ever light a cigarette by the exposure to secondhand smoke. Even brief exposure can be dangerous because nonsmokers inhale many of the same carcinogens and toxins in cigarette smoke as smokers. For children and babies, this means acute respiratory infections, ear problems, and more frequent and severe asthma attacks and sudden infant death

The most troubling aspect of these unnecessary deaths is that most smokers begin at a young age when they do not fully understand the consequence of their actions, the strength of addiction, and the manipulations of tobacco industry's marketing tactics.

As a nurse faculty, I educate nursing student on the importance of assisting people to quit and have referred multiple individuals to the quit line. Not funding comprehensive tobacco control in ND is condemning many people to continued suffering and death from an extremely difficult addiction. North Dakota voters recognize the need to stop the tobacco control epidemic and in November 2008 voted to spend a portion of the tobacco settlement funds to support a comprehensive statewide tobacco prevention and control program.

It is the duty of this body to address this epidemic, to respect the vote of the people, and to appropriate the tobacco settlement dollars to the implementation of the comprehensive tobacco program.

Wanda Rose PhD, RN, BC

North Dakota Nurses Association, Pres.

701-323-6274

SUBMITTED TESTIMONY
ATTACHMENT 21

Testimony HB 1353

My name is Wanda Agnew – I have almost 40 years of experience working in public health with local, State, and Tribal governments and programs. As a professional in the area of nutrition, I see how the addictive substance of tobacco impacts chronic diseases and economic conditions, for individuals and families.

Today I am representing over 200 Public Health professionals in North Dakota on behalf of the ND Public Health Association. The mission of the NDPHA is to improve, promote, and protect health for residents of North Dakota through leadership in policy, partnerships and best practices. NDPHA believes tobacco is a difficult, real problem that needs planned, real solutions for individuals and families – which is exactly what Measure 3 funding enables our great public health workforce at the local level to do.

North Dakota Public Health Association opposes HB 1353.

SUBMITTED TESTIMONY ATTACHMENT 22

January 26, 2011

Dear North Dakota Legislator:

Business as usual at the University of North Dakota School of Medicine.

Graduating class of 55 this past year but only seven (7) remained at in-state residency programs filled mostly by foreign medical graduates who statistically will not remain or practice in North Dakota. "Crisis" cries the Dean of Medical School...now...to the legislature...while he has done nothing significant over the past four years to address this looming catastrophe.

> Yes--there is a crisis in medical care looming---"a deficiency of at least 125,000 physicians nationally by 2025...with 32 million more patients in 2014 when the health reform law kicks in"...(AMA News 17 January 2011).
>
> No--the medical school bill (HB1353: Skarphol, Weisz, Lee and Holmberg) committing up to $104 million over the next six years for more building, more students (who do not remain in North Dakota) and more jobs in the Red River Valley does not guarantee or demonstrate significant change in existing admission policy or responsible utilization of existing residency programs. "Trust me, I am a doctor"?

Our tax dollars...Look at the medical school record. Business as usual. This is wrong.

The medical school mission as mandated by Chapter 15-52 of the North Dakota Century Code is "to enhance the quality of life of North Dakotans by producing doctors who would practice in North Dakota". The issue is not can we train doctors (yes, we can...and, damn fine ones, too). **The issue is**, and always has been, can we train primary care physicians wanting to remain and practice medicine in the State of North Dakota.

As a 64-year-old native North Dakotan, physician for 36 years, father of three, US Army veteran (10 years Viet Nam era) who has served on Lake Region public school, state college, hospital and bank boards...I say enough! I am vested in North Dakota but now, along with all those heroic individual nurses, PA's, and administrators who have been for years keeping our rural clinics, hospitals and emergency departments afloat, we are tired of being scammed by this University Medical School that has hurt our people and threatens our small communities by its mission failure.

If the School of Medicine cannot provide us with doctors and "improve our quality of life" (Century Code), then we should certainly not provide our tax, or any other, dollars for support...just plain wrong!.

Richard E. Johnson, MD

From: Dale Klein [dklein@mohs.org]

Sent: Friday, January 21, 2011 5:03 PM

To: Rohr, Karen M.

Subject: HB 1353

Rep Rohr

Hope your first session is going well.

I want to ask your help in giving 1353 a do not pass.

When you were campaigning we spoke briefly about the tobacco money. We have the first CDC fully funded plan in the nation and are starting to

Make real impact on smoking in the state. To eliminate the prevention plan in total sacrifices the health of our state residents. For every $1 spent on

Tobacco prevention we save $6.

I'm glad there looks to be support for expanding the medical school. I am concerned the bill wants the mission to increase doctors in the state but doesn't target primary care where the need is the greatest. Another funding source should be sought. If you want to help both the medical school and the health of our residents at the same time, increasing the tobacco tax to $2.00 per pack with the money going to medical education would decrease smoking selectively in youth and lower social-economic groups and provide revenue for the medical school at the same time..

Thanks for any help you can give. Dale Klein cell 226-3857

From: ibdarwin@aol.com [mailto:ibdarwin@aol.com]
Sent: Tuesday, January 25, 2011 5:37 PM
To: Heilman, Joe A.
Subject: Paying for the medical school expansion by gutting the state's tobacco cessation program is a mistake.

Dear Rep Heilman:

I am in favor of the UND Medical School. I and my family have benefited greatly from its existence. I, and many of the people that I went to medical school with and the physicians that I practice with, would not be physicians without its existence. It does increase the supply of physicians for the state. There are 7 of my medical school class practicing in the Bismarck-Mandan area. I am in favor of expanding this opportunity to other North Dakotans and encouraging them to go into primary care. These are all good things.

With that said, I am confused by the bill. I do not see how changing the make-up of the advisory board toward members from small communities will change where physicians practice when they graduate. Additionally, accepting students from small communities likely will not change where they practice. In our group, we sent to school in Cando, Lamoure, Flasher, and Eldridge, yet we all practice in Bismarck-Mandan and not the small communities we grew up in. Mandating that 80% of the residency spots are filled by UND graduates is also not practical. Once students graduate they can apply to residency spots everywhere in the country; they are not captive. This bill will not guarantee that one doctor will practice in any community in North Dakota, much less the smaller rural communities.

Paying for the medical school expansion by gutting the state's tobacco cessation program is a mistake. This program is cost effective and saves lives. I have had smoking patients comment on the millions of dollars from tobacco taxes and the tobacco settlement, asking what smokers get out of these dollars. Without Measure 3, they get nothing. The efforts made in smoking cessation will help them stop smoking and prevent their children from being seduced by the false advertising of tobacco companies. These efforts need to be continued. We all knew what we were voting for with Measure 3. Don't let it be undone.

Sincerely,

Darwin Lange

January 31, 2011

Members of the North Dakota House

I am a native of North Dakota, a 2004 graduate of the University of North Dakota School of Medicine, recently completed my training at the Mayo Clinic and the University of Wisconsin, and currently treat head and neck cancer patients as an Otolaryngologist - Head and Neck Surgeon in Bismarck, North Dakota.

In May of 2001 I was completing my first year of medical school. I was the lone North Dakota medical student representing our state amongst several hundred students from around the country at the American Medical Association National Convention in Chicago. The keynote speaker was Mississippi State Attorney General Michael Moore. To refresh, he is the lead attorney to bring litigation against big tobacco..... also known as the "Master Settlement Agreement". Apparently he worked quite hard to bring a monetary damage claim against the tobacco industry to help states recoup costs suffered due to tobacco. The primary take home point of his presentation was to bring awareness regarding the allocation of the major settlement funds. He was outright disgusted with many states utilization. He singled out North Dakota during his presentation. He wanted to make a point. He asked all of the North Dakotans to raise their hand, just me, and he rattled off statistics on youth smoking in North Dakota, tobacco related death rates, and how we were spending our settlement 'grab bag' money that he worked so hard for. Turns out we weren't spending much of anything to help fight tobacco at that time. How embarrasing, thanks guys. Well, we are slowly making progress here in North Dakota. Let's not step backward.

As a Head and Neck Surgeon that now treats head and neck cancer, a Graduate of the University of North Dakota School of Medicine, please do not cut down Measure 3. I support the School of Medicine, but providing a little support to a few students that may go into primary care, and that may treat North Dakotans would come at a huge expense to fighting tobacco.

Please protect the people of this state and continue to fight tobacco the way the way Attorney General Michael Moore and the Major Settlement Agreement intended. Vote no on House Bill 1353.

Andrew Hetland, MD
UNDSOMHS Class of 2004
Otolarygology - Head and Neck Surgeon
Mid Dakota Clinic
Bismarck, ND

Testimony of Heidi Heitkamp in Opposition to the portions of HB1353 that Repeal Measure #3

Simply stated, HB 1353 funds the UND Medical School expansion and operation costs by repealing Measure #3, approved by the voters in 2008, and uses the money the voters set aside for tobacco prevention and control programs for the medical school.

I strongly oppose the repeal of Measure #3. I also strongly oppose this cynical attempt to set two important public health interests (the need for more primary care professionals and tobacco prevention and control) against each other. I, for one, will not take the bait. The medical school is an important public health institution in North Dakota. I wish all involved good luck in their attempts to retool the Medical School so that North Dakota's future health care needs are addressed.

In the public debate that has ensued since the introduction of this bill, I have heard many justifications in support of the bill including:

- We have done all we can in tobacco prevention so its ok to take the money (totally ignoring the facts);
- The bill helps all North Dakotans instead of just smokers (never mind the health care cost the entire state bears because of tobacco usage and the fact that smokers are the ones who pay for the tobacco settlement); and
- North Dakota spends too much on tobacco prevention (an argument that confuses tobacco prevention with all prevention programs).

All of these arguments can be discussed and addressed (see attached sheet) but I would like to address the most insulting of all the justifications: **Rep. Bob Skarphol's comment that Measure #3 should be repealed because the voters did not know what they were doing when they voted.** Wow. Ironically, Rep Skarphol is a sponsor of HB 1257 that requires that UND not be allowed to change its nickname until the people of Standing Rock Sioux Nation are allowed to vote on the issue. Yet Rep. Skarphol believes it is completely acceptable to ignore the votes of 162,793 North Dakotan who voted for Measure #3. As we say in the legal world, this fact speaks for itself.

I ask the House Education Committee to honor the 162,793 voters who said yes to a North Dakota future without tobacco deaths and costs. Let common sense prevail. Training primary care doctors and other professionals is important and should be discussed and supported, but training more people to cure disease should not be done at the expense of disease prevention. In support I would remind the committee of the wise words of one of our greatest founding fathers, Ben Franklin, who said, "An ounce of prevention is worth a pound of cure."

The Human Cost of Tobacco in North Dakota

- Each year in North Dakota, tobacco usage costs 910 lives.
- 11,000 North Dakota kids living today will die prematurely from tobacco addiction if we maintain our current rate of smoking.
- These deaths are not acceptable, nor have we done all we can in tobacco prevention.

The Monetary Cost of Tobacco Use in North Dakota

- Each year in North Dakota, tobacco costs $247 million in increased healthcare costs. Tobacco costs each household in North Dakota $567 annually. We all pay these costs when we pay our insurance premiums.
- Each year in North Dakota, taxpayers pay $47 million in increased Medicaid costs because of tobacco.

North Dakota's Tobacco Prevention Program is Working

- 3 million fewer packs of cigarettes were sold per year in North Dakota starting in 2007
- Based on current trend lines, because of the success of our prevention program, the North Dakota Tax Department projects that the number of packs of cigarettes sold will decline by 7 million by 2013.
- Since the passage of Measure #3 more North Dakotans have quit and are trying to quit. ND Tobacco Quitline program use has dramatically increased and counseling enrollment is up by 195%.
- Tobacco use has declined to 18.6% in North Dakota, down from almost 21% in 2007.
- Public health experts know that these successes will reverse if we discontinue the prevention effort.

North Dakotans Demanded that Tobacco Settlement Money be Spent on Tobacco Control

- When we passed Measure #3, North Dakota voters ordered the legislature to spend tobacco settlement money on an effective, science based tobacco control program.
- Today 80% of North Dakotans still support using tobacco settlement for tobacco prevention and cessation programs (2010 public opinion study).
- The prevention effort only requires the state to use less than 10% of the total tobacco settlement funds on a science based tobacco prevention and control program. 10% is not too much to ask for when the cost of the settlement is paid by smokers, and the health and monetary costs of tobacco usage are so high.
- If HB1353 is passed, Measure #3 will be completely repealed and there will no longer be a guarantee that any tobacco settlement dollars be used for tobacco prevention programs.

SUBMITTED TESTIMONY ATTACHMENT 23

Good morning, Chariman Kelsch and members of the House Education Committee. My name is Kimberlee Schneider, I am the program manager for the American Lung Association in North Dakota based in Bismarck. I am here to testify against HB1353 relating to the redirecting of the funds mad possible by a vote of the people in North Dakota.

The American Lung Association in North Dakota worked together in a grassroots campaign with citizens across the state to assure that a small portion of the Master Settlement dollars be used as promised in the foundation of the litigation to reduce the harm and destruction caused by the tobacco industry commonly referred to as Measure 3. Let me be clear, Measure 3 was a movement of the voters, Republicans, Democrats, Independents, old, young, smokers and non-smokers, who together voted to change the way tobacco is used in our state and focus on prevention.

Redirecting those dollars to any other issue, including important issues like rural health, is wrong and clearly flies in the face of the will of the people.

The science, research, and Best Practices related to tobacco use and preention is sound and the framework for the work made possible by Measure 3 across our state.

In the American Lung Association's recent report on the State of Tobacco Control, North Dakota was one of only two states to receive an "A" in tobacco control spending North Dakota is leading the nation on this important public health issues, HB1353 would change our grade in next year's report to an "F". Failing in preventing the deaths of loved ones across North Dakota is just not acceptable.

On behalf of the Lung Association I urge you to vote NO on HB1353.

SUBMITTED TESTIMONY ATTACHMENT 24

January 27, 2011

TO: North Dakota State Legislators

FROM: North Dakota Society for Respiratory Care

RE: Oppose HB 1353

As the North Dakota Society for Respiratory Care representing the 480 licensed respiratory therapists in the state, we are writing to register our opposition to HB 1353.

As respiratory therapists in North Dakota, we are interested in the health of the citizens in the state. We care for patients with lung disease and treat those who suffer from tobacco related illnesses. The funding provided is an essential component to continue to provide tobacco control and cessation programs to the many North Dakotans in need of these services.

While we understand the budget challenges concerning the University of North Dakota School of Medicine and Health Sciences, the citizens of North Dakota were very clear in 2008. When Measure 3 was placed before the voters as to whether to support tobacco prevention and cessation programs, the clear majority of North Dakota voters voted "yes". Enacting HB 1353 would be in complete contrast to what the citizens of North Dakota have clearly stated they want and support.

As respiratory therapists in North Dakota we believe it is critical to continue to fund tobacco prevention and cessation programs. It not only is what the people of North Dakota said they wanted, but also the most effective way to keep our youth from starting to use tobacco and provide support and help to those who want to quit. This plan can not only save money for North Dakota's future but save the lives of its citizens.

Please oppose HB 1353

SUBMITTED TESTIMONY

ATTACHMENT 25

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
9425 North MacArthur Blvd., Suite 100, Irving, TX 75063, (972) 243-2272, Fax (972) 484-2720
http://www.aarc.org, E-mail: info@aarc.org

January 27, 2011

TO: North Dakota State Legislators

FROM: Karen Stewart, MS, RRT
President, American Association for Respiratory Care

RE: Oppose HB 1353

As President of the American Association for Respiratory Care (AARC) and on behalf of our 52,000 members, I am writing to register our opposition to HB 1353.

Respiratory therapists, including over 500 licensed respiratory therapists in North Dakota, are health care professionals who treat and care for patients of all ages suffering from lung diseases. These include high-risk patients with chronic conditions such as asthma and chronic obstructive pulmonary disease (COPD), emphysema and chronic bronchitis. Respiratory therapists are one of the key health care professionals involved in providing tobacco control and cessation programs.

While the AARC appreciates the merits of enhancing projects undertaken by the University of North Dakota School of Medicine and Health Sciences, this effort can not and should not be advanced by diverting the essential funding for North Dakota's tobacco prevention, control and cessation programs. In 2008, when Measure 3 was placed before the voters as to whether to support tobacco prevention and cessation programs, the clear majority of North Dakota voters voted "yes". Enacting HB 1353 will effectively reverse what the citizens of North Dakota have clearly stated they want and support.

To essentially cease funding critical tobacco cessation and prevention programs is short-sighted and does not reflect the will of the voters. These prevention and cessation programs keep young people from starting to smoke and increase the number of people who successfully quit. Investing in tobacco prevention and cessation saves money. Most importantly, it also saves lives.

Please oppose HB 1353

SUBMITTED TESTIMONY ATTACHMENT 26

The amendment I am proposing increases tobacco product taxes to fund the proposed increases for the medical school programs. For example, cigarette taxes are increased from 44 cents per pack to $2.00 per pack. Increases for other tobacco products are commensurate with the increase for cigarettes. I note that the increased tax will not only fund the new medical school programs proposed by this bill, but similar increases in other states have also resulted in a decrease in tobacco use.

While funding is provided for the new medical school programs, the general fund is held harmless because no funding is provided until the twenty-two million seven hundred and fourteen thousand dollars ($22,714,000) expected in tobacco tax collections each year of the 2009-2011 biennium, has been deposited into the general fund. Any tobacco product taxes collected above that amount in any fiscal year will be deposited at the beginning of the next fiscal year into the Rural Health Care Trust Fund to be used for the benefit of the new medical school programs. It is estimated that increase in the cigarette tax will raise $33.4 million annually and that the additional revenue from the increase in the tax on other tobacco products will raise $3.2 million annually.

The amendment removes all language in HB 1353 that references the original Measure #3 language. In short, if this amendment passes Measure #3 and the will of the people will remain intact, there will be a funding source for these new medical school programs, and tobacco use will also decline.

PROPOSED AMENDMENT TO HOUSE BILL NO. 1353

Page 1, line 1, after "Act" insert "to create and enact a new section to the century code establishing the rural health care trust fund,"

Page 1, line, 1, after "15-52-04," insert: "subsections 1 and 2 of sections 57-36-25, subsections 1 and 2 of section 57-36-26, subsection 1 of section 57-36-27,"

Page 1, line 1, after the second "and" replace "54-27-25" with "57-36-32"

Page 1, line 4, after the second "and" replace "the tobacco settlement trust fund" with "rates of taxation on tobacco products"

Page 1, line 4, remove "to repeal chapter"

Page 1, remove line 5

Page 1, line 6, remove ""prevention and control program and water development trust fund expenditures;"

Page 5, line 16 remove "Section 54-27-25 of the North Dakota Century Code is"

Page 5, remove lines 17 through 31

Page 6, replace lines 1 through 30 with

"Subsections 1 and 2 of section 57-36-25 of the North Dakota Century Code are amended and reenacted as follows:

1. There is hereby levied and assessed upon all cigars and pipe tobacco sold in this state an excise tax at the rate of ~~twenty-eight~~ one hundred twenty seven and one-third percent of the wholesale purchase price at which such cigars and pipe tobacco are purchased by distributors. For the purposes of this section, the term "wholesale purchase price" shall mean the established price for which a manufacturer sells cigars or pipe tobacco to a distributor exclusive of any discount or other reduction.
2. There is levied and assessed upon all other tobacco products sold in this state an excise tax at the following rates:
   a. Upon each can or package of snuff, ~~sixty cents~~ two dollars and seventy two cents per ounce and a proportionate tax at the like rate on all fractional parts of an ounce.
   b. On chewing tobacco, ~~sixteen~~ seventy-three cents per ounce and a proportionate tax at the like rate on all fractional parts of an ounce.

   For purposes of this subsection, the tax on other tobacco products is computed based on the net weight as listed by the manufacturer.

SECTION 5. AMENDMENT. Subsections 1 and 2 of section 57-36-26 of the North Dakota Century Code are amended and reenacted as follows:

1. There is levied and assessed, upon all cigars and pipe tobacco purchased in another state and brought into this state by a dealer for the purpose of sale at retail, an excise tax at the rate of ~~twenty-eight~~ one hundred and twenty eight percent of the wholesale purchase price and, upon all other tobacco products purchased in another state and brought into this state by a dealer for the purpose of sale at retail, an excise tax at the rates indicated in section 57-36-25, at the time the products were brought into this state. For the purposes of this section, the term "wholesale purchase price" means the established price for which a manufacturer sells cigars or pipe tobacco to a distributor exclusive of any discount or other reduction. However, the dealer may elect to report and remit the tax on the cost price of the products to the dealer rather than on the wholesale purchase price. The proceeds of the tax, together with the forms of return and in accordance with any rules and regulations the tax commissioner may prescribe, must be remitted to the tax commissioner by the dealer on a monthly basis on or before the fifteenth day of the month following the monthly period for which it is paid. The tax commissioner shall have the authority to place any dealer on an annual remittance basis when in the judgment of the tax commissioner the operations of the dealer merit that remittance period. In addition, the tax commissioner shall have the authority to permit the consolidation of the filing of a dealer's return when the dealer has more than one location and thereby would be required to file more than one return.

2. If cigars, pipe tobacco, or other tobacco products have been subjected already to a tax by any other state in respect to their sale in an amount less than the tax imposed by this section, the provisions of this section apply, but at a rate measured by the difference only between the rate fixed in this section and the rate by which the previous tax upon the sale was computed. If the tax imposed in the other state is ~~twenty percent of~~ equal to or greater than the ~~wholesale purchase price or more~~ rates in section 57-36-25, then no tax is due on the article. The provisions of this subsection apply only if the other state allows a tax credit with respect to the excise tax on cigars, pipe tobacco, or other tobacco products imposed by this state which is substantially similar in effect to the credit allowed by this subsection.

SECTION 6. AMENDMENT. Subsection 1 of section 57-36-27 of the North Dakota Century Code is amended and reenacted as follows:

1. A tax is hereby imposed upon the use or storage by consumers of cigarettes in this state, and upon ~~such~~ those consumers, at the ~~following~~ rates:

~~a. On cigarettes weighing not more than three pounds [1360.78 grams] per thousand, five mills on each such cigarette.~~

~~b. On cigarettes weighing more than three pounds [1360.78 grams] per thousand, five and one-half mills on each such cigarette~~ in sections 57-36-06 and 57-36-32.

SECTION 7. AMENDMENT. Section 57-36-32 of the North Dakota Century Code is amended and reenacted as follows:

57-36-32. Separate and additional tax on the sale of cigarettes - Collection - Allocation of revenue - Tax avoidance prohibited. There is hereby levied and assessed and there shall be collected by the state tax commissioner and paid to the state treasurer, upon all cigarettes sold in this state, an additional tax, separate and apart from all other taxes, of ~~seventeen~~ one-hundred mills on each cigarette, to be collected as existing taxes on cigarettes sold are, or hereafter may be, collected, by use of appropriate stamps and under similar accounting procedures. No person, firm, corporation, or limited liability company shall transport or bring or cause to be shipped into the state of North Dakota any cigarettes as provided herein, other than for delivery to wholesalers in this state, without first paying the tax thereon to the state tax commissioner. All of the moneys collected by the state treasurer under this section shall be credited to the state general fund.

SECTION 8. A new section to the North Dakota Century Code is hereby created:

Rural health care trust fund - Interest on fund - Uses. There is created in the state treasury a rural health care trust fund. At the end of each fiscal year, the state treasurer shall transfer to the rural health care trust fund all revenues derived from taxes on tobacco products that are in excess of twenty-two million seven hundred and fourteen thousand dollars during the fiscal year. Interest earned on the rural health care trust fund must be credited to the fund and deposited in the fund. The principal and interest of the rural health care trust fund may only be used to defray the expenses of the university of North Dakota school of medicine and health sciences projects and programs related to increasing the health care workforce in the state, with a focus on the education of primary care physicians."

Page 7, line 1 replace "6" with "9"

Page 7, line 2, replace "health care programs" with "rural health care"

Page 7, line 7, replace "7" with "10"

Page 7, line 8, replace "health care programs" with "rural health care"

Page 7, line 14, replace "8" with "11"

Page 7, line 14, replace "**TOBACCO PREVENTION AND CONTROL TRUST**" with "**GENERAL**"

Page 7, line 15, replace "**HEALTH CARE PROGRAMS**" with "**RURAL HEALTH CARE**"

Page 7, line 16, replace "any balance remaining in the tobacco prevention and control trust fund" with " the sum of $34,700,000, from the general fund"

Page 7, line 17, replace "health care programs" with "rural health care"

Page 7, line 17, remove "For purposes of this section, "at the"

Page 7, remove lines 18 and 19.

Renumber accordingly

NEW REVENUES, PUBLIC HEALTH BENEFITS & COST SAVINGS FROM A $1.56 CIGARETTE TAX INCREASE IN NORTH DAKOTA

Current state cigarette tax: 44 cents per pack (46th among all states)
Smoking-caused costs in North Dakota: $10.48 per pack

Annual healthcare expenditures in North Dakota directly caused by tobacco use: $247 million
Smoking-caused state Medicaid program spending each year: $47.0 million

New Annual Revenue from Increasing the Cigarette Tax Rate by $1.56 Per Pack: $33.4 million

Additional Revenue from Raising Other Tobacco Product Rates to Parallel New Levels: $3.2 million

New Annual Revenue is the amount of additional new revenue over the first full year after the effective date. The state will collect less new revenue if it fails to apply the rate increase to all cigarettes and other tobacco products held in wholesaler and retailer inventories on the effective date.

Projected Public Health Benefits from the Cigarette Tax Rate Increase	
Percent decrease in youth smoking:	**25.7%**
Kids in North Dakota kept from becoming addicted adult smokers:	**7,900**
Current adult smokers in the state who would quit:	**5,300**
Smoking-affected births avoided over next five years:	**1,800**
North Dakota residents saved from premature smoking-caused death:	**3,900**
5-year health savings from fewer smoking-affected pregnancies & births:	**$3.1 million**
5-year health savings from fewer smoking-caused heart attacks & strokes:	**$2.4 million**
Long-term health savings in the state from adult & youth smoking declines:	**$188.6 million**

- Tax increases of less than roughly 25 cents per pack or 10% of the average state pack price do not produce significant public health benefits or cost savings because the cigarette companies can easily offset the beneficial impact of such small increases with temporary price cuts, coupons, and other promotional discounting. Splitting a tax rate increase into separate, smaller increases in successive years will similarly diminish or eliminate the public health benefits and related cost savings (as well as reduce the amount of new revenues).
- Raising state tax rates on other tobacco products (OTPs) to parallel the increased cigarette tax rate will bring the state more revenues, public health benefits, and cost savings (and promote tax equity). With unequal rates, the state loses revenue each time a cigarette smoker switches to cigars, RYO, or smokeless. To parallel the new $2.00 per pack cigarette tax, the state's new OTP tax rate should be at least 65% of wholesale price with minimum tax rates for each major OTP category linked to the state cigarette tax rate on a per-package or per-dose basis.

Needed State Efforts to Protect State Tobacco Tax Revenues

Having each of the following measures in place will maintain and increase state tobacco tax revenues by closing loopholes, blocking contraband trafficking, and preventing tax evasion.

State tax rate on RYO cigarettes equals the state tax rate on regular cigarettes	Yes
State tax rates on other tobacco products match the state cigarette tax rate	Yes
State definitions of "cigarette" block cigarettes from wrongfully qualifying as "cigars"	No
State definitions of "tobacco product" reach all tobacco products	No
Loopholes for the new generation of smokeless products (snus, tablets, etc.) closed	No
Minimum taxes on all tobacco products to block tax evasion and promote tax equity	No
"High-tech" tax stamps to stop counterfeiting and other smuggling and tax evasion	No
Retailers lose license if convicted of contraband trafficking	Yes
Street sales and mobile sales of cigarettes and other tobacco products prohibited	Yes
Non-Tobacco nicotine products without FDA approval banned	No

More information available at http://tobaccofreekids.org/research/factsheets/index.php?CategoryID=18

Campaign for Tobacco-Free Kids 10.07.10 / Ann Boonn & Eric Lindblom, December 13, 2010

Explanations & Notes

Projections are based on research findings that each 10% cigarette price increase reduces youth smoking by 6.5%, adult rates by 2%, and total consumption by 4% (adjusted down to account for tax evasion effects). Revenues still increase because the higher tax rate per pack will bring in more new revenue than is lost from the tax-related drop in total pack sales.

The projections incorporate the effect of both ongoing background smoking declines and the continued impact of the 61.66-cent federal cigarette tax increase (effective April 1, 2009) on prices, smoking levels and pack sales.

These projections are fiscally conservative because they include a generous adjustment for lost state pack sales (and lower net new revenues) from possible new smuggling and tax evasion after the rate increase and from fewer sales to smokers or smugglers from other states. For ways that the state can protect and increase its tobacco tax revenues and prevent and reduce contraband trafficking and other tobacco tax evasion, see the Campaign for Tobacco-Free Kids factsheet, *State Options to Prevent and Reduce Cigarette Smuggling and to Block Other Illegal State Tobacco Tax Evasion*, http://tobaccofreekids.org/research/factsheets/pdf/0274.pdf.

Kids stopped from smoking and dying are from all kids alive today. Long-term savings accrue over the lifetimes of persons who stop smoking or never start because of the rate increase. All cost and savings in 2004 dollars. Projections will be updated when new relevant data or research becomes available.

Ongoing reductions in state smoking levels will, over time, gradually erode state cigarette tax revenues (in the absence of any new rate increases). But those declines are more predictable and less volatile than many other state revenue sources, such as state income tax or corporate tax revenues (which can drop sharply during recessions). In addition, the smoking declines that reduce tobacco tax revenues will simultaneously produce much larger reductions in government and private sector smoking-caused costs. See the Campaign for Tobacco-Free Kids factsheet, *Tobacco Tax Increases are a Reliable Source of Substantial New State Revenue*, http://tobaccofreekids.org/research/factsheets/pdf/0303.pdf.

For other ways states can increase revenues (and promote public health) other than just raising its cigarette tax, see the Campaign factsheet, *The Many Ways States Can Raise Revenue While Also Reducing Tobacco Use and Its Many Harms & Costs*, http://tobaccofreekids.org/research/factsheets/pdf/0357.pdf.

For more on sources and calculations, see
http://www.tobaccofreekids.org/research/factsheets/pdf/0281.pdf

Additional Information on Tobacco Product Tax Increases

Raising State Cigarette Taxes Always Increases State Revenues and Always Reduces Smoking, http://tobaccofreekids.org/research/factsheets/pdf/0098.pdf.

Responses to Misleading and Inaccurate Cigarette Company Arguments Against State Tobacco Tax Increases, http://tobaccofreekids.org/research/factsheets/pdf/0227.pdf.

State Cigarette Excise Tax Rates & Rankings, http://tobaccofreekids.org/research/factsheets/pdf/0097.pdf.

Top Combined State-Local Cigarette Tax Rates (State plus County plus City), http://tobaccofreekids.org/research/factsheets/pdf/0267.pdf.

State Cigarette Tax Increases Benefit Lower-Income Smokers and Families, http://tobaccofreekids.org/research/factsheets/pdf/0147.pdf.

The Best Way to Tax Smokeless Tobacco, http://tobaccofreekids.org/research/factsheets/pdf/0282.pdf.

The Problem with Roll-Your-Own (RYO) Tobacco, http://tobaccofreekids.org/research/factsheets/pdf/0336.pdf.

How to Make State Cigar Tax Rates Fair and Effective, http://tobaccofreekids.org/research/factsheets/pdf/0335.pdf.

State Benefits from Increasing Smokeless Tobacco Tax Rates, http://tobaccofreekids.org/research/factsheets/pdf/0180.pdf.

The Case for High-Tech Cigarette Tax Stamps, http://tobaccofreekids.org/research/factsheets/pdf/0310.pdf.

State Options to Prevent and Reduce Cigarette Smuggling and to Block Other Illegal State Tobacco Tax Evasion, http://tobaccofreekids.org/research/factsheets/pdf/0274.pdf.

The Many Ways States Can Raise Revenue While Also Reducing Tobacco Use and Its Many Harms & Costs, http://tobaccofreekids.org/research/factsheets/pdf/0357.pdf

For questions or model legislation, please contact factsheets@tobaccofreekids.org.