Bill as Introduced

SB 206-FN-A-LOCAL – AS INTRODUCED

1999 SESSION

99-0481
01/09

SENATE BILL ***206-FN-A-LOCAL***

AN ACT establishing the tobacco use prevention fund and continually appropriating a special fund.

SPONSORS: Sen. Squires, Dist 12; Sen. Hollingworth, Dist 23; Rep. Pilliod, Belk 3; Rep. M. Fuller Clark, Rock 36

COMMITTEE: Public Institutions, Health and Human Services

ANALYSIS

This bill establishes the tobacco use prevention fund into which 25 percent of the funds received by the state of New Hampshire as a result of the settlement of the litigation against tobacco companies shall be deposited. The fund is to be used by the department of health and human services for tobacco prevention activities.

The bill distributes a portion of the litigation settlement funds to the counties for reimbursement of nursing homes.

The bill also distributes a portion of such settlement funds to the health care fund.

This bill was requested by the department of health and human services.

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

99-0481
01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord One Thousand Nine Hundred and Ninety-Nine

AN ACT establishing the tobacco use prevention fund and continually appropriating a special fund.

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

1 Purpose.

I. The general court recognizes that the use of tobacco is the number one public health problem both in the country and in the state of New Hampshire. More people die prematurely from tobacco related causes than from any other factor. This heinous problem is especially troublesome because of the reprehensible way tobacco manufacturers target youth. The settlement of the litigation by New Hampshire and other states against tobacco companies has provided an opportunity to address this critical public health problem in this state. The emphasis within the settlement on actions to reduce and prevent tobacco use among young people is all the more relevant to New Hampshire where the rate of tobacco use among children is among the highest in the country. The general court recognizes that prevention is a key strategy for reducing consumption of tobacco and consequently decreasing chronic illnesses, premature deaths and excessive health care costs.

II. The general court recognizes that funds are provided through the settlement both for prevention activities and to reimburse the state for costs incurred in providing treatment to persons whose illnesses and disabilities have resulted from tobacco use. It is acknowledged that county governments pay 50 percent of the non-federal portion of medicaid costs and a share of the funds provided through the settlement should be returned to the counties.

III. The general court recognizes that action needs to be taken to assure the continuous availability of funds to support tobacco prevention activities. The success of the heath care fund established by RSA 167:70 and its community grant program provides a model which can be used to assure widespread and effective distribution of tobacco prevention project funds for activities that have broad community support and participation.

2 New Subdivision; Tobacco Use Prevention Activities. Amend RSA 126-K by inserting after section 14 the following new subdivision:

Tobacco Use Prevention Fund

126-K:15 Tobacco Use Prevention Fund.

I. There is hereby established in the office of the state treasurer a fund to be known as the tobacco use prevention fund.

II. The total of 25 percent of all funds received by the state of New Hampshire as a result of the settlement of the litigation against tobacco companies shall be deposited into the fund.

III. The state treasurer shall invest and reinvest the assets of the fund in accordance with law, and the principal assets and accumulated income in the fund shall be nonlapsing.

126-K:16 Purposes of the Fund. The tobacco use prevention fund and interest therefrom shall be used by the department of health and human services for activities that will prevent or reduce the use of tobacco products by minors, provide assistance and treatment for cessation of tobacco and other drug use among children and adults, evaluate and assess tobacco use prevention strategies, and otherwise promote tobacco use prevention and control.

126-K:17 Accumulated Income. Commencing with the fiscal year ending June 30, 1999, the state treasurer shall annually, on or before October 1, certify an amount to the commissioner of health and human services which shall be the sum of the accumulated income in the fund plus the market value of the principal assets held in the fund. The amount of accumulated income certified by the state treasurer and the amount deposited annually into the fund pursuant to RSA 126-K:15, II are hereby appropriated to the department of health and human services for expenditure in accordance with this subdivision. Any funds not obligated by the end of the fiscal year in which they are made available shall lapse back to the tobacco use prevention fund.

126-K:18 Community Grant Program. The annual appropriations of the fund shall be expended by the department of health and human services for the purposes set forth in RSA 126-K:16, including grants for community initiatives in response to proposals submitted by community organizations in New Hampshire. The department shall not expend funds for any proposal until the advisory committee established pursuant to RSA 126-K:19 has reviewed and provided advice thereon. All recommended awards, including amounts and duration, shall be submitted by the department to the legislative fiscal committee and the governor and executive council for approval.

126-K:19 Advisory Committee.

I. There is hereby established a tobacco use advisory committee to advise the department of health and human services on the criteria for the expenditure of funds available from the tobacco use prevention fund and on expenditure proposals submitted to the department.

II. The committee shall be appointed by the commissioner of health and human services and at a minimum shall include the following members:

(a) A member of the senate, appointed by the senate president.

(b) A member of the house of representatives, appointed by the speaker of the house.

(c) One representative of the New England affiliate of the American Heart Association.

(d) One representative of the American Lung Association of New Hampshire.

(e) One representative of the New Hampshire division of the American Cancer Society.

(f) One representative of the New Hampshire Medical Society.

(g) One representative of a community law enforcement agency, appointed by the commissioner of health and human services.

(h) One representative of the New Hampshire Hospital Association.

(i) Two representatives of the Smoke Free New Hampshire Alliance, of which one shall be a minor and one shall be a community coalition member.

(j) One representative of the Norris Cotton Cancer Center.

(k) The commissioner of the department of education, or designee.

(l) One representative appointed by the New Hampshire liquor commission.

(m) Three public members, appointed by the governor.

(n) The commissioner of health and human services, or designee.

3 Distribution of Funds. Upon receipt by the state of New Hampshire of funds as a result of the settlement in 1998 of litigation against tobacco companies, the sum of 6.25 percent of funds received shall be appropriated and disbursed to county governments. The allocation to each county shall be based upon the proportion that each paid to the state in the prior state fiscal year pursuant to RSA 167:18-b. This appropriation shall be a charge against the funds received by New Hampshire for the settlement of the tobacco litigation.

4 Health Care Fund. Upon receipt by the state of New Hampshire of funds as a result of the settlement in 1998 of litigation against tobacco companies, the sum of 25 percent of funds received shall be deposited into the health care fund established by RSA 167:70 only when, and to the extent that, the assets and accumulated income of the fund are less that the sum of $100,000,000.

5 New Subparagraph; Special Fund. Amend RSA 6:12, I by inserting after subparagraph (vvv) the following new subparagraph:

(www) Moneys received under RSA 126-K:15, which shall be credited to the tobacco use prevention fund.

6 Effective Date. This act shall take effect 60 days after its passage.

LBAO
99-0481
2/25/99

SB 206-FN-A-LOCAL - FISCAL NOTE

AN ACT establishing the tobacco use prevention fund and continually appropriating a special fund.

FISCAL IMPACT:

The Department of Health and Human Services stated this bill could increase state expenditures by $8,990,109 in FY 1999, $24,017,641 in FY 2000, $25,935,192 in FY 2001, $31,140,596 in FY 2002 and $31,435,308 in FY 2003. County revenue and expenditures could increase by $998,901 in FY 1999, $2,668,627 in FY 2000, $2,881,688 in FY 2001, $3,460,066 in FY 2002, and $3,492,812 in FY 2003. There will be no impact on state and local revenue or local expenditures.

This bill appropriates annually 25% of the revenue from the tobacco settlement funds to the tobacco use prevention fund (TUSF), 25% to the health care fund (HCF), and 6.25% to county government.

METHODOLOGY:

The Department stated that 56.25% of tobacco settlement funds will be allocated to the TUPF, the HCF and the counties for FY 1999 and each year thereafter. The following calculations were based on information from the Department of Justice, which represented the state in its claims against the tobacco companies:

Receipt	Settlement Amount	TUPF @ 25%	HCF @ 25%	Counties @ 6.25%
FY 1999	$15,982,417	$ 3,995,604	$ 3,995,604	$ 998,901
FY 2000	$42,698,026	$10,674,507	$10,674,507	$2,668,627
FY 2001	$46,107,009	$11,526,752	$11,526,752	$2,881,688
FY 2002	$55,361,060	$13,840,265	$13,840,265	$3,460,066
FY 2003	$55,884,993	$13,971,248	$13,971,248	$3,492,812

The Department stated that 25% deposited into the TUPF, plus interest, would be available annually for Department expenditure for the purposes of this bill.

Amendments

Sen. Squires, Dist. 12
April 12, 1999
1999-0818s
01/09

Amendment to SB 206-FN-A-LOCAL

Amend the title of the bill by replacing it with the following:

AN ACT establishing the tobacco use prevention fund and continually appropriating a special fund and relative to the health care fund.

Amend the bill by replacing section 1 with the following:

1 Purpose.

I. The general court recognizes that the use of tobacco is the number one public health problem both in the country and in the state of New Hampshire. More people die prematurely from tobacco-related causes than from any other factor. This heinous problem is especially troublesome because of the reprehensible way tobacco manufacturers target youth. The settlement of the litigation by New Hampshire and other states against tobacco companies has provided an opportunity to address this critical public health problem in this state. The emphasis within the settlement on actions to reduce and prevent tobacco use among young people is all the more relevant to New Hampshire where the rate of tobacco use among children is among the highest in the country. The general court recognizes that prevention is a key strategy for reducing consumption of tobacco and consequently decreasing chronic illnesses, premature deaths, and excessive health care costs.

II. The general court recognizes that funds are provided through the settlement both for prevention activities and to reimburse the state for costs incurred in providing treatment to persons whose illnesses and disabilities have resulted from tobacco use. It is acknowledged that county governments pay a portion of medicaid costs and a share of the funds provided through the settlement should be returned to the counties.

III. The general court recognizes that action needs to be taken to assure the continuous availability of funds to support tobacco prevention activities. The success of the heath care fund established by RSA 167:70 and its community grant program provides a model which can be used to assure widespread and effective distribution of tobacco prevention project funds for activities that have broad community support and participation.

IV. The general court recognizes the need to develop tobacco prevention programs that are comprehensive and sustainable over time. The general court finds that the United States Centers for Disease Control and Prevention have developed a successful tobacco control model supported by

evidence-based studies which includes community programs to reduce tobacco use and the burden of tobacco-related diseases, tobacco prevention programs for schools, enforcement of tobacco-control laws, partnership grants with other tobacco prevention organizations, tobacco counter-marketing, and smoking cessation programs.

Amend RSA 126-K:15, II as inserted by section 2 of the bill by replacing it with the following:

II. Upon receipt by the state of New Hampshire of funds as a result of the settlement in 1998 of litigation against tobacco companies, the balance of the funds remaining after the distribution in accordance with all other statutory requirements and before the distribution enumerated in section 3 of this act, the sum of $10 for each resident of the state, as determined by the office of state planning, shall be deposited into the fund.

Amend the bill by replacing all after section 2 with the following:

3 Distribution of Funds to Counties. Upon receipt by the state of New Hampshire of funds as a result of the settlement in 1998 of litigation against tobacco companies, the sum of up to 10 percent of funds remaining after distribution in accordance with all other statutory requirements shall be appropriated and disbursed to county governments. The allocation to each county shall be based upon the proportion that each paid to the state in the prior state fiscal year pursuant to RSA 167:18-b. The governor is authorized to draw a warrant for said sums out of funds received by the state from settlement of the tobacco litigation.

4 Health Care Fund. Upon receipt by the state of New Hampshire of funds as a result of the settlement in 1998 of litigation against tobacco companies, the sum of 50 percent of the balance remaining after distribution to the counties, pursuant to section 3 of this act, and to the tobacco use prevention fund, established in section 2 of this act, shall be deposited into the health care fund established by RSA 167:70.

5 Medicaid Costs. Upon receipt by the state of New Hampshire of funds as a result of the settlement in 1998 of litigation against tobacco companies, the sum of 50 percent of the balance remaining after distribution to the counties, pursuant to section 3 of this act, and to the tobacco use prevention fund, established in section 2 of this act, shall be allocated and are hereby appropriated to the department of health and human services to reimburse the department for the cost of medicaid long-term care services. The governor is authorized to draw a warrant for said sums out of funds received by the state from settlement of the tobacco litigation.

6 New Subparagraph; Special Fund. Amend RSA 6:12, I by inserting after subparagraph (vvv) the following new subparagraph:

(www) Moneys received under RSA 126-K:15, which shall be credited to the tobacco use prevention fund.

7 Clarification of Fund Initiatives. Amend RSA 167:71, I to read as follows:

I. Fund the planning and implementation of public or private health initiatives which promote access to or improve the quality of available health care services*; including initiatives which assist people in obtaining health insurance, long-term care insurance, dental care, and prescription drugs.*

8 Health Care Fund; Limitations. Amend RSA 167:74, I to read as follows:

I. Health care initiatives as established in RSA 167:71 shall be available for a limited time period which shall not exceed 4 years*, except when a longer period of support is determined to be necessary by the commissioner of health and human services.*

9 Reference Deletion. Amend RSA 9:13-e, II to read as follows:

II. There is hereby established within the general fund general ledger a revenue stabilization reserve account. At the close of each fiscal biennium, any surplus, as determined by the official audit performed pursuant to RSA 21-I:8, I(h) shall be transferred by the comptroller in the following manner: 50 percent to a special nonlapsing revenue stabilization reserve account and 50 percent to the health care fund established pursuant to RSA 167:70; provided, however, that in any single fiscal year the total of such transfers shall not exceed 1/2 of the total potential maximum balances allowable under paragraph V [~~and RSA 167:74, III~~]. The comptroller is hereby directed to establish the revenue stabilization reserve account in which to deposit any money received from a general fund operating budget surplus. The state treasurer shall invest funds in this account as authorized by RSA 6:8. The interest so earned shall be deposited as unrestricted general fund revenue.

10 Repeal. RSA 167:74, III, relative to certain fund limitations, is repealed.

11 Effective Date. This act shall take effect upon its passage.

1999-0818s

AMENDED ANALYSIS

This bill establishes the tobacco use prevention fund into which $10 per resident after distribution in accordance with other statutory requirements of the funds received by the state of New Hampshire as a result of the settlement of the litigation against tobacco companies shall be deposited. The fund is to be used by the department of health and human services for tobacco prevention activities.

The bill distributes up to 10 percent of the litigation settlement funds after all other statutory requirements, including the tobacco use prevention fund, to the counties for reimbursement of nursing homes and to the department of health and human services for reimbursement for long-term care costs.

The bill distributes 50 percent of the balance remaining after distribution to the counties and to the tobacco use prevention fund of such settlement funds to the health care fund and 50 percent of such balance to the department for the cost of medicaid long-term care services.

The bill clarifies the initiatives of the health care fund.

Public Institutions, Health and Human Services
April 27, 1999
1999-1005s
01/10

Amendment to SB 206-FN-A-LOCAL

Amend the title of the bill by replacing it with the following:

AN ACT establishing the tobacco use prevention fund and continually appropriating a special fund and relative to the health care fund.

Amend the bill by replacing section 1 with the following:

1 Purpose.

I. The general court recognizes that the use of tobacco is the number one public health problem both in the country and in the state of New Hampshire. More people die prematurely from tobacco-related causes than from any other factor. This heinous problem is especially troublesome because of the reprehensible way tobacco manufacturers target youth. The settlement of the litigation by New Hampshire and other states against tobacco companies has provided an opportunity to address this critical public health problem in this state. The emphasis within the settlement on actions to reduce and prevent tobacco use among young people is all the more relevant to New Hampshire where the rate of tobacco use among children is among the highest in the country. The general court recognizes that prevention is a key strategy for reducing consumption of tobacco and consequently decreasing chronic illnesses, premature deaths, and excessive health care costs.

II. The general court recognizes that funds are provided through the settlement both for prevention activities and to reimburse the state for costs incurred in providing treatment to persons whose illnesses and disabilities have resulted from tobacco use. It is acknowledged that county governments pay a portion of medicaid costs and a share of the funds provided through the settlement should be returned to the counties.

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evidence-based studies which includes community programs to reduce tobacco use and the burden of tobacco-related diseases, tobacco prevention programs for schools, enforcement of tobacco-control laws, partnership grants with other tobacco prevention organizations, tobacco counter-marketing, and smoking cessation programs.

Amend RSA 126-K:15, II as inserted by section 2 of the bill by replacing it with the following:

II. Upon receipt by the state of New Hampshire of funds as a result of the settlement in 1998 of litigation against tobacco companies, the balance of the funds remaining after the distribution in accordance with all other statutory requirements and before the distribution enumerated in section 3 of this act, the sum of $10 for each resident of the state, as determined by the office of state planning, shall be deposited into the fund.

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4 Health Care Fund. Upon receipt by the state of New Hampshire of funds as a result of the settlement in 1998 of litigation against tobacco companies, the sum of 50 percent of the balance remaining after distribution to the counties, pursuant to section 3 of this act, and to the tobacco use prevention fund, established in section 2 of this act, shall be deposited into the health care fund established by RSA 167:70.

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I. Health care initiatives as established in RSA 167:71 shall be available for a limited time period which shall not exceed 4 years***, except when a longer period of support is determined to be necessary by the commissioner of health and human services.***

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10 Repeal. RSA 167:74, III, relative to certain fund limitations, is repealed.

11 Effective Date. This act shall take effect upon its passage.

1999-1005s

AMENDED ANALYSIS

This bill establishes the tobacco use prevention fund into which $10 per resident after distribution in accordance with other statutory requirements of the funds received by the state of New Hampshire as a result of the settlement of the litigation against tobacco companies shall be deposited. The fund is to be used by the department of health and human services for tobacco prevention activities.

The bill distributes up to 10 percent of the litigation settlement funds after all other statutory requirements, including the tobacco use prevention fund, to the counties for reimbursement of nursing homes and to the department of health and human services for reimbursement for long-term care costs.

The bill distributes 50 percent of the balance remaining after distribution to the counties and to the tobacco use prevention fund of such settlement funds to the health care fund and 50 percent of such balance to the department for the cost of medicaid long-term care services.

The bill clarifies the initiatives of the health care fund.

Committee Minutes

Date: MARCH 22, 1999
Time: 1:05 PM
Room: LOB 102

The Senate Committee on Public Institutions/Health Human Services held a hearing on the following:

SB 206-FN-A-L establishing the tobacco use prevention fund and continually appropriating a special fund and relative to the health care fund.

Members of Committee present:
Senator Squires
Senator Wheeler
Senator McCarley
Senator Pignatelli

Senator Frederick W. King, Sr. opened the hearing by calling upon the Prime Sponsor, Senator Squires.

Senator James W. Squires, D. 12: Good afternoon Senator King and all of you who have come to be part of this bill. My name is James Squires and I represent District 12 and I have sponsored this legislation which deals with the funds that will be coming to the State of New Hampshire as a result of the agreement entered into by the State's Attorney General and the cigarette manufacturers.

Before I get into the specifics of the bill and I also have an amendment which I will talk about in some detail, I would like to say it's not often that a state or an individual has a second chance and we have a second chance in this bill to correct what I have long felt to have been a miscarriage of justice. That was the use of the money that came to the State via Medicaid earlier this decade. It was placed in a fund, the Healthcare Transition Fund now the Healthcare Fund, for the purposes of serving healthcare needs of New Hampshire and then in a rather systematic and cynical fashion was raided for other purposes. The fund, which originally started at $100 million, is now about $34 million. It no longer has a sufficient amount of interest to cover the grants that have been awarded, which means that the principal unless it's replaced will be eroded.

That money, the Medicaid money, came to the State of New Hampshire as a result of issues surrounding healthcare specifically care given to Medicaid patients and it wasn't used for healthcare. It was used as a bank to balance the general fund from the state of New Hampshire. I believe that was wrong and I believe the present tobacco settlement offers to us the same temptation for misbehavior and if you don't believe that you can look at some of the bills that are addressing the school funding problem and you will see in them some or a great deal of the funds that this bill attempts to deal with.

Let me talk about, if I might, the amendment because it is somewhat different. **See Attachment A.** As you know, there are issues in the settlement that recognize the fact that the State needs to embark on programs of prevention and tobacco cessation. There are also issues which says that the funds should be used to be off-set the ongoing cost of cigarette related illnesses and as I've testified before of the 8,000 deaths in New Hampshire every year, approximately 2,125 result from either directly or indirectly the consumption of cigarettes.

The opening paragraph in the amendment is essentially the same. It recognizes the settlement, the need for prevention and for costs and it acknowledges that there is an issue relating to the counties. I hesitate to even mention in the counties and in the face of the Chairman of this hearing who knows more about the counties than I do but I know enough to realize that the counties and their respective government have a legitimate claim on these funds.

In line 16 of the amendment you will see that some of the funds go towards a tobacco prevention fund, the purposes of which are set forth in the main bill beginning in line 26. Now this amount has been reduced to 1% partly because those of you that have been following this issue realize that in connection with the proposed cigarette tax, the Senate Finance Committee passed an amendment to fund cessation and prevention efforts which I think is a very legitimate use of cigarette tax revenue. This adds to it. My fear of this bill and of the settlement is that these funds will gradually become eroded out of here, therefore if we can tie cessation efforts to tobacco tax revenues we guarantee a much more sustained program.

In line 21 of the amendment you will see that the bill allocates 6.25% of the settlement funds to counties. This is arbitrary. There's no way that one can ever figure out what the percent should be and it certainly ought to be a subject of discussion but it's there as a matter of principal to make sure that the obligation to the counties is recognized. It's one of the problems of using this settlement for the education issue. It takes away that obligation.

Beginning on line 27 of the amendment, you will see that 43.75% of these funds go back to the Department of Health and Human Services to offset the ongoing costs of tobacco consumption. Thus, by the bottom of page one of the amendment we have allocated 50% of the funds.

Turning to page 2, reference is here made and this is a difference between the original bill and the amendment. Reference if made to the Healthcare Fund which until recently was the Healthcare Transition Fund and we deposit in that fund 49% of the tobacco revenues. Then because the purposes of the Healthcare Fund are limited under the present statutes we have to change the purposes and add to them by saying that they will include initiatives which assist people in obtaining health insurance, long-term care insurance, dental care and prescription drugs, which are ways that the tobacco settlement funds could be used.

Then finally you will see that these initiatives in line 14 are limited to 4 years except in the perhaps unique situation when in the judgement of the commissioner they should be extended for a longer time.

In summary, the bill identifies the need to send some of these funds to the counties. It recognizes the need to offset the ongoing cost. It establishes a mechanism and a depository for 50% of the funds in the Healthcare Fund. It enlarges the purposes of the Healthcare Fund to include these specific items and it allows for the commissioner to extend the duration of these grants beyond 4 years.

I hope that is a clear explanation of what we're trying to do here, what the amendment does and I look forward to hearing testimony of those who have come.

Now you and I will switch positions Senator King and I'll listen to you. Thank you very much.

Senator Frederick W. King, D. 1: Thank you very much. Thank you Mr. Chairman. For the record I'm Senator Fred King. I represent Senate District 1.

This is a very important piece of legislation. I think there are lots important pieces of legislation floating around in these two buildings that aren't receiving a lot of attention because of some of the things that are going on. I certainly agree with Senator Squires. I agree with you that this money that we're going to be receiving as a result of the settlement lawsuit should not be used in the general fund. I think that this money is coming back as recognition of the costs that the state and local units of government have

incurred over time and so I don't think it should be used to solve the Claremont problem. I don't think it should be used to solve the general fund problem if there is one. I think this is a good source of money to fund educational programs and reduce teen smoking, which is certainly the objective.

I'm here today specifically to testify on Section 3 of the bill. I'm here to testify on behalf of Coos County. This bill calls for 6.25% of the funds to be disbursed to the ten county governments in the state. For 23 years I worked in Coos County and prepared county budgets as the County Administrator. My office was located in the Coos County Nursing Hospital in Stewartstown. So I had an opportunity on a day-to-day basis to see the types of residents we had at out facility. During my years with the County I became a licensed Nursing Home Administrator. What we know to be a fact is that we had individuals in that facility and in the County Nursing Home that the County also operates in Berlin, people who had a variety of illnesses that could be equated to smoking. Coronary Artery Disease, COPD. Pulmonary Heart Disease, emphysema, asthma and so on.

Over the years the County taxpayers which really are the property tax payers because the County gets its tax revenue from the property taxes that are collected from the towns and turned over to the County. The property tax payers in Coos County have contributed millions and millions of dollars to help pay for caring for these people who became sick. Not all of the people in nursing homes are there because of tobacco related illnesses but I think that you will hear testimony form others that will more clearly document that case.

It's interesting as we look at the percentages that the bill and I'm not being critical but I'm forced to comment that the counties and prior to the counties that the communities years ago before – is it one time the actual towns and cities paid the first year of care for people in nursing homes – are scheduled to get back 6.25% when in fact they've been paying in 31%. The state is to get 43.75% when in fact they didn't pay 18% in the Medicaid fund. So I think that – I believe that a portion of the fund should be more heavily weighted in favor of counties. I would suggest something in the range of 15%. That might be something more appropriate.

I have a chart for the Committee members, which clearly shows what the fact of the matter is in the case of Coos County. **See Attachment B.** This chart – the counties have paid in the case of Coos County the blue line is what the County has actually paid into the Medicaid Program in the years that are shown. The green is the total county tax. You have to discount the fact that the counties operate nursing homes. This is the payment they made to the

state for people that they were responsible for that were in nursing homes whether it was in their nursing homes or private nursing homes or other nursing homes throughout the state. The (inaudible) ranked during that period of time form as much as more than 50%. I think the lowest year was 43%. So the taxpayers actually have spent probably nearly every year of the tax dollars that they raised a total tax dollars – they spent about half of it to support the Medicaid program in my County.

So it is a significant amount of money and the taxpayers, I think if there's going to be some relief, are entitled to get that money back. The counties are going to continue to maintain the care of these individuals well into the future that are going to continue to suffer from these diseases.

So I guess on behalf of Coos County I would ask you and the Committee to consider a different portion of the funds because I think clearly based on the historical value 6.25% simply is not enough. Thank you.

Senator James W. Squires, D. 12: Is this pattern, do you think Senator King, replicated in other counties? Is it roughly the same?

Senator Frederick W. King, D. 1: I believe so. I believe it's pretty much the same. Coos County – it's a small county geographically. It's a small county population wise. It operates a larger number of nursing home beds per capita than the other counties so I can't speak to that. I know that in the case of Coos County the bulk of the money that's raised goes to Medicaid programs and all the other money goes to support the other programs the county has to operate.

Senator James W. Squires, D. 12: Thank you. Representative Pilliod.

Representative James Pilliod, Belk. D. 3: Thank you. Good afternoon. I am Jim Pilliod representing Belmont and am a co-sponsor of this bill. May I ask a question Mr. Chairman? It says in the amendment that 1% of these funds will be deposited. Is that what we're dealing with or – under II. *The total of one percent of all funds received by the state of New Hampshire as a result of the settlement of the litigation against tobacco companies shall be deposited into the fund.* Is that the sole source of funds? One percent?

Senator James W. Squires, D. 12: That is currently an issue that is some...The cigarette tax bill that the House kindly sent to us has been modified to include approximately 2½¢ to be used for tobacco prevention and cessation. For a variety of reasons it is also being smeared in the funding debate. If the efforts to include cessation and prevention efforts if cigarette revenues fails, I think the majority of the Committee believe that this

number needs to go up. The 1% in the amendment is there on the assumption that amendment will not fail. So, the amendment on the tobacco tax...

Representative Pilliod: Will not exist.

Senator James W. Squires, D. 12: Will be present. There will be – I forget what the number is.

Angeljean Chiaramida, NH Lung Association: $3 million.

Senator James W. Squires, D. 12: There's $3 million per year forever in that to fund these programs. If that's the case we don't need this much money coming from this source. So, it remains to be seen what happens to that effort. As I say, if it fails I think there would be great sentiment of the Senate to increase this percentage here.

Representative Pilliod: Mr. Chairman if I may ask which percentage? The 1%?

Senator James W. Squires, D. 12: Right.

Representative Pilliod: Of all funds?

Senator James W. Squires, D. 12: Correct.

Representative Pilliod: My testimony will be against the amendment.

Senator James W. Squires, D. 12: The whole thing or just the 1%?

Representative Pilliod: Pretty much the 1% because that governs the entire effort of a tobacco use prevention fund or a healthcare fund is dependent on whatever funds are received. Therefore, since I now for the first time as co-sponsor seen the amendment I have to speak against the amendment very strongly if that's permitted.

Senator James W. Squires, D. 12: Absolutely.

Representative Pilliod: Thank you. In speaking against it I speak as a pediatrician and as a person who have been somewhat instrumental at least in terms of philosophy of trying to get some reasonable settlement out of tobacco companies if we ever receive it. That's doubtful. Nonetheless, I will speak now against this amendment which in effect restricts when the original request to have 25% of all funds devoted to these efforts, both prevention and

health, to then reduce it to 1% if I'm correct in reading it that way, I find pathetic. And to the degree that I think this Committee can in fact have some influence over the future of this there is no point really in talking about all the things this work can done, all the things this fund can do when the fund has in fact been not just decimated but whatever ...attempt of decimated is. In fact I would have to say right now you're absolutely right I do not believe that this in effect should go into education of anything other than tobacco usage and the healthcare that is required from the use of tobacco.

Now as a pediatrician. We talked about the county needs, which is correct because county homes are filled with folks with emphysema, with asthma, with chronic lung disease, with heart problems, circulatory problems, etc. Many of these stemming from tobacco use. That's understood but what isn't usually commented about is the effect of the tobacco that has been used over the years on children. As a pediatrician I have to cry out for them and say we want to decrease the use so that they are innocently exposed now and hopefully will be not exposed later if we can enough education going to reduce the use of tobacco.

It seems to me somewhat a cruelty to expose a toxin – to expose children to toxins and addicting substances and not do anything about it. I find that we could do that if we had the money. Do something about it. Therefore I have to plead against this restriction of funds for totally irrelevant purposes. I think that will conclude my testimony on this. I would love to testify about the value that could be gained from this tobacco use prevention fund and the healthcare fund but I'm not going to talk about it when there is so little that's left over. It is pathetic.

Senator James W. Squires, D. 12: Is there 25% - would be $12,500,000 a year.

Representative Pilliod: I'm sorry. What was that?

Senator James W. Squires, D. 12: If we took 25% it would be $12,500,000 roughly per year. Do you think for all time that level of expenditure is required in this field or should the funds be used for some other matter? Or if asked another way, if you spend $12 million do we get twice as good as $6 million?

Representative Pilliod: You could cover twice as many people as you will be able to with a lessor amount. The answer in my opinion is that yes. I think that this such a relatively small fund compared to the healthcare cost directly

or indirectly related to tobacco use that we have to go to 100% in my opinion of the entire available funds if we ever see them to do what we strive to do.

I only ever agree to 25% because I figured that was a good start until we if in fact this really is going to come to pass and then it is not adequate in my opinion.

Senator James W. Squires, D. 12: Senator Wheeler?

Senator Katherine W. Wheeler, D. 21: I apologize for being late Senator Squires. Since I came late to the discussion I think I'll listen before I some questions.

Senator James W. Squires, D. 12: Senator Pignatelli any questions?

Senator Debora B. Pignatelli, D. 13: No.

Senator James W. Squires, D. 12: Thank you.

Representative Pilliod: Thank you Senator. I appreciate the opportunity.

Senator James W. Squires, D. 12: Representative Ham.

Representative Bonnie Ham, Graf. D. 4: Good afternoon. I'm Representative Bonnie Ham, Grafton 4. I am employed by Tri County CAP one of the programs, one of the programs on the Granite State Guardianship Service. That particular program services individuals throughout the state of New Hampshire not just the northern three counties. I have clients in various county nursing homes, other facilities, in their own home. Basically our population is a vulnerable population. A good many of them are elderly, Medicaid recipients. There are families. Tri County CAP has 30 programs everything from weatherization to fuel assistance. You name it. Transportation for the elderly to health services.

Speaking from the program I work for, Granite State Guardianship, I have personally myself and there are 5 other staff guardians, I am the staff guardian for 65 individuals. A good many of them in nursing homes and Medicaid recipients.

They have a variety of health issues. I can say how many of them are directly related to tobacco but certainly a good percentage must be. If I went down through the list of illnesses that my seniors are now facing a good many of them were not helped by using tobacco.

I am fully aware because I work with it daily that there is a need out there fore additional services for a good many individuals. They need access to health insurance that's affordable, ability to get a new hearing aid or be able to afford the prescription drugs. I know there's a need out there.

We are constantly searching for funds and it's not going to go away. It certainly isn't. To move a lot of the individuals into the community and out of nursing homes they're going to be needs that need to be met in the home that perhaps we can't even anticipate now.

So all I'm saying is I know the need is there. I think it's only fair that a good portion of the tobacco settlement money be applied to healthcare issues rather than other issues. I am in full support of that and I would 1% to me seems like a very small figure. I would have to think that the original bill at 25% would be far more realistic. I think as the previous Representative said we probably could spend the entire amount wisely. I have no doubt about that. If anything, it's a step in the direction to help meet some of the needs of a very vulnerable population out that cannot have all their needs met for healthcare and other related services.

So I just wanted to come here and say I have ... dealing with the populations that would be served by this bill and I know the money can be very well spent.

Senator James W. Squires, D. 12: Thank you. Any questions? Thank you very much. I know that as I came in a physician asked me if they could speak. Is that gentleman here? (turn over tape)

Dr. Phil Maiorano: I'd like to thank you for allowing me to give testimony here today. I am a physician and a respiratory therapist. I understand we're here to talk about the recent tobacco settlement. I just wanted to be here to emphasize the importance of being sure that adequate funding is directed toward smoking prevention.

I'd like to just briefly discuss my qualifications for being here testifying. I can tell you that this is my 25th year in the field of respiratory care. I began as a respiratory therapist. I work in an acute care environment as well as rehabilitative care at Gaylord Hospital in Wallingford, Connecticut. I subsequently attended medical school, completed post-graduate training as a pulmonary specialist. Became board certified in Internal Medicine in 1990 and Pulmonary Diseases in 1992. I've been in private practice in the Lakes Region since 1994 and I'm Medical Director and CEO of an organization called Lakes Region Pulmonary Medicine. We're a private independent organization committed through education in the field of respiratory care as

well as providing individualized consultative specialty medical services. I've served on the NH Governor's Committee for Cancer and Chronic Diseases since 1995. I'm also an ex-three pack a day smoker. I personally have measurable damage to my own lungs from having this tobacco that occurred before I realized the importance of quitting 9 years ago.

My motivation comes from the patients who seek my advise and from my young children who are going to face this problem at a much earlier age than they really should have to.

I think that there are a very few of us in this room who would ever want to see a loved one become a smoker. That's because we all intuitively know that this is very bad for us. Most people now who are dealing with smoking, when they began it was a question. We didn't know it was bad for us. There was not even a warning on the packages. My question I think has been adequately answered.

I think that alone should produce a sense of urgency as to how important a problem this really is and what a burden this creates on the health system. When the problem becomes more personal and assumes a human face it becomes even more urgent and that's the way it seemed with my ...perspective – my background.

As a private practitioner I can tell you it's not easy to see proud former CEO's of major corporations and celebrities who are reduced to tears because they're learning that they need to be on supplemental oxygen now for the rest of their lives. They relate their feelings, these folks, to feeling like a dog on a leash or a puppet on a string or a conspicuous spectacle. They're reluctant to even leave their homes with an oxygen tank or oxygen in place. We try to make it as nice as we can for them and certainly they need to adjust because it is a matter of survival. It's very difficult and might I add very, very expensive.

It's hard to see someone losing weight because the work required just to keep them breathing by their own bodies is consuming so much of their energy that they can't possibly gain weight if they tried.

It's hard to see people working so hard to derive so little benefit. Patients with established tobacco related illness go through something analogized to running ten miles to move about a foot. They can't get any benefit at all but they have to work very hard and it's becoming more and more clear that the answer is to prevent the problem in the first place.

I don't want to present you with another series of tobacco related horror stories. There are plenty of those out there. All sorts of interesting posters one can look at. It is important though to understand how little can actually be done once tobacco-related illness grabs hold of someone to help them resume a normal lifestyle.

Additionally, COPD has now become the fourth leading killer of Americans today. It was the fifth leading killer 10 years ago. So it's gaining ground. Many other health problems are also intimately related to the use of tobacco. Coronary disease, stroke, peptic ulcer disease and many malignancies just to name a few. The chronic and serious nature of the majority of these tobacco related health problems underscores what I feel is an indisputable fact that prevention of smoking remains the best means of reducing the occurrence of all of these problems among our citizens.

I would gladly pursue another career if the necessity of (cough) created by the elimination of serious illness but the fact is if everyone were to quit smoking immediately today, the incidence of tobacco related illness would continue to increase for at least the next 10 years. Of course everyone quitting immediately today is very unlikely as an ex-smoker I can tell you that. And it underscores again how difficult this problem really is to do deal with.

The statistics show you that we do not have it licked. There's still no reliable means of quitting. There's still no reliable means of insuring that smoking will be unappealing to our youth. We need to take a lesson from tuberculosis. We felt we had that licked and we slacked off and the disease again had a resurgence. We need to be certain to pursue this issue until it is completely resolved.

Many patients who are afflicted with tobacco related problems began smoking as I mentioned before before it was known to be a problem and yet, frequently these patients when there's (cough) by the healthcare system are told "you've done this to yourself." They didn't do this to themselves. I remember the catchy little slogans and songs that used to be on television when I was young and growing up. You were the odd ball if you didn't smoke back then. I can't tell you how thrilled I was when I had permission from my parents to be allowed to smoke in the household. I was only 14.

Because of these facts it's important to be certain that well I don't think I should get bogged down in percentages or dollar amounts but however much of the settlement money you feel needs to be directed toward tobacco prevention, for good measure I would consider very, very strongly multiplying that times 10 or possibly even 100. At some point in time when the problem no longer becomes a problem I think it would be a lot easier to them to maybe

slack off. I think that the benefits over the long-term from assuming this type of posture will be beyond any calculable dollar amount in the future.

Thanks again for letting me say my couple of things.

Senator James W. Squires, D. 12: Any questions? Thank you very much. There was one other gentleman that indicated that they needed to catch a plane.

Audience: Dearell. He's not here.

Senator James W. Squires, D. 12: Alright. Nicole Cann.

Nicole Cann, Smoke-Free Coalition, Franklin High School, Franklin, NH: Written testimony handed in. **See Attachment C.**

Senator James W. Squires, D. 12: Any questions? Senator Pignatelli.

Senator Debora B. Pignatelli, D. 13: Thank you Mr. Chairman. Nicole, thank you very much for coming and testifying. Did you have to take the day off from school?

Ms. Cann: I took some of it off.

Senator Debora B. Pignatelli, D. 13: I have a question for you. Did you say you were in 7th grade?

Ms. Cann: I'm a Freshman.

Senator Debora B. Pignatelli, D. 13: So, you're 9th grade?

Ms. Cann: Yes.

Senator Debora B. Pignatelli, D. 13: Are there no smoking – do you get any health education on the problems with smoking in your school and did you when you were in elementary school that you can remember?

Ms. Cann: We did have some programs in 8th grade. Mary Cook, which she comes to the 8th grade. She teaches the smoking classes and health classes.

Senator Debora B. Pignatelli, D. 13: How is that perceived by the students in her class in terms of deciding whether to smoke or not smoke?

Ms. Cann: A lot of kids by then have already started smoking. Some kids that haven't smoked do think about it but a lot are smoking by then.

Senator James W. Squires, D. 12: Senator Wheeler?

Senator Katherine W. Wheeler, D. 21: Thank you Nicole. It's great that you came. You did such a good job with your testimony. Are your teachers allowed to smoke in the building in teacher's rooms?

Ms. Cann: No.

Senator James W. Squires, D. 12: Thank you. Brendan Driscoll.

Brendan Driscoll, Dover Youth 2 Youth: Written testimony handed in. **See Attachment D.**

Senator James W. Squires, D. 12: Any questions? Senator Wheeler.

Senator Katherine W. Wheeler, D. 21: Brendan. Great job. Thank you for coming. Since I represent Dover I do spend a lot of time there and at least in other years I've seen a lot of students who appear to be middle school aged along the sidewalk outside the middle school with cigarettes. Are there people that you know in middle school you do smoke?

Mr. Driscoll: Not that I know of.

Senator Katherine W. Wheeler, D. 21: Good. (laughter)

Senator James W. Squires, D. 12: Brendan did your mom or dad come with you today?

Mr. Driscoll: Yes. My dad.

Senator James W. Squires, D. 12: Could you just stand up so we could say hello? You should be very proud of your son.

Mr. Driscoll: Yes. He did very did.

Senator James W. Squires, D. 12: You both did. Thank you very much. Commissioner Shumway.

Commissioner Don Shumway, Department of Health and Human Services: Written testimony handed in. **See Attachment E.** (change tapes)

Senator James W. Squires, D. 12: Any questions. Senator Wheeler.

Senator Katherine W. Wheeler, D. 21: Thank you Mr. Chairman. Commissioner Shumway, the amendment to 206 is the request of DHHS?

Commissioner Shumway: Yes. We would be supportive of the amendment though we would certainly do so with flexibility considering how you might consider that and its relationship to any other, for example, cigarette tax resources or other considerations which you feel a necessity in that.

Senator Katherine W. Wheeler, D. 21: May I have a further question? I apologize for asking this question. It's because I was late and I know how rude that is. I just couldn't help it but in the amendment I don't understand what the 1% is when we started out with what was 25% and what's now 1%.

Commissioner Shumway: Well, 25% had been the original consideration that was set aside for a tobacco prevention and treatment resource. In working with Senator Squires and considering whether or not cigarette tax money might also be used for that purpose. We recognize that there might may be interplay between those two factors. However, I would like to underscore the fact that in working with the Tobacco Advisory Committee, we are working on a detailed plan based on the CDC research as to what has worked nationally as well as our own experience in the state. We will be able to furnish for you a detailed allocation schedule of resources that certainly will exceed the availability of that 1% amount. We hope that over long-term you'd support that plan.

Senator Katherine W. Wheeler, D. 21: One further question? So the 1% would just be for tobacco cessation...

Commissioner Shumway: Exclusively.

Senator Katherine W. Wheeler, D. 21: Exclusively. And then the 99% would be divided the way the amendment states?

Commissioner Shumway: That's correct.

Senator Katherine W. Wheeler, D. 21: So the 100% is going to health related costs.

Commissioner Shumway: Precisely.

Senator Katherine W. Wheeler, D. 21: I guess I lied. I have two more questions. Do you think the 1% would be sufficient to do anything? It would

have to be in combination with something else I suppose because New Hampshire's share of the settlement money is good but it's not great.

Commissioner Shumway: One percent would clearly by and of itself not be sufficient for the comprehensive and sustained tobacco (cough) that is needed. Ultimately, the combination of questions that are at your doorstep relating to cigarette tax money the total apportionment of this would be something that we'd hope that you would consider as coming together to support a plan which will have detailed schedule of expenditures and rollouts that we would hope will become a plan that we all can commit ourselves to for decades to come.

Senator Katherine W. Wheeler, D. 21: Thank you.

Senator James W. Squires, D. 12: Commissioner, I received a call from the County Commissioner who asked that I solicit your opinion regarding in the composition of the Advisory Committee your feelings about including a representative of the County Association.

Commissioner Shumway: They'd be welcomed. Absolutely.

Senator James W. Squires, D. 12: I see no problem.

Commissioner Shumway: Quite the opposite. Volunteers are always appreciated.

Senator James W. Squires, D. 12: How soon do you think the detailed view of the projected expenditures could be made available to the Committee? We ought to have it before we exec on this bill.

Commissioner Shumway: We work best under deadline. (laughter)

Senator James W. Squires, D. 12: Tomorrow? (laughter)

Commissioner Shumway: Let me tell you what we have. We have the combination of science that exists in this field and we are able to document that for you. We have the allocation of resources and we have our documented initial efforts that we have conducted. We haven't the final piece of sitting down and saying the exact rollout in each of these areas who would (cough) fashion. I think it's just a few days work. So I would hope sometime next week or the week after.

Senator James W. Squires, D. 12: That would be fine. I would hold the discussion and executive action until we received that keeping in mind that

we will have a crossover date at some point. Thank you very much. Senator Pignatelli.

Senator Debora B. Pignatelli, D. 13: Thank you Mr. Chairman. Commissioner Shumway, I just have some questions about the total amount of money and do you see the total tobacco settlement and I think you said it was somewhere between $42 million and $56 million a year. That total amount of money going into this healthcare transition fund?

Commissioner Shumway: No. What I would suggest to be allocated in several different ways for example, approximately half would be dedicated to the county for the state's portion of the healthcare transition fund. The other half would be dedicated to the tobacco prevention and treatment fund plus reduction in Medicaid expenses. Pardon me. I mixed those together a little bit but basically a portion would go into Medicaid expense reduction which was 43.75% and the counties receiving 6.25%. That's half the fund. That would go towards basically healthcare. Either Medicaid or county portions. The other half would be in 1% tobacco prevention or the 49% for the healthcare transition fund.

Senator Debora B. Pignatelli, D. 13: That health – if I could – the healthcare transition fund will be built up back to $100 million in how many years do you think?

Commissioner Shumway: Well, it would all depend on the payments out into the various (cough) and the like. We would expect it to be built up again in a period of a few years. I would certainly hope so.

Senator James W. Squires, D. 12: Thank you very much. Is there anybody else that's under time pressures other than all of us but specifically? You have to catch a plane. You have to return to a meeting. Yes.

Adar Cohen, Citizen: My name Adar Cohen. I come from CONVAL High School in Peterborough. I come to you with my next year's scheduling classes, with Intro to Public Speaking at the top of my list. So I'm not there yet but I'll do my best.

I'm connected with this issue with a marketing class that I had last semester in which Stewart Weeks, Pierre Angler, my teacher and former marketing executive for Newport Cigarettes Norman Black was with us. Form the two classes that worked with this there were about 50 kids involved and seven of them did not smoke. I was one of them.

So I come to you with less experience than somebody else might have but an overall perspective that might be useful to you.

23,777 New Hampshire youth currently under the age of 18 will die prematurely of a tobacco related illness unless the smoking trend changes. That's from the Center for Disease Control. In my person Marketing class there were 25 students and approximately 3 that didn't smoke. One quit and two tried very hard and quit and started again and many tried. I think it was due to the close examination of the marketing behind tobacco. The ads, we looked very closely at the ads and many began to question smoking a lot more than they had when they started in middle school just because everyone else was doing it an so on.

Also in my Environmental Science class we've been testing air qualities and a big issue at my high school is the smoking in the bathrooms. Rooms were tested that were far away from any bathroom and normal levels of harmful chemicals were found. A room at all near a bathroom, which was always heavily clogged with smoke, was always off the charts with harmful chemicals found in tobacco smoke.

This is a big concern at our school and once again I feel that in the marketing class people gained a perspective that's very valuable and I think that the education of this is vital.

Surgeon General Coop at the very poignant statement that he makes often, "This Saturday 5,000 youths are planning to smoke their first cigarette. 3,000 of them will do it and 1/3 will die prematurely of a tobacco related illness." I think it's a very strong statement and I think it leaves us with the final question which is whether we want to end this millennium and begin caring more about profits than health, paying off debts rather than saving lives and caring about our children, all of your children, my classmates and our future. Thank you very much.

Senator James W. Squires, D. 12: Wait a second. I'd like to say by virtue of the authority vested in us by the voters of New Hampshire, we the members of the Health and Human Services Committee award you an honorary A for public speaking. (laughter) I hope you will convey that to your teacher next year. Thank you.

Senator Katherine W. Wheeler, D. 21: Thank you. I'm very glad that Dr. Squires said because certainly that was my intent also. What is your first name?

Mr. Cohen: Adar. A-D-A-R.

Senator Katherine W. Wheeler, D. 21: Thank you. In your school I presume it's against the rules to be smoking in the bathroom but it's being done. One final question. Are the faculty members allowed to smoke anywhere in the building in your school?

Mr. Cohen: No. That's recent. A new rule has been passed that no one may smoke on school grounds. Not even faculty members. I remember I think a year ago when I was also in school teachers had a special area behind the school where they could smoke and now that's not the case. They need to leave school grounds.

Senator Katherine W. Wheeler, D. 21: One more question. What is the trouble with enforcing this so that there's no smoking in the building? I'm assuming that this testing of the air and so on, this is smoking that's going on in the restrooms now.

Mr. Cohen: Right. The testing isn't really being done by administration. It's individual experiments for a science class but your question about why it's not being enforced or being enforced enough is tough for e because it's not really my department. (laughter)

Senator Katherine W. Wheeler, D. 21: Not yet. (laughter)

Mr. Cohen: I really don't know.

Senator Debora B. Pignatelli, D. 13: I just have a couple of questions. I've already talked to me kids. They're a little older than you are but since your younger I'm going to ask you those questions. You didn't start smoking and you didn't start for a reason. What was that reason?

Mr. Cohen: That's also a ...question. I think that to tell you the truth the scare tactics didn't prevent me from smoking. They prevented me from questioning my decision to not smoke. I think that's a very fine line but to answer your question, I think that what really scared me away from it was my family. My parents. My mom who made me take my camera today to get a picture of myself in front of the building. (laughter) I think that that's what it was.

Senator Debora B. Pignatelli, D. 13: Let me ask you a follow-up question. Your friends that have started smoking and probably when they were a little younger, do you think that they did not know that smoking was harmful?

Mr. Cohen: I think that they had heard it. I think that they had seen the ads and I think they had seen the posters that was not cool. I think that at that age you're invincible and I think that further exposure is going to be helpful to sort of having children understand that when you're 40 it's not centuries and centuries and years and years away. It's coming and you're not invincible.

Senator Debora B. Pignatelli, D. 13: And just one final question. Do you think it's possible to convince kids in the 6th, 7th and 8th grade that if they start doing something now then in 30 years or 20 it's going to be harmful to them? Do you think that there's enough that we could tell them that's going to convince them that it's not a good idea to start smoking? Do you think it's possible?

Mr. Cohen: I think it's possible. I do.

Senator James W. Squires, D. 12: Thank you. Mr. Niemeyer.

Dearell Niemeyer, CDC: Good afternoon. It is a pleasure to be here today to talk to you about what the CDC knows about what works. I have some testimony for you. I won't read it verbatim. I'll try to summarize some key points and leave time for questions and answers.

My name is Dearell Niemeyer. I'm the Branch Chief of the Program Services Branch of the Office of Smoking and Health at Centers for Disease Control and Prevention in Atlanta, Georgia. I'm here at the request of the NH Tobacco Task Force and to present some scientific evidence of what we've been working on for tobacco control prevention and how we begin to try to document what works across the country and other situations. I'm not here to speak in favor of any specific bill or against any specific piece of legislation.

I'm sure you've heard lots of data this afternoon so I won't spend a lot of time on that but I want to remind ourselves the reason we're here is that 430,000 deaths each year are caused by tobacco use. That's 1 in 5 deaths and is the probably the single most preventable cause of disease and death that we have in our Nation.

It's an enormous health burden. You know that from the settlement that you went through yourselves. Nationwide it's about $50 billion in medical expenses for tobacco use. Also for the non-smoker there's the issues of environmental tobacco smoke. Estimated 3,000 deaths from environmental tobacco smoking. For young people it's 300,000 respiratory illnesses that can be traced back to tobacco use.

If we don't change current patterns of use of tobacco children over 18 years of age – 5million of those individuals will lose their lives to tobacco. For New Hampshire that means about 23,000 young people or roughly 8% of your state's young people will die prematurely from tobacco related diseases.

Our interest in looking at tobacco control has taken us to study several programs. I'd like to report what we've found today. We've called these best practices, evidence of what's working. We have a best practice document that looks at programs that have been working. Conclusions we've made must be comprehensive, must be sustainable and they must be accountable.

Our experiences draw from the tax-based programs that have been in effect in California and Massachusetts. For California for almost eight years now. Massachusetts almost six. For two-week programs or even Maine, which has tax-based programs, and also we've been working with Florida, Minnesota, Mississippi and Texas on their tobacco laws and program. The evidence from California and Massachusetts had shown if you could reduce tobacco use, you can reduce it among young people, you can reduce it among smokers and you can protect non-smokers. Evidence from these programs indicates that we can't find community, media, schools to prevent tobacco use you can't have sustained reductions in consumption of tobacco.

California is one of the best examples of this where their tax was raised from 10¢ to 35¢ in 1989. Between 1990 and 1998 they had a very slight increase of about 2¢. So it gives a real good trend to watch what happens when we implement a tax and also what happens when you implement a long-term program. Their decline in tobacco use has been 2 to 3 times faster than the rest of the country.

Unfortunately very few states spend much on tobacco control. In fact it's probably pennies and nickels per capita. When we look at the larger states that have been ...tobacco control comprehensive programs, that ranges from about $2.50 per capita to about $10.00 per capita.

While the funding sources contribute to the basic development of programs no program is being implemented in this country that does all the CDC recommended components.

For New Hampshire, when we look at what New Hampshire's population, types of programs that might work in New Hampshire we've estimated that may range from $9.00 to $21.00 per capita or that's approximately $11 million to $25 million per year. Admittedly that's unprecedented commitment to tobacco prevention but you must compare that against settlement that occurred in this state and the approximately $94 million you

spend annually on tobacco related diseases through Medicaid kind of expenses. Or, look at it another way, the tobacco industry will spend about $5 billion this year to promote its products to young people and to adults.

With the best practices we recommend that you consider the following:

- Preventing the initiation of tobacco use among young people
- Promoting cessation among young people and adults
- Eliminating exposure to environmental tobacco smoke
- Identifying and eliminating the disparities of tobacco use among the different populations.

We've outlined certain components of a program that seemed to be effective in other places and have been sustained by further research. This would be:

- Community programs to reduce tobacco use
- Community programs to reduce the burden of tobacco related diseases
- School programs
- Enforcement
- Statewide programs
- Counter-marketing
- Cessation programs
- Surveillance and evaluation
- Administration and management of the program

I'll touch just briefly those individual points.

One of the things that sustain individual behavior change requires a complete change of whole communities in the way communities approach the tobacco being sold, promoted and used. This is done while changing the knowledge, attitude and practices of young people, tobacco users and non-users.

Effective community programs involve people in their homes, work sites, schools, places of worship, entertainment, civic organizations and other places.

To achieve the lasting changes, state governments, local governments, voluntary groups, civic organizations, community organizations must be able to hire staff, must be able to put together educational information resources packages. They must be able to do training and technical assistance programs, support community programs, community based media programs, establish long range plans and draw others into the tobacco control activities.

The other area community programs is reducing the burden of tobacco related diseases. These diseases are often times around cardiovascular disease, oral cancers, asthma. We recommend that you consider building these kind of programs into your long term tobacco prevention programs.

School based programs have been proven to be effective. CDC has curricula and guidelines that could help schools make decisions about tobacco control. As you've probably heard stated, most people start smoking before the age of 18. School programs can plan an early role in preventing the onset of this tobacco use particularly if these tobacco programs are tied to community based programs and media programs.

Enforcement of youth access laws, enforcement of clean indoor air restrictions and hopefully enforcement on further restrictions on advertising and promotions will be adopted in your state. All of these would need to be enforced sending a message tot he public that you're serious about tobacco control and a community reducing its use.

Statewide programs are opportunities to intermix what you can't do at the local level or what you can't do across county lines but to provide programs that serve mass populations or diverse populations such as business (cough), law enforcement, youth groups, groups that have memberships and other organizations. This encourages their participation in local programs as well as statewide efforts.

Counter-marketing can be used to promote smoking cessation and decrease the likelihood of initiation. In addition to counter-marketing there's a very powerful influence on public support of tobacco control and intervention instead of supporting climate for communities and school programs.

Children buy the heavily advertised tobacco products. Youth are 3 times more affected by advertising than adults. The average 14-year-old has been subjected to $20 billion of advertising and promotion of tobacco products. These promotions have gained a very friendly familiarity to tobacco products and is seen as something that is glamorous, social and very normal to do.

Counter-marketing attempts can counter these pro-tobacco influences and increase pro-health messages. They can be done throughout a state, region or community level. It consists of paid advertising, radio, billboards, print media and other kinds of local advancing media activities.

A couple of the programs that have been looked at. As a matter of fact one of your neighboring states, the University of Vermont, looked at school and mass media projects and how mass media affected those individuals and

found that by having these activities with media programs, they've been able to postpone tobacco us in 20% to 40% of adolescents.

But what's important about advertising campaigns or marketing campaigns is that they reach far enough in your community, that they're happening often enough, the frequency and the duration and that they're long lasting. So I think at times we counter what the particular ad is and we question its effectiveness, if you consider the reach frequency and duration that's what you're looking for out of your programs.

Cessation is probably the quickest return on your public health dollars and benefits of not smoking. A smoker who quits smoking by the age of 50 cuts in half the risk of dying within 15 years. The cost of a cessation program can be returned in 3 to 4 years. Often times I think we don't recognize that the cessation programs are as cost-effective as other clinical services such as mammography, pap tests, colon cancer screening, testing for hypertension or treatment for high cholesterol. Cessation programs can be as effective in reaching these populations.

There are guidelines that are published on this so you have some research and some examples of ways to do that. We'd be happy to share those with you.

Surveillance and evaluation is a theme that we emphasize a lot. The programs – the reason we're able to talk to you about the programs are because programs have been evaluated. There have been strong surveillance programs put in place in these states so we can turn around and tell you what's happening. If you take Florida for example a year and a half ago they began to launch their program and get a baseline in the spring. They now have done a second baseline testing and they're already showing some declines in tobacco use in middle age and high schools. So we strongly emphasize that you build in surveillance and evaluation and build these into the programs so the decision-makers can make their decisions.

Administration and management is key to protect the programs. We're not looking for a bureaucracy here but we're looking for local programs that are coordinated with state program and are coordinated with the media and coordinated with schools so they can be strongly evaluated plus properly administered and managed.

We'll be happy to work with New Hampshire in trying to develop your programs that reach your needs. Our best practice document is a calculation of what's occurring across this nation. It will be refined as we learn more but

what we want to emphasize is that we know enough now to take action and there are effective interventions that you may use in your state.

I'd be happy to answer any questions.

Senator James W. Squires, D. 12: Any questions?

Senator Katherine W. Wheeler, D. 21: I thank you for coming.

Senator James W. Squires, D. 12: I had a question. First of all I think I speak for all of us when I say we appreciate all your efforts at the CDC in this area. We have unique problem in New Hampshire and I wonder if you've had experience evaluating it. In another committee in another series of testimony we heard data that New Hampshire's pricing structure makes this an attractive area to purchase cigarettes particularly those coming from out-of-state. In fact something like 60% of the cigarettes purchased in New Hampshire are not purchased by New Hampshire citizens, which means we have an enormous per capita sales conflict. That being the case, if when we put in a program we may not see the decline that you might measure in customary (turn over tape) how are going to measure the effectiveness and ensure our ...?

Mr. Niemeyer: Well the thing about consumption data is the (cough) of all the data. Prevalence data is a harder number. You can do the prevalence data in your state. There's the youth tobacco survey which we would be happy to share with you. Four or five other states are using that survey technique now. That's how Florida's been able to detect its change in tobacco use in the year. So, really some good prevalence data in there. Also unless there's a major restructuring of the tobacco tax states around you, you'll be able to research consumption data and compare in comparable quarters. Consumption data is real strange. It's kind of – it's not – it's when it's taxed. It's not when it's actually purchased. So with having some history there we can go back and unless some state changes around you drastically it will give you some immediate indications. I think we can tease that out for you.

Senator James W. Squires, D. 12: Well just a comment. One of the issues here is that if we raise our tax then it will discourage cross-border sales so you will see a drop in consumption, which has nothing to do with cessation programs whatsoever.

Mr. Niemeyer: Right. One thing I didn't mention in the testimony is that two of the indicators are that youth are the most sensitive to price and the U.S. Treasury just put out a report that looks like about 10% increase in tobacco products can bring about a 7% decline in youth using tobacco. So

those are some rough ideas of what we've been looking at in economy models of tobacco sales and other products. So for what it's worth the Department of Treasury supported this.

Senator James W. Squires, D. 12: Thank you. Thank you very much. I hope you make your plane ok. Two individuals indicated that perhaps they might speak together on behalf of the Association of Counties. Mr. Maglaras and Mr. Disko.

Commissioner George Maglaras, NH Association of Counties: Thank you very much Mr. Chairman. For the record my name is George Maglaras. I am the Chairman of the Board for County Commissioners in Strafford County and I am here to appear as the Chairman of NH Association County Commissioners Council and Chairman of our sub-committee of the Association on Tobacco.

First of all, Mr. Chairman if I may, on behalf of all county governments statewide I would like tot hank you for recognizing county government's contribution to our healthcare system by including us in this process and including us in the disposition of the tobacco funds.

I won't repeat a lot of what's already been said but there's a couple of points I'd like to bring up if I could.

Number 1, I would agree with Senator King in the way that we should if at all possible use these funds ..total for health related programs.

Number 2, the question that came up earlier regarding how much money does the counties for Medicaid programs and in general through my association of 22 years in county government, it's been true that about half of the money we raise by property taxes are spent on Medicaid programs. That is in respect to nursing home operations. So, that's what I want to bring to the Committee's attention. So, about half is what we spend and that's been true for my 22 years. Although those formulas have changed and those programs have changed somewhat since the institution of Medicaid. Prior to the institution of Medicaid most folks' costs were borne first year by their own communities, prior to 66 or 67.

We have engaged some technical assistance recently to give us and to try to make a good faith effort to determine how much we had spent collectively in the past since the inception of Medicaid. I'll have John Disko speak to that about the technical information and hopefully we'll be receiving that within the week's end. We'll be more than happy to share that with you.

I'd certainly be happy to answer any questions you may have regarding present funding and with this found partnership we have with the State, a 50/50 partnership as we move forward down the road. We all recognize this is a 25 year program and I'm happy to see some Senators and members of the House that feel that some of this money ought to be spent in the health related industry and .....are not so much that solve the Claremont issue.

We're all faced not only with the grain of America but as time goes on we have ....people of government people over the age 65, many of those people have tobacco-related illnesses. We're dealing with them today. It's a problem that isn't going to go away. So we're looking forward to working with the State and that found partnership as we try to do with the services to our people and do so with a reasonable cost.

I'm going to have Mr. Disko, Mr. Chairman, speak to you regarding our technical assistance.

Senator James W. Squires, D. 12: Mr. Disko?

John Disko, NH Association of Counties: Thank you Mr. Chairman and members of the Committee. My name is John Disco. I serve as Executive Director for the NH Association of Counties. For the last 20 years I have represented county government before the legislature.

Just to follow-up on Commissioner Maglaras we retain services of Dr. Jeffrey Harris and he's Ph.D. economist on the faculty of MIT. He's also a physician who is on the faculty of Harvard Medical School. He is in the process as we speak of putting together numbers on how much, since 1970, the county government contribution towards Medicaid for tobacco related illnesses. He's going to quantify it so that we just don't come in and say, "We feel we're entitled to $30 million of the settlement or $60 million." He will be able to come in with a report which we will have available to the Committee and anyone else so they may take a look at it and we feel that we're very comfortable – He's an expert and he's willing to come up and testify.

Senator James W. Squires, D. 12: Any questions? Senator Wheeler.

Senator Katherine W. Wheeler, D. 21: Thank you Mr. Chairman. John or George, when will this report be available?

Commissioner Maglaras: Hopefully within the next few days we'll have it in our possession. As soon as we get it in our possession we'll make sure you receive copies of it immediately if not sooner.

Senator James W. Squires, D. 12: Thank you both very much. Dr. Russell Jones.

Dr. Russell Jones, NH Public Health Association: Written testimony handed in. **See Attachment F.**

Senator James W. Squires, D. 12: Senator Pignatelli.

Senator Debora B. Pignatelli, D. 13: Thank you. Dr. Jones, you gave us a statistic in your last paragraph of $200 million to $350 million a year. I didn't get what – is that what we're currently spending on healthcare?

Dr. Jones: The estimates using the methodology the CDC has developed to determine how much of medical care costs is related to tobacco use and that's based on prevalence of smoking, the diagnosis, people being hospitalized, mortality of combination.

Senator Debora B. Pignatelli, D. 13: So, if I could just – so that $200 million to $350 million a year spent in New Hampshire is on smoking related treatment?

Dr. Jones: Medicaid payments. Yes. Obviously the total economic costs these days is much, much higher.

Senator Debora B. Pignatelli, D. 13: Thank you very much.

Senator James W. Squires, D. 12: Thank you very much. Tina Wisell.

Tina Wisell, American Heart Association: Written testimony handed in. **See Attachment G.**

Senator Katherine W. Wheeler, D. 21: I'm impressed by the Massachusetts statistics.

Senator James W. Squires, D. 12: Any questions? Thank you very much. Andrew Smith.

Andrew Smith, UNH Survey Center: **See Attachment H.**

Senator James W. Squires, D. 12: Any questions? Thank you. Dr. Wahrenberger.

Dr. Jon Wahrenberger, Dartmouth Hitchcock Medical Center, American Heart Association: Written testimony handed in. **See Attachment I.** (change tapes)

Senator James W. Squires, D. 12: Thank you. Mr. Vorel.

Jon Vorel, NH Tobacco Prevention Task Force: I didn't intend to speak but I left you all packets. **See Attachment J.**

Senator James W. Squires, D. 12: Alright. Sir, would you like to speak?

Gary Lechman: Thank you for giving me this opportunity today to speak about allocating the 25% towards tobacco education for the state of New Hampshire. It is a pleasure to meet you Senator Squires and Senator Wheeler and Senator Pignatelli.

I just hope the noise from this thing does not put you to sleep because it does do that. I was doing a senior citizen group over in Manchester last weekend. One of the little ladies in front fell asleep.

I'm from ...., North Dakota and I started smoking at the age of 12. I smoked for 52 years. I left home at an early age of 17 for the military and in those days our parents had to sign for you to go into the military because of the live Sullivan Brothers. I think you remember that. You know the principal came out to my home and said, "Marjorie and Luther, if you do not let this boy go in the service you might as well take him up to ... and push him over a cliff." (laughter) That is where I was headed for. I joined the military. I came from .... North Dakota and Texas and then ended up in Manchester. I've been here ever since 1952.

Now, I quit my Senior year of school and I spent 1½ years over seas and I got an honorable discharge from the Air Force after 8 years. Four year regular and 4 reserve and then I joined the Navy. I got an honorable discharge from the Navy.

I've got my high school diploma through the State of New Hampshire and I have spent two years at Hesser College. I got the highest award last November from the Governor. It was the ....Award for Volunteer Work. I was going around to all the high schools and talking to the teenagers and whatnot.

Now I am not sitting here bragging about this. I'm just telling you that I am very proud of all of that. What I'm not proud about is to sit here and tell you

about my smoking. My life was smoking. Now I went through some very, very extensive chemo in 1994.

First of all, I work for Public Service Company of NH and retired in 1991 as a line bucket foreman. I was going out on all the trouble calls and everything making sure your power was on so you'd have a good night sleep in the wintertime. Anyway it was a great job and I retired and three years later I came down with – I'm losing my voice – I went to the doctor and he diagnosed it and did a biopsy later on in the hospital. Just before I went in for the biopsy I smoked a cigarette 20 minutes before. Now I was – I don't want anybody to count out as stupidity. It's not. It's very, very addictive. I was addicted.

I went to a convention last August of 470 people over in Indianapolis like myself. I was very fortunate. Three out of ... were able to use this thing to speak. We were able to speak and others that were unfortunate could not speak except this way. That's because of all the cancer they got from tobacco. That's how they sounded.

Now, I'm here in support of all of this. We have 790,000 teens in the state of New Hampshire, not counting senior citizens because I go around speaking to senior citizens too. We have 790,000 teenagers and I've spoken to about 125,000 and just last December I've ... and she says, "Gary you know you keep on talking the way you are and the way you're doing it, you're doing an eloquent job." I said, "you know we had 790,000 teens in this state. I've talked to," at that time "about 80,000 and as far as I'm concerned we have 790,000 to speak to." It's got to be this – we've got to have tobacco education. We need it very, very badly in all of these schools. I – from all of the schools that I've spoken in and I've been at all these types of schools to talk to different kids. It's unbelievable what I've seen out there. They take one look at me and they say, "Well I'm not going to light up again." But there's other children out there that they do smoke and they're hooked on it very badly.

The former Winston man, Dave Borlack. I had a chance to speak to him on the Capital steps last April 1st and he was telling me that before he resigned from RJ Reynolds he went into an Executive Board Meeting and he offered on eof the Executives a cigarette and that Executive said "No. Thanks Dave. We reserve that tobacco for the young, the poor, the stupid and the black." I do not count myself as stupid. I'm a pretty smart man. I'm not the smartest man in the world but I am pretty smart with commonsense and that was very bad of him to say stupid. It is not stupid. It is addictiveness.

Now, where I live over in Manchester by Memorial High School, a couple of years ago just before I testified to raise the taxes on that 25%...I was walking

around there and these two teenage boys, 15 years old, they lit up and as I walked around and I said to them, "if you saw what I've got here you wouldn't be sucking on those butts." This kid says, "yeah. Yeah. We know all about it." I turned to them and said, "If you know all about it why are you sucking on those cigarettes?" Immediately they threw them down on the ground. I said to them, "You know someday I may be over there to talk to you kids about tobacco." They need it very, very badly.

We need this 25% allocation for tobacco education and if we do not get it I'm sorry I'm going to be one disappointed human being. I'm having a bad day today as it is. I don't want to make it any worse. (laughter)

I thank you very much. It is a pleasure to be here. I certainly hope that we can do something with this because it is needed and we have to extend it and go deeper into it. You've got this. It is deep sand. I don't have to sit here and tell you statistics. That's for sure. You've heard them all today. If there's any questions I'd be glad to answer anything that you might want to ask me.

Senator James W. Squires, D. 12: Any questions? Senator Wheeler.

Senator Katherine W. Wheeler, D. 21: I have basic question and that's what is your name?

Mr. Lechman: My name is Gary Lechman. I work with the NH Lung Association and I'm with the Tobacco Alliance. I do have a cute story for you. A couple of weeks ago I was over in Memorial High School and I did 5 ..classes that day but between the 4th and the last one, after I had spoken for about 35 or 40 minutes I said to the kids, "Now I'm ready for questions and I'll give all the answers that I can." Well, I got about 7 or 8 answers and I gave them the questions and then there was a bit of a pause and nobody was asking me anymore. So, I said, "let me ask you a question. Now you have studied the Civil War in history and everything like and you know all about the Civil War or parts of it." They're nodding their heads and everything and I said, "well, is it true that General Kuster wore and arrow shirt?" (laughter) The teacher started laughing. It went right over their heads. I got such a kick out of that. Thank you very much.

Senator Katherine W. Wheeler, D. 21: One more quick question. We've heard so much about how young children are when they start smoking, do you always speak only to high schools or do you speak sometimes to elementary or middle schools?

Mr. Lechman: I'm glad you asked that question because just last Wednesday I was down at Girls, Inc. down on Bartlett Street in Nashua. Now, these kids

are third graders all the way up to sixth grades and then there was a few in the seventh grade. When I got these kids, one little girl said to me as she pulls down her lip, "My daddy chews tobacco." I told her to ask her daddy to put it down and put it away. It's not very good. They had very, very good questions and I was so amazed and so surprised that these little kids, 8, 9 and 10 can ask questions the way they did. I was really, really impressed. We have to speak to everybody. I don't care who it is. We have to speak to everybody and I tell these kids that marijuana has all the harmful agents in it that tobacco has. In fact they inhale the cigarette longer and they hold it deeper. They smoke that sucker right down and they burn their fingertips. It is not a safe alternative to tobacco. (laughter) My God, they really listen up. But what really turns them on is the voice. (laughter)

Senator James W. Squires, D. 12: Thank you. Leslie Melby. I see you' re here with two hats.

Leslie Melby, Governor's Advisory Panel on Cancer and NH Hospital Association: Written testimony handed in. **See Attachment K.**

Senator James W. Squires, D. 12: Leslie, the Commissioner testified that there's a participating range to pay out outside. He said between $43million and $48 million per year for 20 years. Do you think it would be better instead of using a percent to use a dollar figure?

Ms. Melby: I do.

Senator James W. Squires, D. 12: Because if we hit the low range it will fall out of the CDC guidelines. The difficulty, however, then becomes if the population grows we'll fall out because we don't have enough – we'll be using a fixed amount. How do we address that kind of a problem?

Ms. Melby: Well I think concern myself and prior to last week before the U.S. Senate cast its vote, there was concern that HCFA would reclaim its 50% of the tobacco funds. So I said to people 25% of what? Or 1% of how much are we actually talking about? So, I think we should be very specific and quantify the amount that we need for the comprehensive program for all the program elements to be put into place. CDC says that a minimum, again for New Hampshire, and they've evaluated this for every state would be $11.4 million per year and the range goes up to $25 million. So, I don't know how the language needs to be written in the bill but I think that when we throw around percentages we can get into trouble if we don't know how much we're actually talking about. If we're real serious about the array of programs that we're promoting, I think we need talk specific dollars.

Senator James W. Squires, D. 12: I assume that the CDC arrives at its number from a per capita calculation so, let's say in the year 2000 the per capita calculations come to $12 million. Then we don't get a census for 10 years. Now the population is 2 million instead of 1.2 million. So, the per capita expenditure drops. Do you know what other states have done? How do we adjust for that as we go along? Or is it inevitable that it will drop?

Ms. Melby: I don't know how other states address it but I'll work with the Tobacco Prevention Task Force and the resources that we have and get you that information on how other states have sorted that out.

Senator James W. Squires, D. 12: We have three possibilities. We could put a per capita expenditure in the bill. We could put a dollar amount in the bill or we could put a percentage. I guess we need some advice about what's the best approach.

Ms. Melby: Well, I'm not exactly sure. I would – I don't know when you're going to be voting on this in Committee but I would like to give you the best advise as to whether it's a percent or dollar amount or per capita. I would like to discuss that with some of the experts and find out what's best rather than telling you off the top of my head. I'm really not sure.

Senator James W. Squires, D. 12: I would like to wait until we get the Department's final analysis because I think (turn over tape) need to figure out a way to take into account ....Maybe the only way to do that is to up the cigarette tax. That" not a bad idea.

Ms. Melby: As far as the estimate of the per capita and the population, I think the Office of State Planning throughout the decade estimates the size of the population growth. We have that through birth and death records. So, I'm not an expert on population statistics but I don't think it's sort of a stagnant number.

Senator James W. Squires, D. 12: That's helpful because if we were to use a per capita we'd need to make reference to what would be the source of the total population ....$12.00 per citizen per year, the ....

Senator Debora B. Pignatelli, D. 13: Mr. Chairman, I had heard somewhere recently that we're growing at 15,000 people a year.

Senator James W. Squires, D. 12: Well if you listen to some of the predictions regarding the topic of discussion tomorrow you can expect we're going to shrink by 500,000 a year. (laughter)

Senator Debora B. Pignatelli, D. 13: I'm shrinking every day. (laughter)

Senator James W. Squires, D. 12: Thank you very much. Ellen-Ann Robinson.

Ellen-Ann Robinson, Citizen: Hi. Good afternoon. For the record I'm Ellen-Ann Robinson. I'm the Director for Human Services for Hillsborough County and I appear before you for Hillsborough County as well as the two county Commissioners, Commissioner Charbonneau and Commissioner Holden, who wished to be here today but were in the middle of budget work.

After having sat here all afternoon and listen to the people testifying and I thought it was interesting to hear the physician, the doctor, the pulmonary specialist who talked about how he was thrilled when his parents said he had permission to smoke in the house. I have a different experience as a child. My parents smoked for me because of second-hand smoke. Again, Commissioner Maglaras talked about what happened in his family relative to illness and his illness and how everyone in his family stopped smoking. I had a little bit different experience in that I kept getting pneumonia. I have to tell you I'm recovering for Viral Pneumonia right now. I kept getting pneumonia as a young child and about the age of 8 or 9 on my fifth or so bout of pneumonia, after x-rays of my lungs, etc. my pediatrician said to me "Well Ellen-Ann, you've got scar tissue on your lungs already. This is not good. So I'm going to know if I ever see you with a cigarette in your hand that you're not going to be long for this world. You will die." This is 1959. So, I never did pick up a cigarette but my parents continued to smoke. My mother, my dad and my grandfather smoked in the house.

My father was a dentist and my uncle was a physician, an anesthesiologist. So it's that they weren't well-educated people. They were. They were just addicted. People didn't really know the extent of what they were really doing as they pursued cigarette smoking. My mother ultimately died of issues related to by-pass surgery that were directly related to her smoking at 72. After having survived cancer related to smoking and continuing to smoke.

So, I would say that I'm very much personally in support of the part of this bill that would have education and cessation support for people – the 25%. However, I heard Senator Squires' original testimony and I also heard the discussion that just went on and frankly, having been on the Finance Committee and things in the House I would recommend you do a two-prong approach.

One is you continue to the cigarette tax. A portion of the cigarette tax to go to smoking cessation and all the education pieces as well as some percentage

of tobacco funds because the cigarette tax will never end. The tobacco settlement will end. My view would be that there's more life in the fact that you have cigarette tax and it makes some sense to have a two-prong way of providing this – I would create a dedicated fund as much as the Legislature hates dedicated funds – to fund these kinds of activities.

My Commissioners did request that I be here to ask that you – and you did speak to it Senator Squires – to ask that you add county representation to the committee. We do provide a significant amount of long-term care in the counties across the state.

I would support the testimony of Commissioner Maglaras and John Disko in that once you get the study results that we've hired someone to really look at – a tobacco fund, by the way, expert. He has some real expertise in that and he's an economist and a physician. I hope you'll look at that because if I can remind you back to a very short time ago, the counties paid more for Medicaid than the State did. Significantly more for Medicaid than the State did. In fact, I would guess given m y experience in Hillsborough County, I pay for about 1,500 nursing home beds. Only 300 of those are in our own County Home or actually less than 300. Probably 275 are in our own County Home. I pay for a significant number of Medicaid beds and I would guess that 6.25% is probably Hillsborough County's share alone.

So I hope you will re-look at the percentage but I hope that you don't take the money away from the education piece that is really necessary. The County taxpayers have supported this and all we'll do is use the money to continue to pay for long-term care as the years go by. Thank you.

Senator James W. Squires, D. 12: Before you leave, do you have any suggestion about who should represent the counties? Should it be somebody from the NH Association or should it be somebody.....

Ms. Robinson: It could be someone who is nominated by the Association is how I would put it in language. It could a Commissioner. It could be Commissioner Maglaras. It could be a nursing home administrator. But the County Association could nominate someone.

Senator James W. Squires, D. 12: Thank you. That is all of the checkmarks. I have two pink cards. Douglas Barry and Diane Smoger.

Douglas Barry, American Lung Association of NH: Good afternoon. Thank you for giving us the opportunity to speak to you this afternoon. Chairman Squires and Senator Pignatelli, my name is Doug Barry and I'm the President of the American Lung Association here in New Hampshire and this

is Diane Smoger one of my associates in the office. I won't speak on her behalf but I'll very quickly – most of the statistics that I have in my report were already done so I'm not going to go through those again.

A couple of just major points to hit that I think are very important. We do support the original bill, 206, with 25% of the tobacco settlement funds being allocated for smoking cessation, prevention and education.

Angel, did you have out a copy of the – very quickly this was a PowerPoint presentation that was made on the behalf of the NH Tobacco Prevention Task Force to Commissioner Shumway and a couple of parts that I just want to make in here real quick, CDC recommends a per capita investment of about $12.00 per person. I think I'd be happy with $10 personally if we could get that much. We are shooting for about 25%.

Tobacco companies spend about $22 million here in the state of New Hampshire for tobacco advertising. I listen to testimony the other day where a store owner receives $50,000 a year from a tobacco company for putting up their advertisements and we on a regular basis has to somewhat beg the current per capita expenditure in New Hampshire is 29¢ and that again comes from the Federal Fund Impact Funds of about $350,000 to $375,000 per (sneeze). State allocation is zero.

So I think this is a real opportunity for us to do some real good things. We're not asking for all of it and we have proof that these programs work. The American Lung Association has been doing programs in New Hampshire for quite sometime. Over the last four or five years that I've been here working with the organization I think some very good things have happened. Are we doing everything? No. We can do a lot more with funding support, with some support. At this time there is some real opportunity and I hope that you will help us to access some of these additional funds.

So, thank you and I'll pass it over to Diane.

Diane Smoger, American Lung Association of NH: I just wanted to comment briefly. I coordinate some of our tobacco prevention and cessation programs and activities for young people throughout the state. So my perspective here today is just to share or reiterate the fact that we do need a strong comprehensive program. I also had an opportunity to work for Massachusetts as part of their comprehensive tobacco program and I saw what a well thought out planned program and well-funded program can do. We saw changes there and there're still continuing to be changed and I'm really happy to be here and certainly would support any effort to really build a comprehensive meaning you've heard a lot about comprehensive programs

today but attacking the schools, attaching the communities, getting people involved from all aspects of the community. Tobacco use is really – we know it's hitting the kids. It's a childhood disease. It's not an adult disease. It starts when the kids are young. That's when they get hooked. That's when I work with them; in some of the programs that I work with are trying to prevent the kids form ever starting to use tobacco. I also work with programs trying to get kids to stop use because I'm working with middle schools who are ready to quit. They're addicted. Some of them are at a pack a day already. Seventh and eighth graders. They don't have a place to go. That's what I hear. They don't have a lot of resources out there. They don't have and even in adults – we hear that as well. There's not a lot of places for them to access services to help them get off their addiction or to be free from their addiction.

Clearly the schools need the support from organizations like Lung Association, Cancer, Heart and many other community groups that are helping them develop and implement effective school-based tobacco prevention programs. This is just one piece of a comprehensive program.

So if you have any questions.

Senator Debora B. Pignatelli, D. 13: Thank you. Where are the seventh and eighth graders getting the money to buy a pack of cigarettes a day?

Ms. Smoger: A lot of them, I'm glad to hear the young person testify earlier, a lot of them are stealing them. A lot of them, this is just from what I hear, are getting them from parents. Some are willing to purchase and some are having them available and accessible in the homes. That's more middle schoolers. Some of them are actually buying them. I don't know the percentage but I do ask them that. With all the kids that I work with. "Where do you get them and how do you afford them?" Many of them are stealing them. They go in, also, on packs. Some of them will share the cigarettes.

In high school, again, many are stealing. Freshmen and Sophomores – the older ones are able to purchase them still. Even though the stores and merchants have been approving in terms of carding, still they know where to get them if they want them. And parents also. Particularly parents if they're using, they have the tobacco available and around the house and it's that whole attitude shift to that we're trying to do with that comprehensive program among the kids but also among the adults. Kids are watching and mimicking what the adults are doing in the household on a daily basis.

Senator James W. Squires, D. 12: We've heard a great deal of testimony in the Finance Committee in the hearings on the cigarette tax bill and one of the point and counter-point arguments was – we heard today that a 10% increase in price results in 7% reduction in smoking. The rejoinder is that New Hampshire is at a steady progressive increase in its price and some age groups arise in consumption of cigarettes. How do you respond to that observation while still making the point that increases in the cost of cigarettes results in a reduction of smoking?

Mr. Barry: If I may answer that question. New Hampshire started out – the cost of tobacco in New Hampshire was extremely low. The increases that we've experienced have been also very low. In order for us to really impact on tobacco use among youth we have to have good size increases in the tobacco tax which will give a brief reduction in use...with an education program that's comprehensive partnered with all the other things they talked about from CDC.

So, a small increase in the tobacco tax is like giving us $100 to help reduce youth smoking in New Hampshire. It's not enough. It's got to be a substantial increase and it has to be a comprehensive program. We're probably doing, I wouldn't say more harm than good but we're not looking at this in a preventive method. We're looking at this as an economic issue when we increase the cigarette tax. In order to really impact it's got to higher than what we do.

Senator James W. Squires, D. 12: Thank you. Mr. Gray.

James Gray, American Cancer Society: Written testimony handed in. **See Attachment L.**

Senator James W. Squires, D. 12: You're testifying in support of this bill?

Mr. Gray: We are supporting the original bill.

Senator James W. Squires, D. 12: Is there anybody else who would like to testify on Senate Bill 206? Seeing none, I will close the hearing and thank you very much for coming.

Hearing closed at 3:55 PM.

Respectfully submitted,

Merideth A. Chandler,
Committee Secretary

Attachment A

Sen. Squires, Dist. 12
March 9, 1999
1999-0335s
01/09

Amendment to SB 206-FN-A-LOCAL

Amend the title of the bill by replacing it with the following:

AN ACT establishing the tobacco use prevention fund and continually appropriating a special fund and relative to the health care fund.

Amend paragraph II of section 1 of the bill by replacing it with the following:

II. The general court recognizes that funds are provided through the settlement both for prevention activities and to reimburse the state for costs incurred in providing treatment to persons whose illnesses and disabilities have resulted from tobacco use. It is acknowledged that county governments pay a portion of medicaid costs and a share of the funds provided through the settlement should be returned to the counties.

Amend RSA 126-K:15, II as inserted by section 2 of the bill by replacing it with the following:

II. The total of one percent of all funds received by the state of New Hampshire as a result of the settlement of the litigation against tobacco companies shall be deposited into the fund.

Amend the bill by replacing all after section 2 with the following:

3 Distribution of Funds to Counties. Upon receipt by the state of New Hampshire of funds as a result of the settlement in 1998 of litigation against tobacco companies, the sum of 6.25 percent of funds received shall be appropriated and disbursed to county governments. The allocation to each county shall be based upon the proportion that each paid to the state in the prior state fiscal year pursuant to RSA 167:18-b. The governor is authorized to draw a warrant for said sums out of funds received by the state from settlement of the tobacco litigation.

4 Medicaid Coasts. Upon receipt by the state of New Hampshire of funds as a result of the settlement in 1998 of litigation against tobacco companies, the sum of 43.75 percent of funds received shall be allocated and are hereby appropriated to the department of health and human services to reimburse the department for the cost of medicaid long-term care services. The governor is authorized to draw a warrant for said sums out of funds received by the state from settlement of the tobacco litigation.

5 Health Care Fund. Upon receipt by the state of New Hampshire of funds as a result of the settlement in 1998 of litigation against tobacco companies, the sum of 49 percent of funds received shall be deposited into the health care fund established by RSA 167:70.

6 New Subparagraph; Special Fund. Amend RSA 6:12, I by inserting after subparagraph (vvv) the following new subparagraph:

(www) Moneys received under RSA 126-K:15, which shall be credited to the tobacco use prevention fund.

7 Clarification of Fund Initiatives. Amend RSA 167:71, I to read as follows:

I. Fund the planning and implementation of public or private health initiatives which promote access to or improve the quality of available health care services***; including initiatives which assist people in obtaining health insurance, long-term care insurance, dental care, and prescription drugs.***

8 Health Care Fund; Limitations. Amend RSA 167:74, I to read as follows:

I. Health care initiatives as established in RSA 167:71 shall be available for a limited time period which shall not exceed 4 years***, except when a longer period of support is determined to be necessary by the commissioner of health and human services.***

9 Reference Deletion. Amend RSA 9:13-e, II to read as follows:

II. There is hereby established within the general fund general ledger a revenue stabilization reserve account. At the close of each fiscal biennium, any surplus, as determined by the official audit performed pursuant to RSA 21-I:8, I(h) shall be transferred by the comptroller in the following manner: 50 percent to a special nonlapsing revenue stabilization reserve account and 50 percent to the health care fund established pursuant to RSA 167:70; provided, however, that in any single fiscal year the total of such transfers shall not exceed 1/2 of the total potential maximum balances allowable under paragraph V [~~and RSA 167:74, III~~]. The comptroller is hereby directed to establish the revenue stabilization reserve account in which to deposit any money received from a general fund operating budget surplus. The state treasurer shall invest funds in this account as authorized by RSA 6:8. The interest so earned shall be deposited as unrestricted general fund revenue.

10 Repeal. RSA 167:74, III, relative to certain fund limitations, is repealed.

11 Effective Date. This act shall take effect upon its passage.

1999-0335s

AMENDED ANALYSIS

This bill establishes the tobacco use prevention fund into which one percent of the funds received by the state of New Hampshire as a result of the settlement of the litigation against tobacco companies shall be deposited. The fund is to be used by the department of health and human services for tobacco prevention activities.

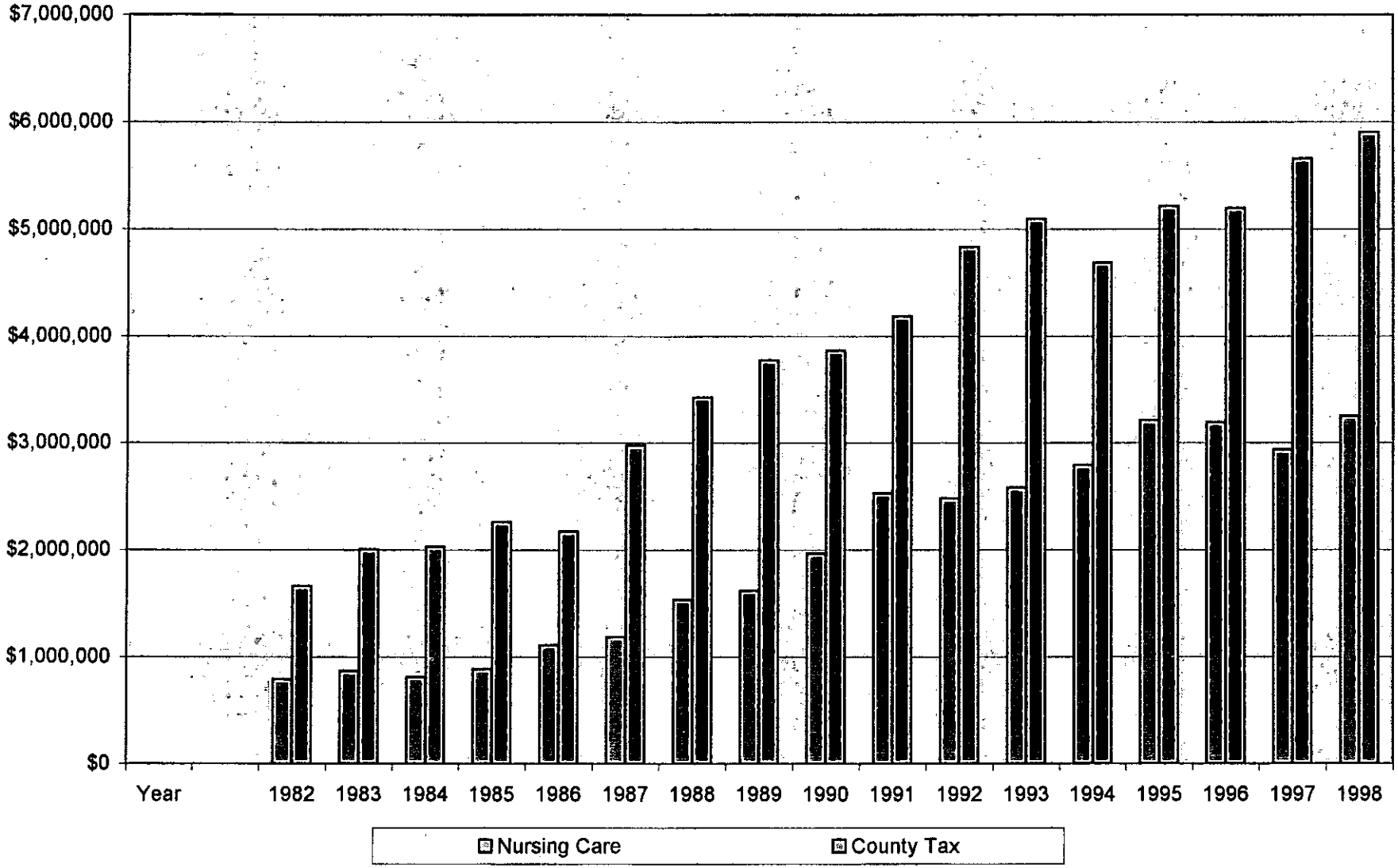
The bill distributes a portion of the litigation settlement funds to the counties for reimbursement of nursing homes and to the department of health and human services for reimbursement for long-term care costs..

The bill distributes a portion of such settlement funds to the health care fund.

The bill clarifies the initiatives of the health care fund.

This bill was requested by the department of health and human services.

COOS COUNTY TAX/INTERMEDIATE NURSING CARE



Attachment B

Attachment C

Good afternoon Senators. My name is Nicole Cann I am a freshman at Franklin High School and also a member and secretary in the Franklin-Winniquam Smoke-Free Coalition. In this coalition, we sponsor many activities about tobacco prevention.

I've come here today to tell you what I see in my school pertaining to smoking and how I feel about it.

At school other students' decision to smoke affects me in several ways. One of the reasons is because we have 6 bathrooms in my school, 4 of which are locked every day. Because of this students like myself have to walk a further distance to get to a bathroom that is monitored across from the office. Even then, the bathrooms still reek of smoke.

You may be wondering how kids my age get cigarettes? From what I hear around school they shoplift them, that's how easy it is to get them. I will admit, however, most stores do a good job by keeping the cigarettes behind the counter or by locking them up, but not well enough.

Most kids are still addicted from the seventh and eighth grade. I am here to tell you that this is a huge problem, not just in Franklin but statewide. There are 123 kids in my freshman class and several of them have a drug abuse problem. A large number of them smoke cigarettes.

I would like to see 25% of the tobacco settlement go to programs in the schools that help kids quit and to help keep them from ever starting. Young people understand the dangers of smoking but they are heavily influenced by cigarette advertisements. We need to put smoke-free ads in magazines and on television to help counter the tobacco industry ads. We can't do this, however, without money.

Please take this into consideration when you vote on Senate Bill 206.

Thank you.

Attachment D

Brendan Driscoll
Dover Youth to Youth
46 Locust Street
Dover, NH 03820
(603) 742-4646

Hi, my name is Brendan Driscoll. I'm from Dover Youth to Youth. I'm in 6th grade at Dover Middle School and I'm eleven years old.

I have learned some things about tobacco from Youth to Youth, which is peer prevention program at the Dover Middle and High Schools. I have also learned a lot from my mom.

My mom works in the Cancer Center at Wentworth Douglas Hospital in Dover. She is a nurse there and sees a lot of people get sick and die because of smoking. My mom told me that these people have been smoking for a long time, and that they started smoking when they were very young. And even though these people are being treated for cancer, some of them are still smoking.

I have learned that smoking can make you sick, take away your money, can make you look bad, and can even cost you your life. I think that people shouldn't smoke. I don't know why they do if it could cost you money, or your life.

I think these people should have been educated when they were younger and told that what the consequences of smoking are. Maybe, if they had this information available to them when they were my age they may not have started smoking at all.

I think that it is a good idea to take money from the tobacco settlement to help people stop smoking, or prevent them from starting. I support the amendment that the State should spend 25 percent of the settlement money on tobacco prevention.

I think the State should spend the money on tobacco prevention if there is even a chance that people will chose to be smoke free.

Attachment E

Donald Shumway, Commissioner
Department of Health and Human Services
Testimony on Senate Bill 206-FN
Before the Public Institutions, Health & Human Services Committee
3/22/99

Good afternoon, Mister Chairman and members of the Committee. For the record, my name is Donald Shumway, Commissioner of the Department of Health and Human Services.

Under the terms of the recently announced tobacco settlement the state will receive roughly 16 million dollars in 1999. From the year 2000 through 2025, we should receive between 42 and 56 million dollars each year. I am here today to speak in support of SB 206, a bill which dedicates the entire proceeds of the Settlement to the health of our citizens in a prudent and thoughtful fashion, allowing for both immediate needs and investment into the future health needs of our state.

As you may know, our Attorney General Philip McLaughlin pursued litigation against the Tobacco Manufacturers with two objectives in mind. These were to reimburse our state for costs incurred in the care of persons who suffer from tobacco related illness, and to prevent our youth from embarking down the road of tobacco addiction and its inevitable consequences.

SB 206 addresses these objectives by doing three things--It establishes a Tobacco Use Prevention Fund, it provides more money for the Health Care Fund, and it sets up a reimbursement mechanism for state and county dollars spent on tobacco related Medicaid services. I will now discuss these topics one at a time:

TOBACCO USE PREVENTION FUND

- SB 206 establishes a Tobacco Use Prevention Fund with a percentage of the Tobacco Settlement money, the majority of which will be apportioned to communities via grants. The Department's intent for this fund is to keep our children and young people from starting to smoke; to assist adults and young people who've already become addicted to stop smoking; to maintain our educational efforts around tobacco use prevention; and to evaluate the outcome of our efforts.

In the area of Tobacco Prevention, as in other areas of Public Health, such as immunizations, communicable diseases, chronic disease, and HIV, the Department often turns to the Centers for Disease Control and Prevention (CDC) for the best practices and the best science on which to base our efforts.

CDC has recommended, and the evidence seems to be growing, that the only way a state can reduce smoking and other tobacco use is to establish a well-funded and sustained Comprehensive Tobacco Prevention Program that employs a variety of effective approaches, all of which are integrated with the other components, to create a cultural "shift" of sorts, that will result in tobacco use becoming less appealing and less acceptable in all social arenas.

Let me share with you the recommended components of such a program:

- **Public Education Efforts:** These would focus on countering the $22 million dollars worth of advertising each year in NH by Tobacco Manufacturers. It would need to include multiple paid media efforts; special events and promotions; and, public relations.

- **Community Based Programs:** The Community Grant Program built into the Tobacco Prevention Fund would direct grants to partners in local communities, including schools, businesses,

local health departments, and community health centers that would focus on scientifically based, proven effective prevention and cessation strategies. They would also seek to decrease the burden of tobacco related diseases, like asthma and cardiovascular diseases.

- **School Based Programs:** Making sure that tobacco prevention is part of every school's curriculum.

- **Enforcement:** Rigorous enforcement of statutes established by this Legislature to prohibit the sales of tobacco to minors is a critical component in establishing a culture understanding that this is not acceptable behavior.

- **Monitoring and Evaluation:** We intend to rigorously evaluate every element of NH's program throughout its existence. Monitoring and evaluation methods will be built into the programs to provide the data necessary for evaluation and continual improvement.

How would we go about setting up such a program? First, we will build on the existing Tobacco Prevention Program infrastructure, developed through federal grant dollars.

Second, the Department and its partners, many of whom will be a part of the Advisory Committee established as a part of the Tobacco Use Prevention Fund, are working to develop a New Hampshire tobacco control plan based on the CDC recommended model that we can present to you in the weeks ahead. The purpose of the plan will be to lay out the structure and rationale for tobacco control efforts based on NH's unique needs. The message is very clear to us that we need to pull together documentation of evidence and science-based programs that have been effective in decreasing smoking, and we intend to do just that.

MEDICAID REIMBURSEMENT

SB 206 will allocate 50% of the tobacco settlement funds to the long-term health care costs of Medicaid patients attributable to smoking. It is important that the contribution of the counties be recognized, and we appreciate Senator Squires including 6.25% of the tobacco settlement moneys for them in this bill. The 43.75% allocation to the Department will be used as the state's match for Medicaid funds that come into the state, thus freeing up General Funds that ordinarily would be used for the match, to be used for other pressing needs.

HEALTH CARE FUND

Next, SB 206 allocates 49 percent of the tobacco settlement funds to the Health Care Fund, which will allow the Department to address existing and emerging health issues in a timely manner. The bill's language also allows the Commissioner to extend funding to projects that are proven to be effective in increasing accessibility and availability of services.

Given the importance of the Health Care Fund I would like to: review the history and purposes of the Health Care Fund, provide an overview of the Community Grant Program, which is funded by the Health Care Fund, and, finally, note the impact of past withdrawals from the Health Care Fund principal.

History

The Health Care Transition Fund was created in 1995 -- with principal in the amount of $99 million.

The moneys in the Fund were originally set aside in 1994 to help New Hampshire transition to the changed health care environment anticipated with national health care reform.

With the demise of national reform, the Department worked with the Legislature to restructure the Health Care Transition Fund.

The 1995 legislation (House Bill 60) envisioned the Health Care Fund as a permanent endowment -- protecting the principal while using the interest earnings to fund health care initiatives.

Community Grant Program

The Health Care Fund serves as the funding source for the Community Grant Program.

The Community Grant Program, as many of you know, invests in innovative approaches and solutions to improve health services at the local level throughout New Hampshire.

By statute, the Program supports community-based initiatives necessary to promote access, improve the quality of health care services, evaluate service delivery and cost models, or improve the purchasing and cost effective utilization of health care services. RSA 167:74 II.(c).

The amount available each year for grant funding is based on the interest generated from the Health Care Fund. Historically, this has been approximately $3 million a year.

Activities to Date

In its first four years, the Community Grant Program has funded 129 community-based health care initiatives throughout New Hampshire. Probably you have heard about some of these projects from people in your own districts.

The program has put $13 million into New Hampshire communities during these four years..

Current grantee categories include: dental, elder services, child care, networking and information technology, primary care, transportation, housing, volunteer support, education and training, research, children and youth services, mental health, and family support.

Grant applications receive a technical/feasibility review by staff drawn from throughout the Department.

Next, an external Advisory Committee reviews the grant proposals and prioritizes its recommendations for the Commissioner, who generally accepts them.

Then the final grantee list is submitted to the Joint Fiscal Committee and finally to Governor & Council for approval.

Valued Added

The Community Grant Program is a distinctly New Hampshire approach to improving health and health care.

It serves as a resource for communities as they prepare for and participate in the rapidly changing health care system.

Local organizations are often the first to identify new approaches to problems affecting the quality of life in their communities.

The Community Grant Program provides a vehicle to tap that vision, creativity, and leadership.

Health care improvements can be piloted at the local level. -- And we can evaluate their application to system change statewide.

Also, this Program provides the seed money necessary to give stability to a promising project so that it can leverage funding from other sources -- for example, federal and national sources.

An early evaluation of the Program showed that the first-year investment of $4 million leveraged an additional $5 million in new funds for a myriad of innovative health care initiatives..

There are a number of examples of projects that have grown beyond initial funding by the Community Grant Program to become self-sustaining and vitally important to the health of their communities.

National Recognition

The value of the Community Grant Program has been recognized nationally by the Alliance for Redesigning Government, a program of the National Academy of Public Administration.

In a study of the Program last summer, the Alliance stated that the Community Grant Program is *"unique in serving as a government catalyst for community-based reform."*

And it called the Program *"one of the country's most creative answers to the escalating challenges of reforming health care to meet the expressed needs of citizens."*

Fiscal Benefit

The Health Care Fund has an added benefit - in tandem with the Revenue Stabilization Reserve Fund (or "Rainy Day Fund").

It improves New Hampshire's Bond Rating and reduces the State's cost in borrowing money.

Financial History

During the past four years, a series of substantial withdrawals have reduced the Health Care Fund's principal.

As of June 30, 1998, the Fund balance was $42.7 million -- less than half than the original amount of $99 million.

Due to the diversions from the Fund, the interest income available to fund potential grantees has dropped substantially.

The consequence is that many innovative solutions to addressing our health care at the local level may go unfunded.

Currently, the income generated by the Health Care Fund principal for "Fourth Round" grant funding (to be awarded in SFY 2000) is approximately $2 million.

Meanwhile, we have just received 73 new requests for funding -- at an amount of over $5 million.

This variance will make the grant review process very competitive and rigorous, but potentially many good proposals may go unfunded.

For that reason, the Department believes it important to avert further depletion of Fund resources, and instead begin to replenish the Health Care Fund.

Future of the Health Care Fund

The Health Care Fund -- through the Community Grant Program -- plays an invaluable role in supporting community-based innovation to

address changing health care needs and emerging issues in New Hampshire's communities.

The continued viability of the Community Grant Program is dependent on having access to sufficient dollars through the Health Care Fund to support the types of innovative solutions that communities need.

The Department believes the Health Care Fund should be preserved for the purposes for which it was established. Absent strong reasons, we believe it should not be diverted to other purposes, particularly as a one-time solution to ongoing needs.

This concludes my testimony, so I will close by again expressing my wholehearted and sincere support of this bill and all of its provisions. Thank you very much for your attention. I will be happy to answer any questions that you may have.

sb206tst.doc

Attachment F

New Hampshire Public Health ASSOCIATION

Testimony on SB 206, establishing the Tobacco Use Prevention Fund and continually appropriating a special fund

Senate Public Institutions, Health & Human Services Committee
March 22, 1999

Good afternoon, Mr.Chairman and members of the Committee. My name is Dr. Russell Jones. I am a family and public health physician and I'm here today representing the New Hampshire Public Health Association. The New Hampshire Public Health Association has a membership of over 200 individuals and organizations committed to promoting and improving public health in New Hampshire.

I would like to share some of my own experience:
A woman in her 40s comes to the Emergency room having a seizure which will not stop, as her family looks on in horror. Her seizures have been caused by a lung cancer which has spread to her brain; she dies within a couple of months.

A man in his early fifties at a family wedding develops heartburn after dinner, goes out to the porch for fresh air, and drops dead. His only risk factor for heart disease (other than being a man) is smoking.

A patient in the nursing home for whom nothing medical can be done except to gradually increase the already large doses of pain medication which he requires because of a smoking-related cancer which began inside his nose and which now progressively destroys his face. Mercifully, he dies within a few weeks.

These are not abstractions; these are not some vague "Tobacco Problem", but are rather a few of my own personal experiences as a family physician. What is important for today's discussion is what these three tragic stories have in common - they could have been prevented.

The Centers for Disease Control and Prevention(CDCP), acknowledged world-wide as the leading authority on matters of population and public health, has examined a broad range of initiatives to reduce tobacco use, and has singled out those that work. It is presented as a list of "Best Practices" which CDCP has recommended to states. A description of the recommendations is included with the written copy of my testimony. The New Hampshire Public Health Association fully supports those recommendations.

Decreasing tobacco use will not be easy; it will take time; and it will be expensive - the CDCP estimates that New Hampshire should spend within the range of $11.4 million to $25 million *per year* on these activities.

95 North State Street, Concord, NH 03301
603-228-2983 Tel 603-271-1517 Fax

But this is no different than other successful public health initiatives. Let me give you a few examples. Between 1982 and 1993, alcohol-related traffic fatalities in the United States decreased by 31%. From 1950 to 1995, cardiovascular deaths, principally deaths from heart attack and stroke, decreased by 58%. In 20 years of practice I have never seen an active case of measles or polio, thanks to a long-term commitment to their eradication through immunization. These dramatic improvements have not occurred by luck. They are the result of the kind of broad-based approach that the Association and CDCP advocate for tobacco.

The New Hampshire Public Health Association believes that the Tobacco Settlement was structured for, and the funds intended to pay for, tobacco prevention efforts. 25% of these funds must be set aside to provide for a minimum level to assure effectiveness.

At the same time, tobacco use is not only a health threat, but is also an enormous hidden but direct tax on public health and health care services. Using the SAMMEC methodology, also developed by the Centers for Disease Control and Prevention, the direct ***medical*** cost of tobacco-related illness in New Hampshire was estimated at $153 million in 1991. That translates to $199 million in 1997 – that's $199 million which was not available for pressing needs such as improving local communities' ability to improve their residents' health, assisting needy elderly patients to pay for expensive medications, providing dental services to those who do not currently have access, and others.

Again, the New Hampshire Public Health Association believes that the Tobacco Settlement funds were intended to undo what tobacco has done to the health of our people, not to provide relief for unrelated funding problems or constitutional dilemmas. We believe that all of the Tobacco Settlement Funds should be allocated to activities which will improve the health of the Public.

I urge you to pass SB 206 as originally drafted to dedicate 25% of New Hampshire's tobacco settlement money to the Tobacco Use Prevention Fund to support effective tobacco prevention and control initiatives.

Thank you.

ESSENTIAL ELEMENTS OF A COMPREHENSIVE STATE TOBACCO PREVENTION PROGRAM

The only way any state can substantially reduce smoking and other tobacco use within its borders is to establish a well-funded and sustained comprehensive tobacco prevention program that employs a variety of effective approaches. Nothing else will successfully compete against the addictive power of nicotine and the tobacco industry's aggressive marketing tactics.

While the new tobacco settlement agreements give every state a tremendous opportunity to establish effective new programs to reduce tobacco use, each state must invest its tobacco company payments wisely to reduce tobacco use as effectively and quickly as possible.

Fortunately, California and Massachusetts have already established comprehensive tobacco prevention programs that have operated with considerable success. These programs can serve as models for other states, which can also build on the enormous amount of available research and experience from other tobacco reduction efforts throughout the country.

ESSENTIAL COMPONENTS

Past experiences show that the following elements must all be included to maximize the success of any statewide program to reduce tobacco use. Conducted in isolation, each of these elements can reduce tobacco use, but done together they have a much more powerful impact.

Public Education Efforts: Research has demonstrated that tobacco industry marketing increases the number of kids who try smoking and become regular smokers. Not surprisingly, one of the best ways to reduce the power of tobacco marketing is an intense campaign to counter these pro-smoking messages. These efforts must include multiple paid media (TV, radio, print, etc.), public relations, special events and promotions, and other efforts. Counter-marketing efforts should target both youth and adults with prevention and cessation messages. Any restrictions placed on the strategies used in these efforts will only hamper effectiveness.

Community-Based Programs: Programs like The National Cancer Institute's ASSIST (American Stop Smoking Intervention Study) Project have demonstrated that community-based programs reduce tobacco use. Because community involvement is essential to reducing tobacco use, a portion of the tobacco control funding should be provided to local government entities, community organizations, local businesses, and other community partners. These groups can effectively engage in a number of tobacco prevention activities right where people live and work, including direct counseling for prevention and to help people quit, youth tobacco education programs, interventions for special populations, worksite programs, training for health professionals, and enforcement of local youth access ordinances. Criteria for eligibility and accountability must be established to ensure that community-directed funds are spent on the most effective efforts.

Treatment of Tobacco Addiction (Cessation): A comprehensive tobacco control program should not only encourage smokers to quit but also help them do it. In fact, most smokers want to quit but have a very difficult time because nicotine is so powerfully addictive. To help these smokers, cessation products and services should be made more readily available and more affordable. Moreover, treatment programs are most effective when they utilize multiple interventions, including pharmacological treatments, clinician-provided social support, and skills

training. Cessation services can be provided through primary health care providers, schools, government agencies, community organizations, and telephone "quitlines." Staff training and technical assistance should be a part of all programs to treat tobacco addiction; and following the cessation guidelines from the Agency for Health Care Policy and Research will increase the effectiveness of any cessation efforts in clinical settings.

School-Based Programs: School-based programs offer a useful way to prevent and reduce tobacco use among kids, especially when based on the CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction.* To operate most effectively, school-based programs must include curricula that have been shown to be effective, as well as tobacco-free policies, training for teachers, programs for parents, and cessation services. Students must learn not only the dangers of tobacco use but life skills, refusal skills, and media literacy in order to resist the influence of peers and tobacco marketers. It is also critical that the school programs be integrated with other community-based programs and with counter-marketing efforts.

Enforcement: Rigorously enforcing laws prohibiting tobacco sales to youth and limiting exposure to secondhand smoke is an essential element of creating an environment conducive to reducing tobacco use. These enforcement efforts should include hotlines for reporting violators, frequent compliance checks, penalties for violators, and compliance enhancing education. Studies show that reducing youth access to tobacco products can reduce use and that establishing smoke-free workplaces, schools, and public areas can both reduce the amount people smoke and even prompt many smokers to quit. To increase tobacco control enforcement, funds must be provided to enforcement agencies to make sure other enforcement efforts are not compromised. Other agencies and organizations should also be supported to provide related educational efforts to raise awareness of the laws and their enforcement and to promote compliance.

Monitoring and Evaluation: Every element of a comprehensive tobacco control program should be rigorously evaluated throughout its existence. Programs should be based on available research and lessons learned from past efforts, and specifically designed to effectively serve their targeted audiences. Careful monitoring and evaluation methods should be built-into the programs to provide the data necessary for continual improvement. Process measures should be developed to monitor the activities conducted under the program from the outside, as well, in order to block the misuse of funds and promote their most efficient and effective use. And regular measurements of key outcomes should also be conducted to assess progress and further improve their performance. Through all this evaluation work, each and all of the elements of a state's tobacco control initiative can be adjusted and improved to ensure that tobacco use declines as quickly and sharply as possible.

Related Policy Efforts: This paper focuses on the key programmatic elements of a tobacco prevention and cessation program, but there are also additional policy initiatives that have been proven effective in reducing tobacco use -- especially as part of a comprehensive strategy. These policies, which can be undertaken at the state and local levels, include increases in cigarette excise taxes, restrictions on tobacco marketing to kids, increased penalties for selling tobacco to kids, and new restrictions on environmental tobacco smoke in public places.

GUIDING PRINCIPLES

Past experience with tobacco control efforts indicates that five principles should guide the development of a successful state program to prevent and reduce tobacco use:

- **It must be comprehensive.** Stopgap or partial measures will meet with only partial success. While research shows that a number of measures can reduce tobacco use, these elements work most effectively when they are combined in complementary fashion.

- **It must be well funded.** Unless properly financed, tobacco prevention will have little effect against the marketing efforts of the tobacco industry (over $5 billion each year). The Centers for Disease Control (CDC) has issued funding guidelines for state tobacco control programs, which can serve as a basis for planning.

- **It must be sustained over a long period of time.** While short-term attitudinal changes can occurr relatively early, it will take years to achieve the significant behavioral and cultural changes necessary to reduce tobacco use substantially and maintain low levels. Reducing youth tobacco use by a third will only get us back to 1991 levels; thus, the effort must be a prolonged one. If tobacco control programs are not sustained over many years, the chances for success will be diminished, and any early gains may be lost in subsequent years. The early investment must be protected by sustaining the effort over time.

- **It must operate free and clear of political and tobacco industry influence.** History warns us that the tobacco industry will employ every manner of tactics to divert money from tobacco prevention and to interfere with any tobacco prevention efforts that are undertaken. To avoid this tobacco industry sabotage, new tobacco control programs must be set up to be independent of these influences and insulated from them.

- **It must address high-risk and diverse populations.** The needs of special populations can and must be taken into account in designing and disseminating the various elements of the tobacco control program.

January 27, 1999

THE TOLL OF TOBACCO IN NEW HAMPSHIRE

Tobacco Use in New Hampshire

- **High school students who smoke: 40%**
- **High school males who use smokeless tobacco: 13%**
- **Number of kids (under 18) who become new daily smokers each year: 5,000**
- **Kids exposed to second hand smoke at home: 70,000**
- **Number of packs of cigarettes illegally sold to kids in New Hampshire each year: 1.2 million**
- **Adults in New Hampshire who smoke: 25%**

While adult smoking has generally been decreasing throughout the country in recent years, these declines have slowed or stopped. In contrast, smoking among kids increased steadily throughout much of the 1990s. Although national underage smoking rates finally dropped slightly from 1997 to 1998, they remain at historically high levels. Over the past ten years, the number of kids under 18 in the U.S. who become new daily smokers each year has risen by more than 70 percent.

Deaths in New Hampshire From Smoking

- **Number of people who die each year in New Hampshire from smoking: 1,700**
- **New Hampshire kids alive today who will eventually die from smoking: 23,000 (if current trends continue)**

Smoking kills more people than alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined – and thousands more die from other tobacco-related causes – such as fires caused by smoking (more than 1,000 deaths/year nationwide), exposure to second hand smoke (more than 40,000 deaths), and smokeless tobacco use. No good estimates are currently available, however, for the number of New Hampshire citizens who die from these other tobacco-related causes, or for the much larger numbers who suffer from tobacco-related health problems each year without actually dying.

Tobacco-Related Monetary Costs

- **Annual health care expenditures in New Hampshire directly related to smoking: $340 million**
- **Yearly New Hampshire government Medicaid payments directly related to smoking: $90 million**
- **Additional annual expenditures in New Hampshire for babies' health problems caused by mothers smoking or being exposed to second hand smoke during pregnancy: $6 to $18 million**

Additional health care expenditures caused by tobacco include the costs related to direct exposure to second hand smoke, smoking-caused fires, and smokeless tobacco use. Although these additional health expenditures certainly total in the tens of millions of dollars in New Hampshire, and increase the New Hampshire government's Medicaid burden, there are no good state estimates currently available. Other non-health costs caused by tobacco use include direct residential and commercial property losses from fires caused by cigarettes or cigars (more than $500 million nationwide); work productivity losses from work absences, on-the-job performance declines, and early termination of employment caused by tobacco-related health problems ($40+ billion per year nationwide); and the costs of the extra cleaning and maintenance made necessary by tobacco smoke, smokeless tobacco spit, and tobacco-related litter (about $4+ billion per year nationwide for commercial establishments alone). No good state-specific estimates of these non-health costs from tobacco are available, but New Hampshire's pro-rata share, based on its population, is at least $190 million per year.

Tobacco Industry Advertising and Other Product Promotion

- **Annual tobacco industry advertising and promotional expenditures nationwide: $5.2 billion**
- **Estimated portion spent in New Hampshire each year: $22 million**

Published research studies have found that kids are three times more sensitive to tobacco advertising than adults and are more likely to be influenced to smoke by cigarette marketing than by peer pressure, and that one-third of underage experimentation with smoking is attributable to tobacco company advertising.

Attachment G

Testimony before Senate Appropriations Committee
March 22, 1999

Hello. My name is Tina Wisell. I am the NH Advocacy Director for the American Heart Association. I am here today to speak against the amendment to SB 206 respectfully urge you to support ~~Senate Bill 206 to~~ using 25% of the tobacco settlement funds for tobacco cessation and prevention programs in this state.

The Heart Association supports the original proposal ~~this proposal~~ because it uses tobacco money to fix tobacco problems and is in line with the recommendations for New Hampshire by the Centers for Disease Control. The CDC estimates that the state of NH will need to spend between $11 and $24 million each year if it is to have an effective tobacco control program. Increased and comprehensive tobacco control measures are desperately needed in this state because the number of young people that smoke has reached crisis proportions.

The Heart Association is also concerned because tobacco related illnesses claim 430,000 lives each year, almost 200,000 from heart disease and stroke. While these may seem like faceless numbers, it probably wouldn't take you more than a moment to think of someone you know who has suffered or died from a tobacco-related illness. My grandfather is my personal example. He smoked every day of his life for over 65 years and only stopped smoking when he was permanently placed on oxygen. Two years ago this Saturday, my grandfather lost the war against tobacco when heart surgery failed to repair all the damage done to his heart from his many years of smoking.

You obviously can't help those who have lost their lives to tobacco, but you do have the opportunity now to do something about the growing numbers of youths in this state who are beginning to smoke. These numbers are shocking. More than 5,000 young people under the age of 18 in NH begin smoking each year. And 14 times that amount are now exposed to second hand smoke at home. We should be mortified by the fact that approximately 40% of our high school students now smoke.

Yes, we can use the $48 million tobacco settlement to supplement the general fund. But would doing little or nothing to address this crisis of young smokers be a wise idea? The answer lies in the fact that if current smoking trends aren't reversed in this state 23,000 NH children currently alive today will eventually die from smoking-related illnesses.

We need to use the tobacco funds to substantially reduce smoking. Making substantial investments in comprehensive and sustained tobacco control and prevention programs today will pay big dividends in the future. Currently, $340 million is spent annually in New Hampshire on health expenditures directly related to smoking. Despite that, 1,700 people die each year from smoking related causes. Spending the tobacco settlement funds on tobacco control will save lives and money by improving public health.

We know that spending money on sustained, comprehensive tobacco control efforts works. Programs in California and Massachusetts have shown promising results. Tobacco use by the youths in those states has slowed in comparison to national trends –

in some cases even declining, and per-capita consumption has declined faster than in the rest of the country.

The Massachusetts Tobacco Control Program has been able to reduce tobacco consumption considerably in the past four years. Citizens of Massachusetts enjoy the fifth lowest smoking rate among adults in the country; smoking among 18-24 year olds has decreased 27%; and smoking among pregnant women has been reduced by 47.8%. If New Hampshire residents are given the tools to be smoke-free, we can and will reduce tobacco-related deaths and illnesses.

The CDC used these states as the basis for its recommendations to other states – emphasizing the need for community based programs as part of a successful overall strategy. Senate bill 206 also emphasizes that needed community input by establishing an advisory board of several organizations who will make sure an effective program is developed in this state. I strongly urge you to support that proposal.

Attachment H

UNIVERSITY OF NEW HAMPSHIRE

Survey Center

Institute for Policy and Social Science Research

Thompson Hall • 105 Main Street • Durham, New Hampshire • 03824-3547

NEW HAMPSHIRE YOUTH SMOKING SURVEY

Summary of Findings

Andrew E. Smith, Ph.D.

The Survey Center
University of New Hampshire

March 22, 1999

Executive Summary

1999 New Hampshire Youth Smoking Survey

This report summarizes the major findings from the 1999 New Hampshire Youth Smoking Survey, conducted by the University of New Hampshire Survey Center for New Futures, an initiative of the New Hampshire Charitable Foundation. The purpose of the survey was to determine the attitudes of New Hampshire voters toward smoking by youths, particularly teenagers, and to gauge how New Hampshire voters believe the money the state will receive from its settlement with tobacco companies should best be spent. Five-hundred nine (509) New Hampshire voters who voted in the 1998 general election were interviewed between February 17 and February 23, 1999. The margin of sampling error for a survey of this size is +/- 4.3 percent. (See the attached Technical Report for a more complete description of survey methods.) The major findings of the study include:

- Eighty-six percent of New Hampshire voters are concerned about smoking by New Hampshire teens. More than half (53%) say they are "very concerned" and another 34% say they are "somewhat concerned" (Figure 1). Women voters and Democrats are most concerned about the issue of teen smoking in New Hampshire.

- Reflecting this concern about teen smoking, 73% of New Hampshire voters think that more needs to be done to reduce teen smoking in New Hampshire (Figure 2). Democrats and young adults (18-29 years old) are most likely to say that more needs to be done to reduce teen smoking in New Hampshire.

- Beginning in the year 2000, the State of New Hampshire will receive approximately $48 million per year over the next 25 years from its settlement with the tobacco companies. In order to determine the priorities for spending this money, voters were asked if they favored or opposed four proposals for spending a significant portion of these funds.
  - Seventy-nine percent of New Hampshire voters favor using the tobacco settlement to fund programs to reduce teen smoking--56% strongly favor this proposal and 23% favor it somewhat (Figure 3).
  - Spending a significant portion on New Hampshire's public school system is also a popular option, favored by 69% of New Hampshire voters--50% strongly favor this option and 19% favor this option somewhat.
  - Spending a significant portion of the tobacco settlement to pay back the state for tobacco related health care costs is favored by 61% of New Hampshire voters--33% strongly favor this proposal and another 28% favored this proposal somewhat.
  - The least popular proposal for spending the tobacco settlement, favored by 50% of voters, is to use it for tax relief for citizens of New Hampshire--31% strongly favor this proposal and 19% favor it somewhat.

- When asked what percentage of the tobacco settlement should be spent on reducing tobacco use by teens, more than one-third of New Hampshire voters (37%) want to spend more than 25% of the tobacco settlement on efforts to reduce tobacco use by teens and 29% of voters believe that 11%to 25% of the monies should be used to reduce tobacco use by teens (Figure 4).

- Voters were also asked if they favored or opposed a recent proposal to dedicate one-quarter of the money the State receives from the tobacco settlement to fund tobacco prevention programs and programs to help smokers quit. Seventy-five percent of voters favor such use of these monies--49% of voters strongly favor this proposal and another 26% favor it somewhat. Less than 20% of voters oppose spending at least one-quarter of the tobacco settlement on anti-smoking programs (Figure 5).

- Not only are New Hampshire voters supportive of spending at least one-quarter of the tobacco settlement on anti-smoking programs, they say they will remember candidates who support this proposal at the ballot box. Sixty-eight percent of voters are more likely to vote for a candidate who favors spending at least one-quarter of the tobacco settlement on anti-smoking programs. Forty percent say that, all other things being equal, they will be much more likely to vote for a candidate who favors spending at least one-quarter of the tobacco settlement on anti-smoking programs and another 29% say they are somewhat more likely to vote for the candidate who favors this proposal (Figure 6). Only 15% of voters say they would be more likely to vote for the candidate who opposed this proposal and 12% say that a candidate's position on this proposal will make no difference in their vote.

- Forty percent of New Hampshire voters say that it is likely they will contact their legislator about how to spend the tobacco settlement.--13% say they are very likely to contact their legislator to let them know how they think the state's money from the tobacco settlement should be spent and another 27% say they are somewhat likely to contact their legislator about this (Figure 7).

- Sixty-nine percent of New Hampshire voters believe that it is important that the U.S. Congress pass legislation giving the U.S. Food and Drug Administration (FDA) authority to regulate tobacco like it does other consumer products--41% believe it is very important for Congress to authorize FDA regulation of tobacco and another 28% think this is somewhat important (Figure 8).

The University of New Hampshire

Survey Center

The UNH Survey Center is an independent, non-partisan academic survey research organization and a division of the UNH Institute for Policy and Social Science Research.

The Survey Center conducts telephone, mail, e-mail, Internet, and self-administered surveys, as well as focus groups and other qualitative research for university researchers, government agencies, public non-profit organizations, private businesses, and media clients.

Our senior staff have 22 years experience in designing and conducting custom research on a broad range of political, social, health care, and other public policy issues.

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Attachment I

Testimony before the New Hampshire Senate
Public Institutions, Health & Human Services Committee
March 22, 1999

Jon W. Wahrenberger, MD, FACC

Members of the Public Institutions, Health & Human Services Committee:

It's a great privilege for me to speak in support of Senate Bill 206, which seeks to allot 25% of tobacco settlement funds to tobacco prevention.

I stand before you in many capacities: as a volunteer with the American Heart Association; as a practicing cardiologist at the Dartmouth Hitchcock Medical Center in Lebanon; as a 14 year resident of New Hampshire; and, finally, as the father of an 8-year old daughter who will pass through her vulnerable teenage years in New Hampshire, affected by what you – and the legislature as a whole - decides to do with the tobacco settlement funds. While I may bring several perspectives to this debate, it is perhaps in the latter regard, a father, that I feel most strongly about the importance of this proposed legislation.

There is no question that tobacco is detrimental to health. The scientific evidence is simply overwhelming. These are the brutal facts: Tobacco is a factor in nearly one in five deaths from preventable causes in this country. It causes most of its deaths through the cardiovascular system. But it's also a potent risk factor for cancer, and leads to malignancy, both in the lung and other parts of the body. It leads to pulmonary disease. It leads to complications of pregnancy and low birth weight babies. Its effects are far-reaching. And it does these things not just to those that smoke, but as we've increasingly come to know, to those that inhale smoke second hand.

What does it do to the heart? Components of cigarette smoke, absorbed into the bloodstream, cause damage to the lining of arteries; they lead to spasm of arteries to the heart; they alter cholesterol metabolism, raising the total cholesterol and lowering levels of protective HDL cholesterol; and they raise the blood pressure. Through these mechanisms, smoking promotes atherosclerosis, the plugging up of arteries. In so doing, tobacco inhalation has been shown to dramatically increase the incidence of heart attack, stroke, sudden death, peripheral vascular disease and aneurysm of the aorta. It's effects on cardiovascular health are insidious: it doesn't simply add to the effect of other risk factors for heart disease, but rather, acts in a synergistic way – in other words it interacts with and multiplies the risk of other factors such as high blood pressure and diabetes. Once heart disease has becomes evident, the implication of continuing to smoke is particularly dramatic. Among those who survive a first heart attack, those that continue to smoke have a substantially greater risk of a second heart attack than those that quit. The bottom-line? In estimates from the Center for Disease Control, in New Hampshire, annually, 1777 individuals die unnecessarily as a result of tobacco. It's killing our citizens.

But there's something so much more important than the scientific evidence, the mechanisms, and the statistics. It's the human toll this addiction is afflicting upon New Hampshire citizens. Every day, as I see patients in Lebanon, and three days a week while in Claremont – I see the fear, the anguish, and the sense of uncertainty – on the faces of people suffering from tobacco induced illness. And many of these people continue to smoke – aware of what it's doing – leading to a sense of frustration and shame over their inability to quit. It is so addicting. It is not from weakness or failing to care that people continue to smoke. I can't tell you how many patients I have seen fail the gamut of smoking cessation techniques – the gum, the patch, the inhaled nicotine delivery device, antidepressant drugs, acupuncture, hypnotherapy. More than half of them fail. And they wonder - as you can imagine - why they ever started. Our best hope – as you know - is to prevent tobacco use in the first place. The kids that begin smoking in their teens, lured by the peer pressure and glamorous images created by tobacco companies, can't imagine the time, perhaps 15 or 20 years later, when they're laying on a stretcher in an emergency room, in a bed in a coronary care unit, or worse yet – five feet under the ground – and unnecessarily so. The human toll – the suffering and the loss of quality years – resulting from tobacco - is just staggering. I dare say there are few in this room, who through a parent, a spouse or a good friend, haven't seen the consequences of tobacco.

I truly believe we are at a pivotal time now. We know so much: we know what tobacco does; we know who in our population is vulnerable to addiction; and we know how tobacco companies are targeting that vulnerable population. But there's something else we know. Comprehensive tobacco prevention measures work. We have examples from Oregon, California, Massachusetts, and early results from Florida. So now, at last, we have the mechanism to turn this around.

I mentioned at the onset that I am the father of an eight-year-old daughter. For that reason more than any, I care so much about the New Hampshire of the future. I know you do, too. As legislators you will be pressured to spend the tobacco settlement funds on other things. But I ask you to remember this: Why is the money here? What led to the suit? The answer is tobacco - and the tragic damage it is inflicting – both financially and in its human toll - in New Hampshire. We have a choice now: we can either sit back and use the tobacco settlement funds for any deserving cause – in some respects sharing in the profits with the tobacco companies – and at the cost of people continuing to smoke and die prematurely in New Hampshire – or we can invest those funds in alleviating the problem.

As a physician, as a New Hampshire citizen, and as father, I strongly support the proposed legislation, and hope you will consider 25% as a minimum to investment in education and prevention.

Thank you.

Tobacco and Cardiovascular Disease

Testimony before the Public Institutions, Health & Human Services Committee
New Hampshire Senate
March 22, 1999

Jon W. Wahrenberger, MD, FACC

1. The epidemiologic Evidence: Numerous studies, beginning in the 1940's, have demonstrated an unequivocal and dose-related relationship between tobacco consumption, cardiovascular disease, and death[1].

   A. Tobacco consumption has been demonstrated to significantly increase rates of:

      - Heart attack
      - Stroke
      - Sudden Death
      - Peripheral Vascular Disease
      - Aortic Aneurysm

   B. The relationship between tobacco and cardiovascular risk is dose-related, i.e. higher doses are associated with higher risk[2,3]

   C. The interaction of tobacco and other risk factors for cardiovascular disease is synergistic[4] (it multiplies the risk when combining with other factors, rather than simply adding to it)

   D. Smoking and the incidence of cardiovascular disease: How bad?

      - The average smoker dies three years earlier than a non-smoker; a smoker otherwise known to be at high risk for coronary heart disease dies 10-15 years earlier than a nonsmoker[5,6].
      - The incidence of a myocardial infarction (heart attack) is increased six-fold in women and three-fold in men who smoke at least 20 cigarettes per day compared to individuals who never smoked[7].

2. Tobacco-related Illness: New Hampshire and Nationwide Statistics

   A. Tobacco is the single largest contributor to preventable (premature) deaths in the USA, causing nearly one in five deaths[8]

Deaths from Preventable Causes in the Unites States in 1990

Cause	Estimated No. Of Deaths	Percentage of Total Deaths
Tobacco	**400,000**	**19%**
Diet/Activity	300,000	14%
Alcohol	100,000	5
Microbial Agents	90,000	4
Toxic Agents	60,000	3
Firearms	35,000	2
High Risk Sexual behavior	30,000	1
Motor Vehicles	25,000	1
Illicit Drug Use	20,000	<1
Total	1,060,000	49

B. Breakdown of how tobacco is causing deaths:

Deaths Attributed to Smoking in the United States in 1990[9]

Disease	Number of Deaths	Percent of Total
Cardiovascular Disease	179,820	43.2
Lung Cancer	119,920	28.8
Other Cancers	31,402	7.5
Respiratory Diseases	84,475	20.3

C. Tobacco Use in New Hampshire[10]:

- High school students who smoke: 39.0%
- Number of kids (under 18) who become new daily smokers each year: 5000
- Kids exposed to secondhand smoke at home: 70,000[11]
- Number of packs of cigarettes illegally sold to kids in New Hampshire each year: 1.2 Million[12]
- Adults in New Hampshire who smoke: 24%

D. Deaths **in New Hampshire** Related to Tobacco Use (estimates from Center for Disease Control and Prevention) 1990 - 1994[13]:

- Average Annual Deaths Related to Tobacco: 1777
- Average Annual years of potential Life Lost in NH: 23,416
- New Hampshire ranks 33 (No. 1 is lowest rate) in the nation in deaths related to smoking with a rate of 361 deaths per 100,000 of population (data from Center for Disease Control – see attachment)

E. Other Costs of Tobacco Use in New Hampshire[14]:

- Total annual health care expenditure in New Hampshire directly related to smoking: $340 million
- Total Annual New Hampshire Government Medicaid payments directly related to smoking: $90 million
- Additional expenditures in New Hampshire for health and developmental problems of infants caused by their mothers' smoking or being exposed to second-hand smoke during pregnancy: $6 - $18 million
- Total state and federal tax burden from tobacco caused health costs per New Hampshire household: $430 per year

3. Reason for Hope: Tobacco cessation makes a difference and comprehensive prevention programs work.

A. Numerous studies have demonstrated that smoking cessation leads to a dramatic reduction in cardiovascular risk[15],[16], with a particularly strong effect in those with existing cardiovascular disease[17].

B. Comprehensive education and prevention programs in other states, including California, Massachusetts, Oregon, and Florida are proving to be effective[18]

References:

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[2] Hammond EC, Horn D. Smoking and Death Rates 0 Report on Forty-Four Months ofFollow-up of f187,783 Men. II. Death Rates by Cause. 1958; 166: 1294-1308

[3] US Dept of Health and Human Services. Reducing the Health Consequences of Smoking: 25 Years of Progress. A Report of the Surgeon General. Us Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 1989; DHHS Publication (CDC) 89-8411.

[4] Anderson KM, Wilson PW, et al. An Updated Coronary Risk Profile: A Statement for Health Professionals. Circulation. 1991; 83: 356-62

[5] William RR, Hopkins PN, et al. Evaluating Family History to Prevent Early Coronary Heart Disease. In: Primer in Preventative Cardiology, Pearson, TA, Criqui, MH, et al. (Eds) American Heart Association. Dallas, 1994, pg. 93

[6] Hopkins, PN, Williams, RR, et al. Magnified Risks from Cigarette Smoking for Coronary Prone Families in Utah. West J.Med 1984; 141: 96

[7] Njolsad I, Arnese E. smoking, Serum Lipids, Blood Pressure, and Sex Differences in Myocardial Infarction. A 12-Year Follow-up Study. BJM 1998; 316: 1043

[8] Bartecchi CE, MacKenzie TD, et al. The Human Cost of Tobacco Use. New England Journal of Medicine 1994; 330(13): 907-980

[9] Adapted from CDC Publication "Cigarette Smoking-Attributable Mortality and Years of Potential Life Lost – United States, 1990" MMWR 1993; 42(33): 645-9

[10] Figures on adult and kid tobacco use obtained from Center for Disease Control and Prevention, Office of Smoking and Health/ National Center for Chronic Disease Prevention and Health Promotion. Available at http://www.ced.gov/nccdphp/osh/statehi/htmltext/nh_sh.htm

[11] Data on second hand smoke obtained from CDC publication "State-Specific Prevalence of Cigarette Smoking Among Adults, and Children's and Adolescents' Exposure to Environmental Tobacco Smoke – United States, 1996" MMWR 1997; 46(44): 1038-1043

[12] Cummings, eet al. The Illegal Sale of Cigarettes to US Minors: Estimates by State. Amer. J Public Health. 19 994; 84(2): 300-302. See also CDC Publication "Tobacco Use and Usual source of Cigarettes Among High School Students – United States, 1995" MMWR 1996; 45(20): 413-8

[13] All statistics obtained from Center for Disease Control and Prevention, Office of Smoking and Health/ National Center for Chronic Disease Prevention and Health Promotion. Available at http://www.ced.gov/nccdphp/osh/statehi/htmltext/nh_sh.htm

[14] Miller L, et al. State Estimates of Total Medical Expenditures Attributable to Cigarette Smoking, 1993. Public Health Reports. 1998; 113: 447-58 (Available on internet at: http://www.tobaccofreekids.org/html/health_care_cost.html)

[15] Gordon T, Kannel WB, et al. Death and Coronary Attacks in Men after Giving up Cigarette Smoking: A Report from the Framingham Study. Lancet 1974; 2: 1345-1348

[16] Ockene JK, Kuller LH, et al. The Relationship of Smoking Cessation to Coronary Heart Disease and Lung Cancer in the Multiple Risk Factor Intervention Trial (MRFIT). Am J Public Health. 1990; 80: 954-58

[17] Salonen JT. Stopping Smoking and Long-Term Mortality after Acute Myocardial Infarction. Br. Heart J. 1980; 43: 463-9

[18] See overview of these programs and success (with extensive references) at Campaign For Tobacco-Free Kids Website (http://www.tobaccofreekids.org/html/statewide_programs.html)

Submitted March 21, 1999

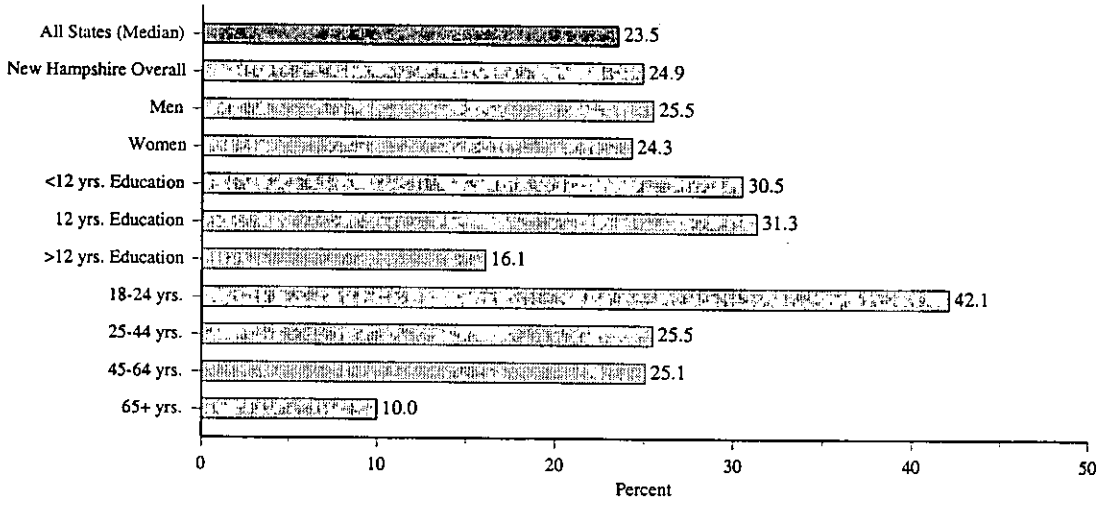
Jon W. Wahrenberger, MD
1 White Ave.
West Lebanon, NH 03784

New Hampshire

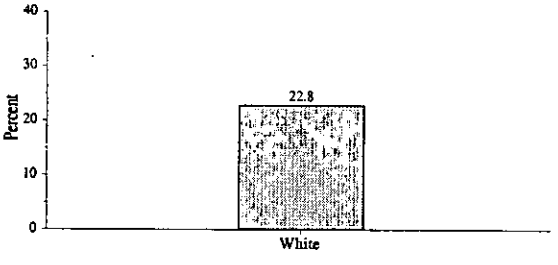
Number of New Hampshire youth projected to die prematurely from their smoking: 23,777

Adult Tobacco Use in New Hampshire

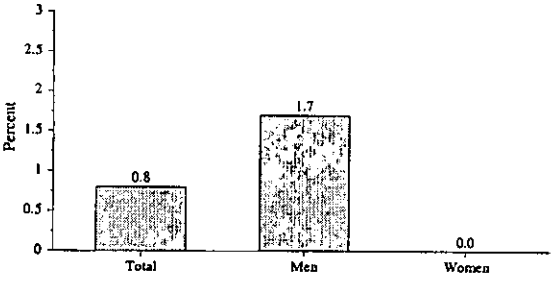
Current Cigarette Smoking Among Adults Aged 18 and Older, 1996



Current Cigarette Smoking Among Adults by Race/Ethnicity, 1995–1996



Current Smokeless Tobacco Use Among Adults Aged 18+, 1992–1993



Health Impact and Costs

Average Annual Deaths Related to Smoking, 1990–1994	*Average Annual Years of Potential Life Lost,* 1990–1994*	*Medicaid Costs Related to Smoking, 1993*
Overall 1,777 Men 1,113 Women 664 Death Rate 361/100,000 Rank 33 (No. 1 is lowest death rate)	23,416 years or an average of 13.2 years for each death due to smoking. *Calculated to life expectancy	$94,531,000

Youth Tobacco Use

*Cigarette Smoking Among Youth, Grades 9–12, 1997**			*Smokeless Tobacco Use Among Youth, Grades 9–12, 1997**
Past Month—smoked one or more days in the past month		Frequent—smoked 20+ days in the past month	All States . . . . . 9.3% NH Overall . . . . . 7.2% Boys . . . . . 12.9% Girls 2.0%
Overall	39.6%	21.5%	
Boys	36.3%	18.8%	
Girls	42.5%	23.8%	

*Unweighted data. May not apply to all youth (grades 9-12) in the state.



Number of New Hampshire youth exposed to ETS in the home in 1996: 70,576

Tobacco Control Legislation, 1997

Minors' Access to Tobacco Products

Minimum age for sale: 18

Penalties: Any person who sells to a minor will be fined $100.

Illegal for minors to:

Purchase ..... Yes
Possess ..... Yes
Use ..... Yes

Restrictions on Vending Machines

Vending machines in all locations must be supervised at all times.

Signage

Signs required on premises.

Licensure

Retail license and vending machine license required.

Excise Tax

Cigarette tax per pack ..... 37¢
Rank = 21 (No.1 is highest tax)
Federal and state taxes as a percentage of retail price 27.7%*
Annual net tax revenue from cigarettes $45,121,750*

Smokeless tobacco tax:
33.4% of wholesale sales price.

*Based on previous tax rate of 25¢ per pack.

Advertising

No restrictions

State Preempts Local Laws

No preemption

Smokefree Indoor Air

Site	Restrictions				Penalties	
	100% Smokefree	Designated smoking areas with separate ventilation	Designated smoking areas required or allowed	None	To businesses	To smokers
Government worksites			✓		✓	✓
Private worksites			✓		✓	✓
Restaurants			✓		✓	✓
Day care centers	✓†				✓	✓
Home-based day care**						

†When children are present.
**Language does not specify home-based day care.

Tobacco Economy

Cigarette Sales, 1996

Number of packages sold and taxed, per capita) 158.0

Tobacco Agriculture, 1996

None

Tobacco Manufacturing, 1994

None

Tobacco Use Prevention and Control Program

Funding: CDC IMPACT
Regional Network: Tobacco-Free New England

Contact

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Deaths Related to Smoking—1990-1994

Rank	State	Deaths per 100,000 Population
1	Utah	188
2	Hawaii	237
3	North Dakota	280
4	Minnesota	287
5	New Mexico	289
6	Idaho	296
7	Nebraska	308
8	Iowa	308
9	South Dakota	309
10	Connecticut	310
11	Wisconsin	313
12	Kansas	319
13	Arizona	325
14	New Jersey	327
15	D.C.	327
16	Colorado	331
17	Massachusetts	331
18	Rhode Island	340
19	California	343
20	New York	343
21	Pennsylvania	346
22	Illinois	347
23	Oregon	348
24	Montana	348
25	Florida	350
26	Maryland	351
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SPECIAL ARTICLE

THE HUMAN COSTS OF TOBACCO USE

(First of Two Parts)

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IT has been 30 years since the surgeon general of the United States released the first report of the Advisory Committee on Smoking and Health. In each of the subsequent reports, cigarette smoking has been identified as the most important source of preventable morbidity and premature mortality in the United States. A total of 418,690 deaths in the United States were attributed to smoking in 1990.[1] That figure included approximately twice as many male as female smokers. Of the 2,148,000 U.S. residents who died in 1990, approximately half died of particular preventable causes[2] (Table 1). The prominence of tobacco as a contributor to mortality prompted former Surgeon General C. Everett Koop to state that cigarette smoking is the leading cause of preventable premature death in our society and the most important public health issue of our time.[3]

The importance of focusing on cigarette smoking in 1994 has recently been underscored by data showing that the prevalence of smoking among adults in the United States, which had been declining annually since 1973, was unchanged at 25.7 percent from 1990 to 1991.[4] This occurred despite increasing evidence associating smoking with disease and death.

THE HUMAN COSTS OF TOBACCO USE

Currently 46.3 million adults (25.7 percent of the population) are smokers.[4] This includes 24 million men (28.1 percent of the total) and more than 22 million women (23.5 percent). The prevalence is highest among persons 25 to 44 years of age. The percentage of smokers who report that they are heavy smokers (20 or more cigarettes per day) has changed little, from 26.0 percent in 1974 to 27.1 percent in 1985.[3]

In 1990 in the United States, smoking-related illnesses accounted for nearly one in five deaths and more than one quarter of all deaths among those 35 to 64 years of age.[5] A breakdown of the deaths due to various diseases attributable to cigarette smoking is shown in Table 2. Peto et al.[6] have estimated that during the 1990s in developed countries, tobacco will cause approximately 30 percent of all deaths among those 35 to 69 years of age, making it the largest single cause of premature death in the developed world.

Though the emphasis of this review will be on cigarettes, the hazards of other tobacco products should not be overlooked. Despite declining consumption of these products (Fig. 1), they continue to play an important part in morbidity and mortality in this country.[3,8]

In viewing the problems and complications related to tobacco use, recognition of the contributions of passive smoking is increasing, as described in a 1992 report by the Environmental Protection Agency (EPA).[9] Reports indicate that environmental tobacco smoke is composed of mainstream smoke exhaled by the smoker and sidestream smoke emitted from the burning tobacco between puffs.[9,10] Sidestream smoke is the main component of environmental tobacco smoke. The great majority of smoke emitted from a lit cigarette is sidestream smoke rather than smoke that is actively inhaled. Sidestream and mainstream smoke contain many of the same air contaminants. Sidestream smoke has more particles with smaller diameters, and these particles are therefore more likely to be deposited in the most distant regions of the lungs.[10] Environmental tobacco smoke is a major source of indoor-air contaminants, and thus some unintentional inhalation by nonsmokers is virtually unavoidable. Since there appears to be no evidence of a safe threshold level, nonsmokers exposed to environmental tobacco smoke appear to be at increased risk for the same problems and complications recognized in smokers. Environmental tobacco smoke has been classified as a known human lung carcinogen, or a "group A" carcinogen, under the EPA's system of carcinogen classification.

CARDIOVASCULAR DISEASE

A relation between cigarette smoking and coronary heart disease was reported by researchers at the Mayo Clinic in 1940.[11] Since that time, it has been well documented that cigarette smoking substantially increases the risk of cardiovascular disease, including stroke, sudden death, heart attack, peripheral vascular disease, and aortic aneurysm.[3] In the United States in 1990, smoking caused 179,820 deaths from cardiovascular disease, accounting for 98,921 deaths from ischemic heart disease and 23,281 deaths from cerebrovascular diseases.[1] Actually, a 10.4 percent decline in deaths from cardiovascular disease was noted in 1990 as compared with 1988.

The Office of Technology Assessment estimates that nearly one fifth of deaths due to cardiovascular disease in 1990 were attributable to smoking.[5] In a study of British doctors, a strong dose–response relation was observed between the duration and extent of smoking and the death rate from ischemic heart disease among men younger than 65 years.[12] Similar trends have been found in studies of women who smoke. The Nurses' Health Study[13] showed that wom-

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Table 1. Deaths from Preventable Causes in the United States in 1990.*

Cause	Estimated No. of Deaths†	Percentage of Total Deaths
Tobacco	400,000	19
Dietary factors and activity patterns	300,000	14
Alcohol	100,000	5
Microbial agents	90,000	4
Toxic agents	60,000	3
Firearms	35,000	2
High-risk sexual behavior	30,000	1
Motor vehicle injuries	25,000	1
Illicit use of drugs	20,000	<1
Total	1,060,000	49

*Reprinted from McGinnis and Foege[2] with the permission of the publisher.

†The values are composite approximations drawn from studies that use different approaches to derive estimates, ranging from actual counts (e.g., firearms) to calculations of population-attributable risk (e.g., tobacco). The numbers have been rounded.

en who smoked one to four cigarettes per day had a 2.5-fold increased risk of fatal coronary heart disease and nonfatal myocardial infarction.

Components of cigarette smoke have been shown to damage vascular endothelium,[14] and endothelial injury is considered a primary antecedent to atherosclerosis.[14,15] The adverse effects of smoking are also related to its effects on coronary vaso-occlusive factors, such as platelet aggregation, vasomotor reactivity, and a prothrombotic state,[16] and factors such as carbon monoxide production, increased plasma viscosity, and fibrinogen levels.[15] Smoking is a major risk factor for coronary vasospasm.[17] Smoking a single cigarette can cause profound silent disturbances in regional coronary blood flow in patients with angina and coronary artery disease.[18] A study[19] using ambulatory electrocardiographic monitoring detected 33 percent more episodes of ischemia per day and a significantly longer duration of ischemia in smoking as compared with nonsmoking patients with coronary heart disease. Cigarette smoking can also affect the vulnerability of the myocardium to ventricular fibrillation and cardiac arrest in patients with established coronary heart disease.[20]

Numerous studies[21,22] have reported elevated total plasma cholesterol concentrations and reduced high-density lipoprotein cholesterol concentrations in smokers, with the degree of alteration being associated with the number of cigarettes smoked per day. There is also strong evidence that cigarette smoking increases the risk of stroke and that there is a dose–response relation.[23] Smokers have a risk of cerebrovascular disease that is 1.5 to 3 times that observed in nonsmokers.[21] A study[24] of identical twins discordant for cigarette smoking found that the total area of carotid plaques was 2.3 times larger in the smoking twins than in their nonsmoking siblings. Studies[21,25] have shown that quitting smoking can greatly reduce the incidence of cardiac disease and death from coronary heart disease.

Table 2. Deaths Attributed to Smoking in the United States in 1990.*

Disease	No. of Deaths
Cardiovascular diseases	179,820
Lung cancer	119,920†
Other cancers	31,402
Respiratory diseases	84,475

*Data were obtained from the Centers for Disease Control and Prevention.[1]

†Includes deaths from environmental tobacco smoke.

Recent reviews[26,27] outline the relation of passive smoking to heart disease. Of the estimated 53,000 deaths[26] caused by passive smoking each year in the United States, 37,000 have been attributed to heart disease. Glantz and Parmley's analysis[26] of 10 epidemiologic studies indicates a significant dose–response effect related to passive exposure and suggests that nonsmokers living with smokers have a 30 percent increase in the risk of death from ischemic heart disease or myocardial infarction. Patients with angina pectoris have a reduction of 20 to 40 percent in exercise capacity after exposure to environmental tobacco smoke.[28] Vasoconstriction from passively inhaled sidestream smoke is even more pronounced than that from mainstream smoke.[29] In addition, more carbon monoxide, with its potential to reduce the oxygen-carrying capacity of the blood, is generated while a cigarette is smoldering than while it is being actively smoked.[10]

Cancer

In addition to being responsible for over 85 percent of lung cancers,[3,30] smoking is also associated with cancers of the mouth, pharynx, larynx, esophagus, stomach, pancreas, uterine cervix, kidney, ureter, and bladder and accounts for about 30 percent of all deaths from cancer.[30,31] The overall rates of death from cancer are twice as high among smokers as among nonsmokers; heavier smokers have rates that are four times greater. Cigarette smoking is undoubtedly the most important preventable cause of cancer in the United States today.

Rosenow[32] estimated that 175,000 new cases of lung cancer would occur in 1993. The rates of lung cancer have increased dramatically over the past 60 years in association with increases in the number of cigarettes smoked (Fig. 2); there is no evidence of a threshold level of exposure. The EPA study[9] points out that active smoking increases the risk of all four major histologic types of human lung cancer and estimates that environmental tobacco smoke is responsible for about 3000 deaths from lung cancer annually. The report[9] also notes that condensates of mainstream smoke or sidestream smoke that are suspended in acetone and applied to the skin of mice for long periods cause papillomas or carcinomas at the site of application. The study concludes from these studies and from the fact that the risk of lung cancer increases with younger ages at the initiation of smoking and decreases with

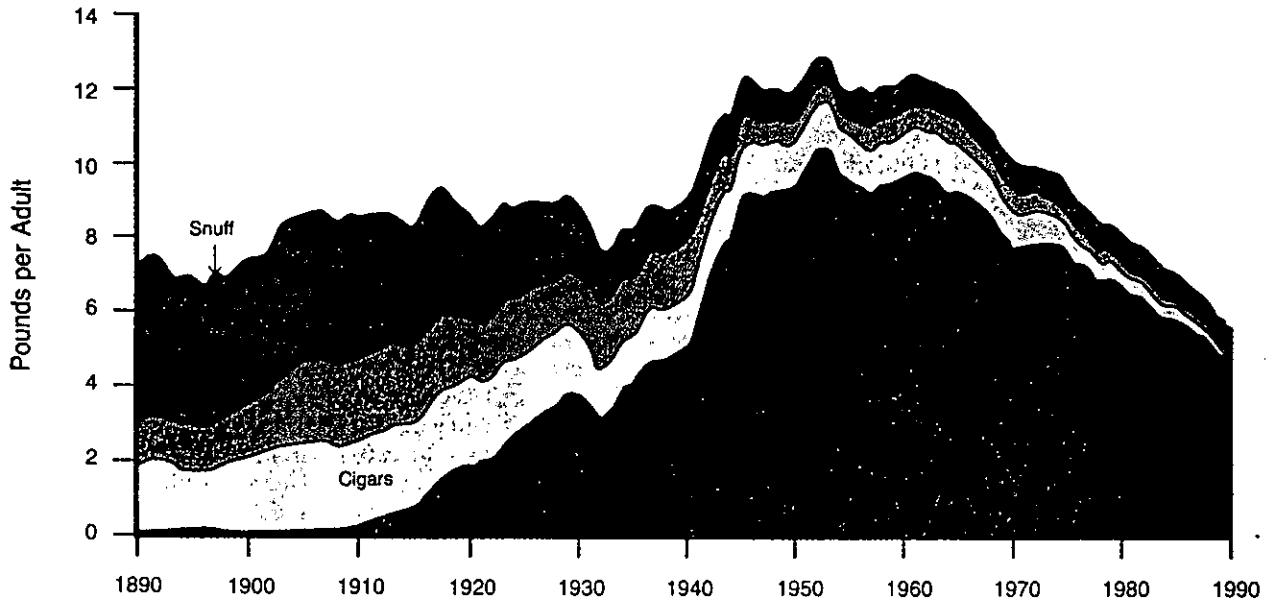


Figure 1. Trends in Per Capita Tobacco Consumption among Adults in the United States, According to Major Product Category, from 1890 to 1990.
To convert pounds to kilograms, multiply by 0.45. Reprinted from a National Institutes of Health publication.[7]

longer times since cessation of smoking that tobacco smoke has both tumor-initiating and tumor-promoting capabilities. It also concludes, from several different analyses, including that of Fontham et al.,[34] that exposure to environmental tobacco smoke from spousal smoking is associated with increased mortality from lung cancer. A recent autopsy study[35] of patients who died of causes other than respiratory diseases found an increase in "epithelial, possible precancerous lesions" in the lungs of nonsmoking women married to smokers. An important case–control study[36] suggested that 17 percent of the cases of lung cancer among nonsmokers can be attributed to exposure to high levels of tobacco smoke during childhood and adolescence.

It is estimated that 82 percent of laryngeal cancers are due to cigarette smoking.[3] The incidence of oral cancer among smokers ranges from 2 to 18 times that among people who have never smoked.[21] Oral cancers include cancers of the tongue, salivary gland, mouth, lip, and pharynx. About 93 percent of oral-cavity tumors in men and 61 percent of such cancers in women are related to tobacco use,[3] the greatest risk being in tobacco users who regularly use alcohol.[37] The combination of smoking and alcohol use accounts for about three fourths of all oral and pharyngeal cancers.[38] Studies have also conclusively established the use of smokeless tobacco as a cause of oral cancer.[7,39] A recent monograph[7] notes that 28 tumorigenic agents have been isolated and identified in smokeless-tobacco products and emphasizes that the nicotine in smokeless tobacco may also have a role as a potentiator in the carcinogenic process.

Of the estimated 10,200 deaths from cancer of the esophagus in 1993,[30] about 80 percent can be attributed to cigarette smoking.[3] The use of alcohol again increases the risk of the development of this cancer. Newcomb and Carbone[39] suggested that contact carcinogenesis is the most likely pathogenetic mechanism for this cancer. Smoke constituents condense on the mucous membranes of the mouth and pharynx and are then swallowed.

Cancers of the hematopoietic system have been linked to cigarette smoking[21]; for example, 14 percent of all leukemias may be due to smoking.[40] Cigarette smoke contains benzene, which has been linked with leukemia in the past. It has been suggested[41] that a typical smoker inhales about 10 times as much benzene as a nonsmoker.

Cigarette smoking is thought to account for about

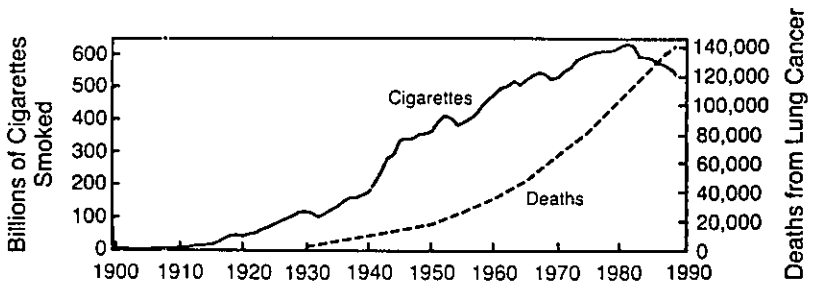


Figure 2. Cigarette Consumption and Total Deaths from Lung Cancer in the United States, 1900 to 1989.
Reprinted from a Department of Health and Human Services publication.[33]

30 percent of the 13,500 new cases of cervical cancer estimated to have occurred in the United States in 1993.[30,39] Studies[42] have linked cancer of the cervix to exposure to both mainstream and sidestream smoke. Various materials found in tobacco smoke, some with mutagenic activity,[43] can be found in the cervical mucus of smokers.

Lung Disease

Cigarette smoking is the leading cause of pulmonary illness and death in the United States.[3,44] In 1990, smoking caused 84,475 deaths from pulmonary disease, mainly due to such problems as pneumonia, influenza, bronchitis, emphysema, and chronic airway obstruction.[1] Chronic bronchitis and emphysema are the most important factors, according to a study[11] of mortality rates among male British physicians. McCusker[45] describes cigarette smoking as a chronic inflammatory disorder of the lower airways. Studies[44,46] have shown a decline in pulmonary function in nonsmoking subjects with asthma after a controlled challenge of environmental tobacco smoke.

Children and Adolescents

An estimated[47] 6 million teenagers and another 100,000 youngsters under 13 years old smoke. Tobacco smoke creates major problems in early life and even in the fetus.[48] The damage induced by the toxins in cigarette smoke during those most vulnerable periods when the lung is undergoing growth and remodeling has important implications for later life.[9] A recent report[48] noted that miscarriages of viable fetuses are increased in smokers and that babies born to mothers who smoke weigh an average of 200 g less than infants born to nonsmokers. Paternal smoking can also decrease birth weights in infants. The same report[48] states that stillbirths and early neonatal deaths are increased by about 33 percent in the babies of smokers as compared with those of nonsmokers and that the effects of smoking in pregnancy extend well beyond infancy, with a reduction in growth and educational achievement.

Cotinine, a metabolite of nicotine, can be easily and accurately measured in saliva, blood, hair,[49] and urine and serves as an indicator of exposure to tobacco smoke[3] and smokeless tobacco.[7] A finding of cotinine in the fetus supports the presence of the constituents of cigarette smoke in the fetus and indicates the degree of exposure to these elements.

The EPA report[9] also reviews studies claiming that exposure to environmental tobacco smoke is causally associated with an increased risk of lower respiratory tract infections such as bronchitis and pneumonia in children, causing 150,000 to 300,000 cases annually in infants and young children up to 18 months of age. It notes that exposure to environmental tobacco smoke is associated with an increased prevalence of fluid in the middle ear, symptoms of upper respiratory tract irritation, and a small but significant reduction in lung function. The report also points out that exposure to environmental tobacco smoke is associated with additional episodes of asthma and increased severity of symptoms in children with asthma. The EPA report estimates that the condition of 200,000 to 1 million children with asthma in this country is worsened by exposure to environmental tobacco smoke and that such exposure is a risk factor for new cases of asthma in children. Mothers who smoke 10 or more cigarettes a day can cause as many as 26,000 new cases of asthma among their children each year. The EPA report reviews studies showing that infants of mothers who smoke are at increased risk of sudden infant death syndrome during the first year of life.

Our society is becoming increasingly concerned about the numbers of young people who smoke or use smokeless tobacco. Very few people begin smoking after reaching adulthood. In the United States, approximately 80 to 90 percent of smokers begin smoking before the age of 21,[3] and an estimated 3000 teenagers start smoking each day.[3,50] Teenage smokers smoke about 0.6 pack per day, or about 1.1 billion packs of cigarettes a year.[51]

Academic performance and the level of educational achievement[52] have predictive value in determining whether a person will become a smoker. The Centers for Disease Control and Prevention reported[4] that in 1991 the prevalence of smoking ranged from 32 percent among the least educated to 13.6 percent among the most educated.

The health problems of children who smoke are summarized in the report[48] of the Royal College of Physicians. In addition to the previously reviewed and the more obvious problems that would be expected from the early initiation and continuation of the smoking habit, the report noted that subarachnoid hemorrhage is six times more common in young smokers than in nonsmokers. Young people can be exposed to sidestream smoke and its serious consequences in multiple settings, such as in the home, in automobiles, at day care, at work, and unfortunately, even at school.

The use of smokeless tobacco, which includes both chewing tobacco and snuff, is increasing throughout the United States, especially among our most vulnerable population — our children.[7] Along with other forms of tobacco, it is a strong contributor to the 29,800 new cases of oral cancer that were projected to occur in 1993.[30] Surveys[7] reveal that in 1988, 25.8 percent of boys between the ages of 12 and 17 had tried some form of smokeless tobacco. Although previously little use of smokeless tobacco was seen among adolescents, the prevalence of its use among older teens increased by 250 to 300 percent between 1970 and 1985.[53] The problems associated with the use of smokeless tobacco reinforce the conclusion of the 1986 Report of the Surgeon General that "there is no safe form of tobacco use."[10]

Women

As of 1991, 23.5 percent of women were reported to be smokers.[4] Fielding[54] points out that today's female smokers are beginning at a younger age and are heavier smokers than in the past. The percentage of female smokers who smoke more than 25 cigarettes per day has almost doubled, from 13 percent in 1965

to 23 percent in 1985.[55] More young women than young men smoke today, and this is especially notable among high-school seniors.[54] Also, in this time of declining prevalence of smoking, the rate of decline has been four times greater for men than for women and the rate of decline of smoking initiation among men was more than three times that observed for women.[56]

Lung cancer, which caused an estimated 56,000 deaths in 1993, has surpassed breast cancer, which caused an estimated 46,000 deaths, as the most important cause of death from cancer among women.[30] A study[13] of more than 119,000 nurses, who were 30 to 55 years of age, over a six-year period confirmed the increased risk of fatal and nonfatal coronary events in female smokers. The heaviest smokers (more than 45 cigarettes per day) had 11 times the risk of women who had never smoked.

Women who take oral contraceptives and smoke are at considerably greater risk of dying of cardiovascular disease than are women who never use the pill or smoke.[57] Female smokers are at greater risk for postmenopausal osteoporosis; an antiestrogen effect of smoking has been postulated to explain this complication.[58,59] Fielding[54] notes that smoking reduces fertility, increases the rate of spontaneous abortion, and increases the incidence of abruptio placentae, placenta previa, bleeding during pregnancy, and premature rupture of the placental membranes. These effects of smoking are thought to result in many thousands of preventable fetal and neonatal deaths.[60]

A study by Colditz et al.[61] found evidence of a strong causal relation between cigarette smoking and stroke among young and middle-aged women. In that study, as compared with women who had never smoked, women who smoked 1 to 14 cigarettes per day had an age-adjusted relative risk of stroke of 2.2, whereas those who smoked 25 or more cigarettes per day had a relative risk of 3.7.

Minorities

In 1991, 31.4 percent of Native Americans and Alaska Natives, 29.2 percent of blacks (35.1 percent of black men), and 20.2 percent of Hispanics smoked.[4] The lowest rate — 15.5 percent — was among Hispanic women. One study[33] showed that only 2.8 percent of Hispanics and 2.5 percent of blacks, as compared with 8.9 percent of whites, were likely to be heavy smokers (to smoke more than 25 cigarettes daily). The prevalence of smoking and the rates at which people began to smoke or quit smoking changed in a similar manner among blacks and whites from 1974 to 1985.[3] More black and Hispanic men than black and Hispanic women begin to smoke during childhood and adolescence.[62]

Problems related to the high prevalence of smoking among black men are reflected in a 1993 report[8] of age-adjusted death rates per 100,000 population for selected smoking-related cancers (those of the lung, oral cavity, and pharynx, esophagus, and larynx); in each case, black men had the highest death rate. An increased incidence of tobacco-related disease has been noted among Native Americans.[63] This increase was recognized in the mid-1970s to be due to the increase in daily cigarette smoking in this group.

The Elderly

In the U.S. population over the age of 65, it has been reported[33] that the percentage of smokers is lowest among Hispanic women (10 percent) and highest among black men (31.1 percent). The same report pointed out that in the group over 65 years of age, 6.9 percent of the men used smokeless tobacco (snuff, chewing tobacco, or both). Oral cancers from smokeless tobacco typically occur in these men (median age at diagnosis, 62.4 years).[7] A prospective study[64] suggests that the hazards of smoking extend well into later life. Among men and women over 65 years of age, the rates of total mortality among current smokers were twice what they were among participants who had never smoked.

Strokes are an especially important problem for the elderly. Among those over the age of 65, 24 percent of cerebrovascular disease in men (6 percent in women) was attributable to smoking.[3,21] Another study[65] suggests a causal relation between smoking and hypertension and subarachnoid hemorrhage, an especially disabling and lethal form of cerebrovascular disease.

Of concern to all smokers, young and old, are recent data[66] that suggest a potential role of cigarette smoking in the development of cataracts. Studies suggest that about 20 percent of cataracts are attributable to smoking in the United States.[67]

Statistically, women in this country have lived longer than men in the 20th century.[68] Fielding[54] notes that "the difference in longevity that leads so many women to survive their male contemporaries is being abridged by an increase in the number of women who fall victim to their most deleterious habit — smoking."

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SPECIAL ARTICLE

THE HUMAN COSTS OF TOBACCO USE

(Second of Two Parts)

THOMAS D. MacKENZIE, M.D., CARL E. BARTECCHI, M.D., AND ROBERT W. SCHRIER, M.D.

ECONOMIC COSTS OF TOBACCO USE

The per capita consumption of cigarettes has risen and fallen, depending on particular events (Fig. 3).[69] Deaths from smoking-related illnesses, however, have climbed, possibly reaching a peak or plateau in 1988.[1] Studies[70] have placed the costs of smoking for the United States as a whole at a staggering $65 billion in 1985 in terms of health care expenditures and lost productivity, a value that would surely exceed $100 billion in current dollars. The estimated average lifetime medical costs for a smoker exceed those for a nonsmoker by more than $6,000.[71] This excess is a weighted average of costs incurred by all smokers, whether or not smoking-related illnesses develop. For smokers in whom such illnesses do develop, the personal financial impact is much higher.[71] The economic effect of smoking has not been overlooked by the life-insurance companies. *Time* magazine reported[72] that even three insurance firms owned by tobacco companies charge smokers nearly double for term life insurance, because smokers are about twice as likely as nonsmokers to die at a given age.

The Congressional Office of Technology Assessment estimated in its 1993 report[5] that the total financial cost of smoking to society in 1990 was $2.59 per pack of cigarettes. Some experts argue that this cost is actually much higher. One study,[73] however, suggested that smokers may pay their own way at the current level of excise taxes mostly because they do not live long enough to enjoy their share of the Social Security and pension benefits for which they have paid. This conclusion is controversial; moreover, most would agree that premature deaths due to smoking are not a humane means of controlling health care costs.

Another economic consideration is the cost associated with employees who smoke. Cigarette smokers are absent from work approximately 6.5 days more per year than nonsmokers. They make about six visits more to health care facilities per year than nonsmokers, and dependents of smokers make about four visits more per year than nonsmokers.[74] The cost to employers of workers who smoke is considerable and reflects costs due to work absences, health care claims, benefits not related to health care, and decreased productivity.[75] The Office of Technology Assessment[5] estimates the costs of lost productivity of persons disabled by diseases attributable to smoking and forfeited earnings of those dying prematurely of such diseases at $47 billion for 1990. With the use of 1985 figures, the costs of lost productivity due to passive smoking were estimated to be $8.6 billion annually.[76]

Fires related to cigarette smoking are the leading cause of civilian fire deaths in the United States. In 1983, the U.S. Fire Administration estimated that fires caused by cigarettes killed more than 2300 men, women, and children and burned more than 5000 others in the United States.[77] The health care costs related to the care of burn victims from such fires are also substantial. The most recent data (1991) from the National Fire Protection Association (unpublished data) list 187,100 fires caused by smoking materials, which caused an estimated $552 million in direct property damage.

THE TOBACCO INDUSTRY

Despite a 20-year trend of declining tobacco consumption in the United States, tobacco sales remain highly profitable. The U.S. tobacco industry is led by Philip Morris and RJR Nabisco, which together controlled 70 percent of the U.S. market in 1988.[78] In 1992, Philip Morris was the seventh largest industrial corporation in the United States, with $50 billion in sales. When these corporations were ranked according to profits, however, Philip Morris made more money in 1992 — $4.9 billion — than any other company in the United States, reflecting the large profit margin of cigarette sales.[79] This economic success in the face of declining U.S. cigarette consumption involved pricing that more than compensated for both inflation and the decrease in domestic sales. Aggressive advertising and marketing, as well as expanding exportation of tobacco, were also important factors.

Tobacco Advertising and Marketing

Cigarette advertising and promotion, despite some government restrictions, have undergone unbridled expansion in the past 30 years. Three years after the publication of the 1964 Surgeon General's report on the ill effects of smoking, the Federal Communications Commission, according to the Fairness Doctrine, ruled that local television and radio stations that broadcast cigarette advertising must also broadcast a balance of tobacco counteradvertising. Cigarette consumption per capita subsequently declined (Fig. 3).[69,80] With the Public Health Cigarette Smoking Act of 1969, Congress banned all cigarette advertising on electronic media.[81] The outcome of this regulation has

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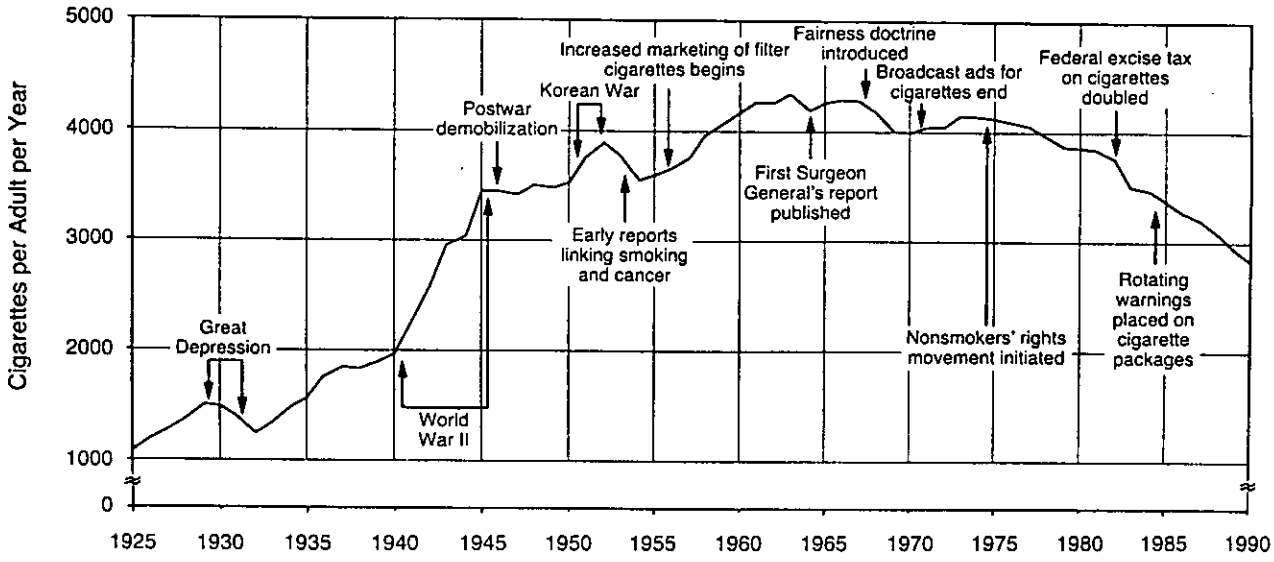


Figure 3. Per Capita Consumption of Cigarettes among Adults in the United States from 1925 to 1990, in Relation to Certain Historical Events.

Data were obtained from the Department of Health and Human Services.[69]

been the subject of great discussion. Advertising against smoking in the electronic media ceased, and cigarette advertising in magazines and newspapers and on billboards increased dramatically.[82] Warner and Goldenhar have reported in a study of 39 magazines that carried cigarette advertisements before and after the electronic-media ban was enforced in 1971 that advertising revenue from the tobacco industry increased by $5.5 million per magazine per year in constant 1983 dollars.[83] Moreover, the coverage of smoking and health issues decreased by 65 percent in magazines that carried cigarette advertisements, as compared with a decrease of 29 percent in magazines that did not.[83] For three years after the ban, per capita tobacco consumption in the United States, which had been declining before the ban, actually increased (Fig. 3).[69]

Since the electronic-media ban, advertising expenditures by the tobacco industry have risen dramatically. From 1975 to 1990, annual expenditures on cigarette advertising and promotional events grew from $500 million to $3.9 billion. In constant 1975 dollars this represents more than a threefold increase.[4,82] In 1989, Philip Morris had the largest advertising budget of any company in the United States, spending $2 billion to promote its products.[84] In 1988, cigarettes were the most advertised product on billboards and the second most advertised product in print media.[82] Promotional expenditures, which include the sponsorship of sporting events and the distribution of free cigarettes and coupons, have grown from one quarter of the marketing budget in 1975 to two thirds in 1988.[82]

A large portion of the marketing budget allocated for promotion supports sponsorship of events such as the Virginia Slims tennis tournament, the Marlboro Grand Prix, and Camel Motocross. The appeal of motor racing to the tobacco industry is not surprising, since it ranks as the second largest spectator sport in the United States behind football.[81] The economics of this high visibility are not lost on RJR Nabisco, which has become the leading sponsor of automobile and motorcycle racing in the United States. Far more important than the audience attending any such event, however, is the audience watching the event on television. For example, during the 93-minute broadcast of the 1989 Marlboro Grand Prix, the Marlboro name was mentioned 11 times and the logo was shown 5922 times, for a total of 46 minutes of exposure. Eighteen minutes of this exposure consisted of "clear, in-focus air time" estimated to have a commercial value of over $1 million.[81]

At what audience are the advertising and promotion by tobacco companies aimed? Recent data on the Camel-cigarette advertising campaign suggest that a principal target group is children. In 1988, with Camel sales declining, RJR Nabisco launched a marketing campaign featuring Old Joe Camel, a "smooth character" presumably modeled after James Bond.[85] In the advertisements, Old Joe rides motorcycles, shoots pool, and associates with attractive women while smoking Camel cigarettes. Three years into the campaign, Pierce et al. showed that 14 percent of adults over the age of 18 identified Camel as the most advertised cigarette brand, whereas 29 percent of teenagers 12 to 17 years of age and 34 percent of 12- to 13-year-olds believed Camel was the most advertised brand.[86] Even more striking are the data from Fischer et al. showing that 30 percent of three-year-olds and over 80 percent of six-year-olds are able to associate a picture of Old Joe Camel with a pack of cigarettes. Among six-year-olds, the same percentage associated a package of cigarettes with Old Joe Camel as were able to

associate a picture of the Disney Channel logo with Mickey Mouse.[87] Other evidence suggesting that children are a target market for cigarettes is RJR Nabisco's sponsorship of events such as the "Camel Mud and Monster Series," tobacco-company–sponsored promotion of brand-name cigarettes in movies aimed at teenage audiences,[88] and the appearance of cigarette advertisements in teen magazines. Currently, a pack of Camel cigarettes comes with a "C-note" that can be used to purchase Camel products with great appeal to teenagers, such as Camel charm earrings, a tropical shower curtain, or a watch with Old Joe Camel on the face.

From a marketing standpoint, the Camel campaign has been very successful. DiFranza et al.[85] compared brand preference in 1988 and 1990 and reported that the proportion of smokers under the age of 18 who smoked Camels had increased from 0.5 percent to 32 percent since the start of the Old Joe campaign. These authors estimated that sales of Camel cigarettes to smokers under the age of 18 had increased from $6 million to $476 million, accounting for one quarter of all Camel sales and one third of all illegal sales of cigarettes.[85]

Over the past two years, the decline in per capita cigarette consumption, which had been uninterrupted since 1973, has ended.[4] This dramatic change has occurred simultaneously with the rapid growth of generic brands and low-priced brand-name cigarettes, which now control 36 percent of the market share.[89] This trend has decreased the average price of cigarettes and forced a landmark price cut in the spring of 1993, first by Philip Morris (Marlboro) and subsequently by its leading competitors. These events may have a lasting impact not only on industry profits but also on smoking prevalence rates, especially among populations that are sensitive to changes in prices, such as teenagers.

Tobacco Exportation

The U.S. tobacco industry, which is second only to China in tobacco production, has recently expanded its activity in foreign markets. Cigarette exportation has increased dramatically in the past eight years and has offset declining consumption in the United States such that domestic cigarette production has been maintained.[90] In 1984, the United States exported 56 billion cigarettes, or 8 percent of its total production. In 1991, however, the United States exported 194 billion cigarettes, which accounted for over 25 percent of total production. The United States exports more than three times as many cigarettes as does any other country in the world.[91]

In some developing countries, little emphasis is placed on the hazards of smoking, and hence there is no legislation governing warning labels, advertising restrictions, or tar content. This has provided the powerful transnational tobacco companies with an opportunity to penetrate foreign markets rapidly. The U.S. government has not thwarted this expansion, and there are several possible reasons for its inaction. First of all, the United States realized a $3.5 billion trade surplus from tobacco exports in 1988, up from $2.5 billion in 1987.[92] The effect of this surplus on the trade deficit may have foiled any political efforts to limit the exportation or regulate the packaging (i.e., warning labels) of tobacco products. Furthermore, U.S. trade representatives, at the request of the tobacco industry (under section 301 of the 1974 Trade Act), have pressured foreign governments to open their markets to the transnational tobacco companies and to lift restrictions on cigarette advertising on television and in print.[92] Some have asked whether it is any less morally offensive for the United States to export cigarettes in the 1990s to lessen the trade deficit than it was for England to export opium to China in the 1830s to balance imports of silk and tea.[93]

With respect to the exportation of tobacco, Dr. James Mason, former assistant secretary for health in the Department of Health and Human Services, was quoted as saying:

> Cigarettes become a health problem only when you combine addiction with greed — greed on the part of the tobacco industry and the advertising industry, who are willing to exchange dollars for the lives of others. Our country has been known for its humanitarian and health-related projects worldwide. This is a hundred and eighty degrees opposite. We're talking about millions of lives — and that totally outweighs and overwhelms what we've accomplished in the humanitarian field. It's outrageous for the United States to allow this misery and suffering to occur.[91]

The Tobacco Lobby

Cigarettes remain the only consumer product sold legally in the United States that is unequivocally carcinogenic when used as directed. Despite mountains of evidence on the health hazards of smoking cigarettes, the American public and government have tolerated the relatively unregulated advertisement, promotion, and sale of such a product. This passive tolerance is fueled in part by one of the most powerful political lobbies in government.

During the 1992 presidential campaign, the tobacco industry gave $2.5 million to the political parties, which represents a fivefold increase in funds contributed in 1988. In addition, contributions to House and Senate candidates during the 1992 campaign by tobacco political action committees exceeded $2.2 million, nearly twice the amount contributed from 1989 through 1990[95,96] (and Samuels B, et al.: personal communication).

Working at the level of the local, state, and federal governments, tobacco-company lobbyists are described by Representative Mike Synar (D-Okla.) as "the most pervasive group in politics today."[96] Their activities include the formation and financial support of so-called grass-roots smokers' rights groups and local business coalitions designed to fight local tobacco-control legislation.[97] The Tobacco Institute and the Council for Tobacco Research, which are funded by the tobacco industry, ostensibly support the study of questions about tobacco use and health and "remain

committed to advancing scientific inquiry into the gaps of knowledge in the smoking controversy."[98] As late as 1986, however, a Tobacco Institute publication stated that "eminent scientists believe that questions relating to smoking and health are unresolved."[98] These statements raise doubt in the minds of the public and their government representatives over a scientific debate that has been settled for nearly 30 years — namely, that cigarettes cause lethal disease in humans.

The Campaign to Prevent Tobacco Use

Although cigarette smoking is the number-one preventable cause of premature death in our society, nearly 50 million Americans still smoke. There are several reasons for this tragic situation. First, the American public is reluctant to change a habit that is both culturally ingrained in their society and powerfully addictive, perhaps as addictive as the use of heroin and cocaine.[99] Second, recognition of the magnitude of this health hazard by U.S. citizens and their government has been hindered by the tobacco industry's expenditure of $4 billion per year for advertising and promotion. Third, the efforts of the tobacco industry to fight legislation on tobacco taxes have resulted in a lower excise tax on tobacco products, as a percentage of the retail price, in this country than in any of the other industrialized nations listed in Figure 4A (Non-smokers Rights Association of Canada: unpublished data); the United States also has among the least restrictive advertising regulations in the industrialized world (Fig. 4B).[95] Furthermore, tobacco products are not subject to regulation by the Food and Drug Administration[100] or by the Consumer Product Safety Commission,[101] which would, given current standards of product safety, undeniably prevent the sale of a similar product were it introduced today. Thus, the obstacles facing the campaign against tobacco use are formidable. To be effective, this campaign must operate on many different levels, from community education programs to support for increases in federal excise taxes (Table 3).

Smoking Restrictions in the Workplace and in Public

Over the past 10 years, public recognition of the dangers of passive smoking (i.e., environmental tobacco smoke) has steadily increased. From 1980 to 1989, the number of no-smoking laws passed by various cities increased 10-fold, and by 1989, 44 states had passed some form of smoking-control legislation.[102] There is great variability, however, among no-smoking laws. Among 902 cities and all 50 states surveyed in a recent study, only 17 percent of the cities and 20 percent of the states had comprehensive laws restricting smoking in government buildings, public places, restaurants, and private workplaces.[102] Nevertheless, it has been shown that local efforts to initiate tobacco-control legislation as a means of protecting citizens against the ill effects of environmental tobacco smoke can overcome tobacco-industry efforts if supported by a strong coalition of community members, local businesses, and sympathetic political leadership.[97]

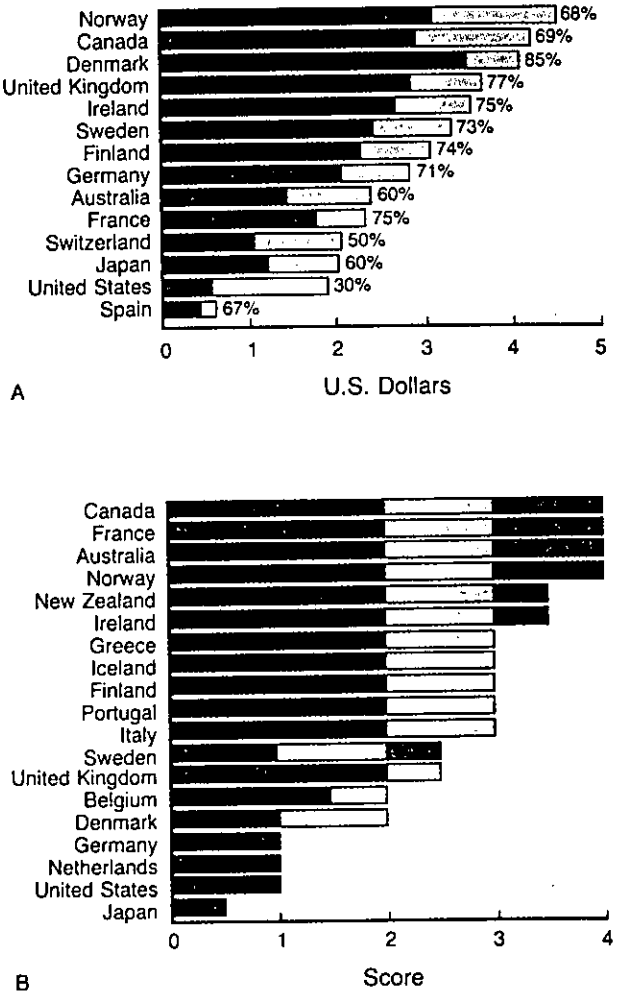


Figure 4. Average Retail Price of a Pack of 20 Cigarettes in Various Countries in 1993 (Panel A) and Regulations Governing Cigarette Advertising in Industrialized Nations (Panel B).

In Panel A, the average total tax per pack is shown in red. The total tax as a percentage of the retail price is given to the right of each bar (Non-smokers Rights Association of Canada: unpublished data). In Panel B, countries were accorded 1 point for a ban and 1/2 point for restrictions on electronic (red), print (blue), and billboard (yellow) tobacco advertisements and event sponsorship (green). Data were adapted from Samuels et al.[95]

Bans on Advertising and Sponsorship by Tobacco Companies

As discussed, cigarettes remain the second most heavily advertised product in the United States, behind automobiles.[10] The American Medical Association is among the many institutions that have recommended a ban on all cigarette advertisements and promotional activities. Several bills have been proposed in Congress either to restrict further cigarette

Table 3. Essential Components of a Campaign to Prevent Tobacco Use.

Increased federal excise taxes
Comprehensive restrictions on smoking in the workplace and in public
Bans on advertising and sponsorship by tobacco companies
Comprehensive and enforced restrictions on sales of tobacco to minors
Limitation of tobacco-crop subsidies
Government support for conversion of tobacco crops to other crops
Financial support for tobacco counteradvertising
Enhanced community-education programs
Divestment of tobacco-company stocks by universities and public institutions
Support for personal-injury litigation against the tobacco industry
Physician-supervised counseling on smoking cessation

advertising or to ban it totally, though none have passed.[103] A strong tobacco lobby has argued that a ban on advertising would violate the industry's constitutional rights of free expression. A close examination of modern case law and the Supreme Court interpretation of the commercial free-speech doctrine, however, reveals that there are precedents for imposing restrictions on the advertisement of legal products when consumer safety is threatened.[100]

Restrictions on Sales of Tobacco to Minors

As stated earlier, approximately 80 to 90 percent of regular smokers start smoking by the age of 18. To influence smoking-related public health outcomes, efforts must be made to limit the availability of cigarettes to minors. An increasing number of states have appropriately supported such legislation. Currently, 46 states have laws prohibiting the sale of tobacco products to minors.[104] Compliance with these laws, however, has been repeatedly shown to be poor.[105-108] Attempts by minors to purchase cigarettes in eight communities in four separate studies had a success rate of 46 to 88 percent. Furthermore, only 22 states have laws prohibiting the free distribution of tobacco products to minors, and only 9 states ban the sale of tobacco products in vending machines or restrict the placement of such vending machines.[104] These data suggest that our society is remarkably passive about the illegal sale of addictive and dangerous tobacco products to children.

Tobacco Subsidies

On the one hand, the Department of Health and Human Services discourages tobacco use among U.S. citizens, whereas on the other hand the Department of Agriculture uses taxpayers' dollars to subsidize the tobacco industry,[109] and the Internal Revenue Service allows the tobacco industry to deduct 100 percent of its advertising and promotional expenditures.[110] Although this tax deduction is not unique to the tobacco industry, given the health consequences of the product and the focus of the advertisements on women, children, and minorities, the U.S. public should be outraged by the mixed messages from our government. Substantial government subsidies to allow conversion from tobacco to other profitable and needed crops would seem indicated.

Tobacco Taxes

The federal excise tax on cigarettes has increased from 8 cents per pack in 1951 to the current 24 cents per pack.[111] With the addition of state cigarette taxes, the average total tax on a pack of cigarettes in the United States is 56 cents, or approximately 30 percent of the retail price. This percentage is dramatically lower than that in all the other industrialized countries listed in Figure 4A (Non-smokers Rights Association of Canada: unpublished data). Switzerland, which taxes cigarettes at 50 percent of the retail price, has the next lowest tax. An increase in the federal tobacco tax of $2 per pack of cigarettes has been recommended by the American Heart Association, the American Lung Association, and the American Cancer Society. Such an increase would still place the United States behind many countries (Fig. 4A). In March 1993, Senator Bill Bradley (D-N.J.) and Representative Mike Andrews (D-Tex.) introduced the Tobacco Health Tax Act of 1993, which would raise the federal excise tax to $1 per pack of cigarettes. Unfortunately, the Clinton Health Care Security Act proposes an increase of only 75 cents per pack.

There are many potential benefits of increased tobacco taxes. First and most important, it is estimated that for every 10 percent increase in price, there will be a 4 percent reduction in tobacco consumption.[69] This figure is likely to be even higher in populations, such as teenagers, that are most sensitive to changes in prices. The effect of user fees has been clearly demonstrated by the small (25 cent) increase in the state cigarette tax in California approved in 1989, which resulted in a substantial acceleration in the decline of tobacco consumption as compared with the rates of decline in the rest of the United States.[112] Similarly, Canada increased federal and provincial cigarette taxes from an average of 46 cents in 1980 to $3.72 in 1991. During this time, cigarette sales fell 39 percent,[113] tobacco consumption decreased 30 percent faster than in the United States,[114] and smoking by teenagers was cut by two thirds.[111] With the recent fall in the prices of Marlboro, Camel, and other brand-name cigarettes, an increase in the cigarette tax becomes particularly important to counteract a potential increase in consumption among teenagers.

Second, with an increase in the cigarette tax, the resultant decline in consumption will lead to a decline in health care costs as former smokers and their children require less medical care. Third, since the Health Security Act estimates that $105 billion in revenues will be generated over a five-year period by a 75-cent increase in the tax on a pack of cigarettes, a $2 increase could yield as much as $250 billion over the same period. This not only would allow the tobacco

industry to pay more equitably for the excess economic burden placed by its products on the health care system, but also could provide important funds for universal access to health care. Revenue generated by an increase in the tobacco tax could also be used to pay for community education and advertising against tobacco. Opponents of the increase in the tobacco tax argue that it is a regressive tax, like that on gasoline or food. Cigarettes are, however, lethal consumer products and cannot be considered in the same class as gasoline and food.

Tobacco use has exacted a tragic toll on the U.S. population. Every segment of our society suffers the consequences of these addictive products, including disproportionate effects on children, women, and minorities. The human and economic costs of tobacco use to our society are overwhelming. A uniform ban on tobacco advertisements, an increase in the number of laws against smoking in public places, more aggressive public education, and a higher tax on cigarettes would diminish some of the human tragedies of tobacco use.

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Attachment J

NH Tobacco Prevention Task Force



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1999 New Hampshire Youth Smoking Survey

Executive Summary

This report summarizes the major findings from the 1999 New Hampshire Youth Smoking Survey, conducted by the University of New Hampshire Survey Center for New Futures. The purpose of the survey was to determine the attitudes of New Hampshire voters toward smoking by youths, particularly teenagers, and to gauge how New Hampshire voters believe the money the state will receive from its settlement with tobacco companies should best be spent. Five-hundred nine (509) New Hampshire voters who voted in the 1998 general election were interviewed between February 17 and February 23, 1999. The margin of sampling error for a survey of this size is +/- 4.3 percent. The major findings of the study include:

- Eighty-six percent of New Hampshire voters are concerned about smoking by New Hampshire teens. More than half (53%) say they are "very concerned" and another 34% say they are "somewhat concerned." Women and Democrat voters are most concerned about the issue of teen smoking in New Hampshire.

- Reflecting this concern about teen smoking, 73% of New Hampshire voters think that more needs to be done to reduce teen smoking in New Hampshire. Democrats and young adults (18-29) years old) are most likely to say that more needs to be done to reduce teen smoking in New Hampshire.

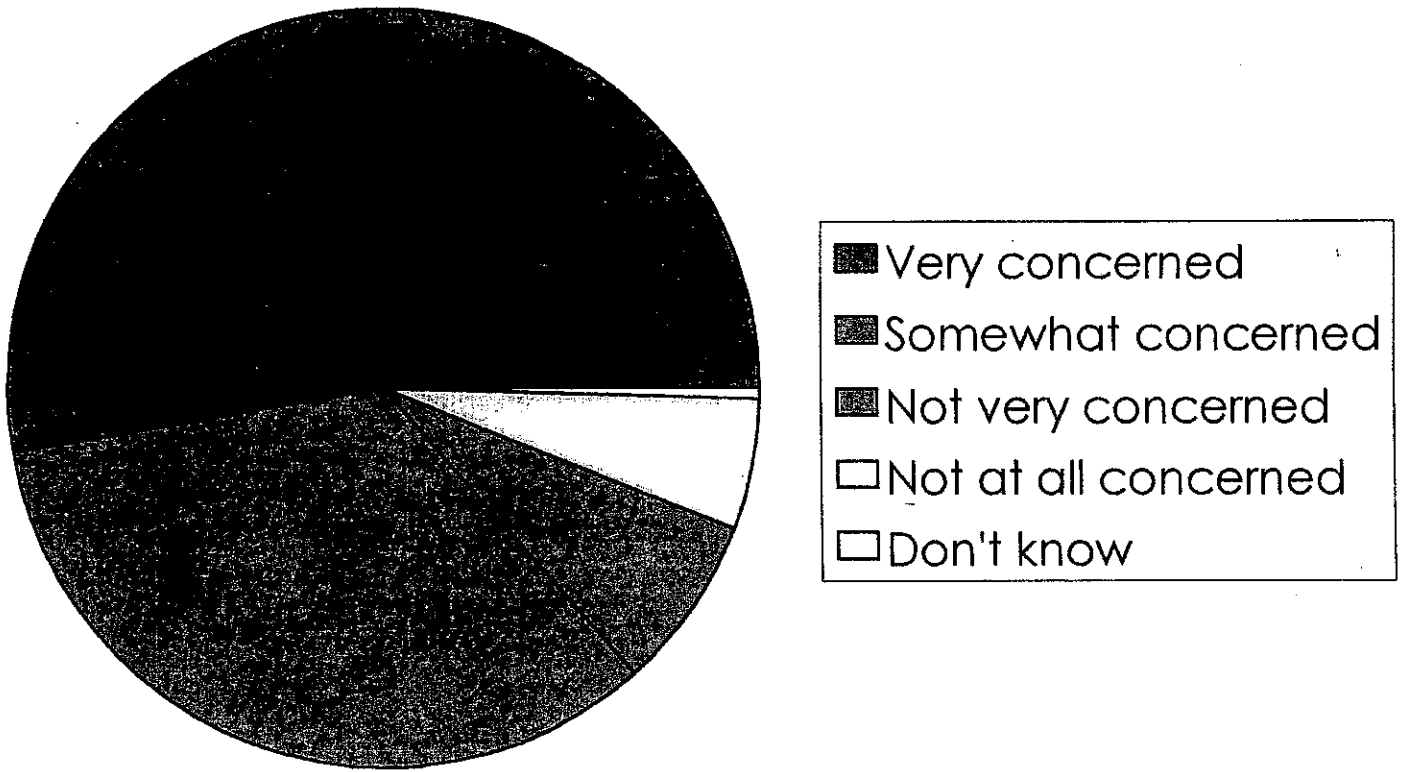
- Beginning in the year 2000, the State of New Hampshire will receive approximately $48 million per year over the next 25 years from its settlement with the tobacco companies. In order to determine the priorities for spending this money, voters were asked if they favored or opposed four proposals for spending a significant portion of these funds.

  -Seventy-nine percent of New Hampshire voters favor using the tobacco settlement to fund programs to reduce teen smoking--56% strongly favor this proposal and 23% favor it somewhat.

- Voters were also asked if they favored or opposed a recent proposal to dedicate one-quarter of the money the State receives from the tobacco settlement to fund tobacco prevention programs and programs to help smokers quit. Seventy-five percent of voters favor such use of these monies. Forty-nine percent of voters strongly favor this proposal and another 26% favor it somewhat. Less than 20% of voters oppose spending at least one-quarter of the tobacco settlement on anti-smoking programs.

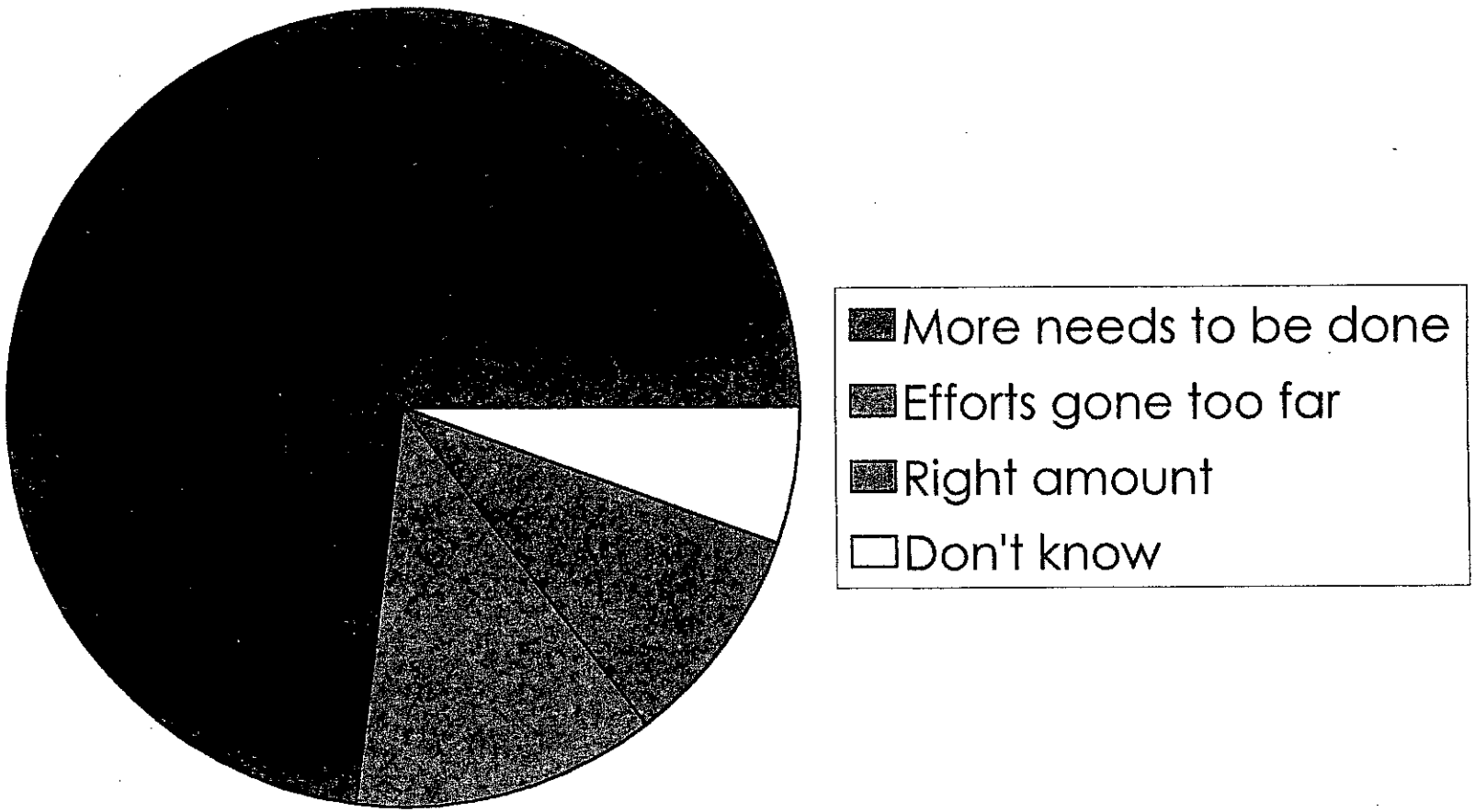
New Hampshire Tobacco Prevention Task Force

Concern About Teen Smoking in New Hampshire: All Respondents



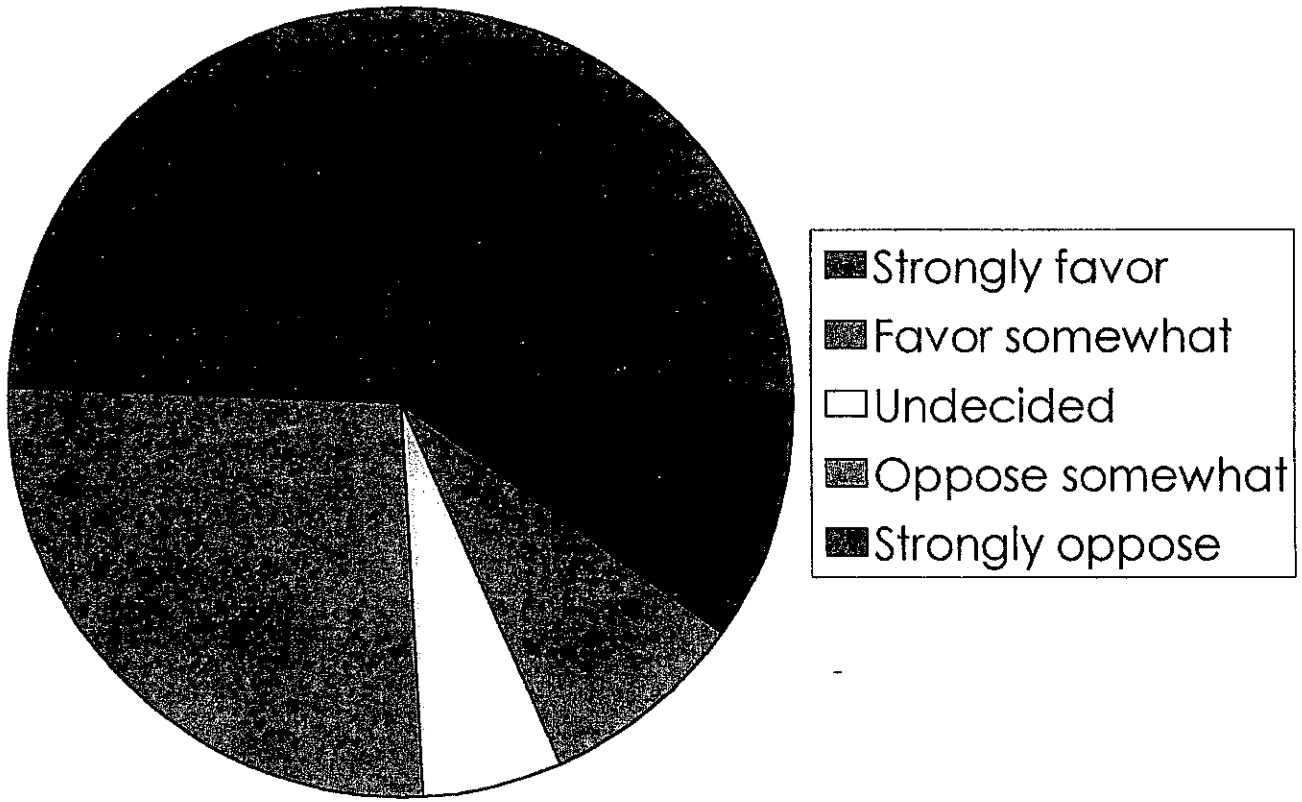
New Hampshire Tobacco Prevention Task Force

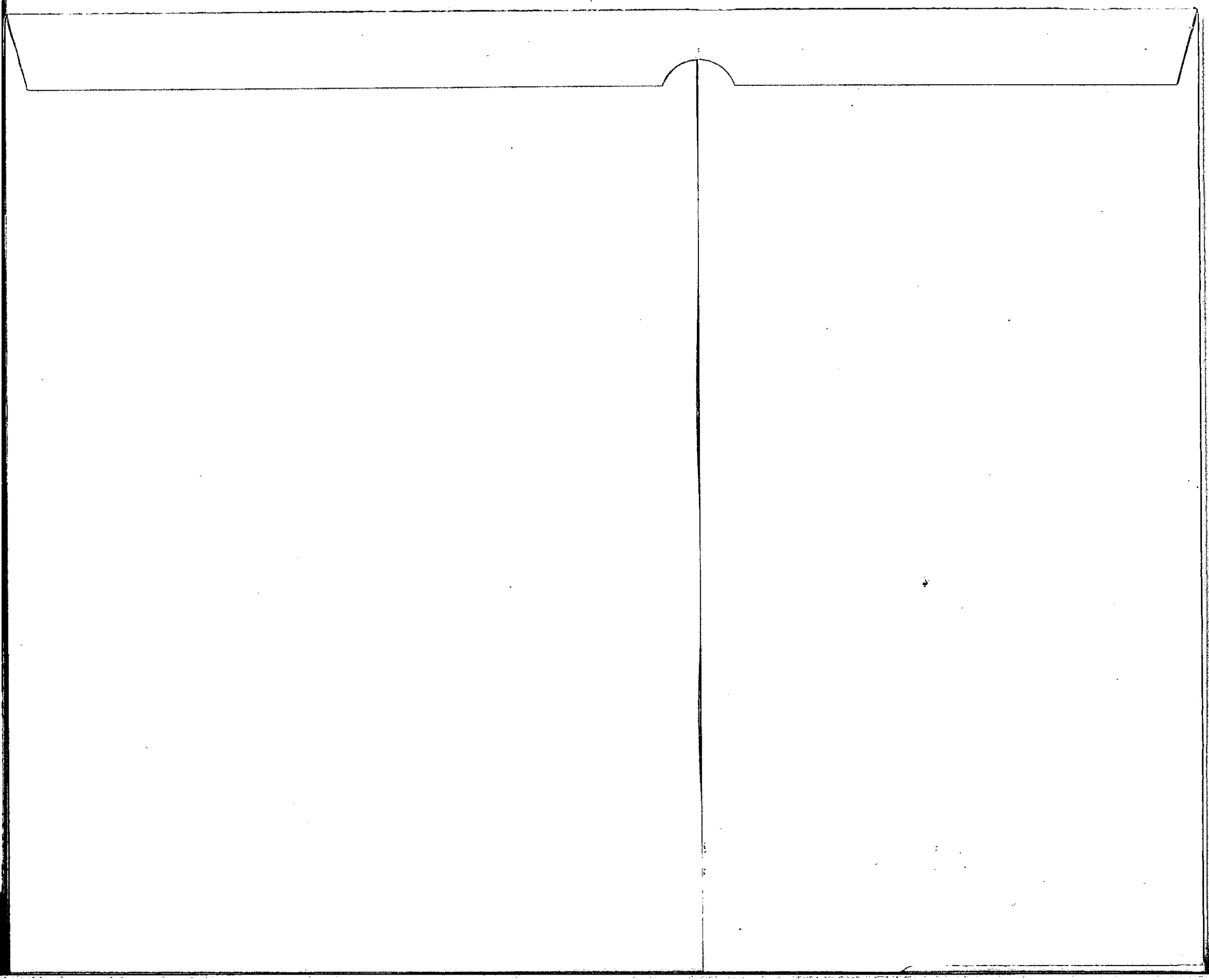
New Hampshire's Efforts to Reduce Teen Smoking: All Respondents



New Hampshire Tobacco Prevention Task Force

Spending of 1/4 of Tobacco Settlement on Anti-Smoking Programs: All Respondents







Investing in a Healthy Future

New Hampshire Tobacco Prevention Task Force

We believe that 25% of the funds coming to New Hampshire from the tobacco settlement should be allocated to a comprehensive tobacco education, prevention and cessation program

We Need a Comprehensive, Consistent Tobacco Education Curriculum that includes....

- Community programs to reduce tobacco use
- Community programs to reduce the burden of tobacco related diseases
- School programs
- Enforcement
- Statewide programs
- Counter marketing
- Cessation programs
- Surveillance and evaluation
- Administration and management

We Do Not Think These Programs Are Effective, Let's Wait and See What Other States Do....

- Oregon... 11.2 per cent reduction in tobacco consumption in two years
- Massachusetts... 30 percent reduction in tobacco use over last ten years
- Florida... Early data shows tobacco use among middle school students dropped from 18.5 to 15.1 percent and from 27.4 to 25.3 percent among high school students
- California... A 40 percent reduction in tobacco use among adults and no increase in youth rates

How Much is Needed?

- CDC recommends a per capita investment of about $8.00-10.00
- NH currently has a per capita investment of 29¢
- By making this investment now, it is GUARANTEED that future health costs related to tobacco use will be drastically reduced

What does "how much" mean?

According to CDC Guidelines

Total of $8,550,000 annual allocation

- 1 million to community programs
- 1 million to community programs to reduce the burden
- 750,000 to school programs
- 750,000 to enforcement
- 1 million to statewide programs
- 2 million to counter marketing
- 750,000 to smoking cessation
- 800,000 to surveillance and evaluation
- 500,000 to administration and management costs

Comprehensive tobacco prevention and control efforts, like those adopted in Oregon, California and Massachusetts, can lead to significant reductions in tobacco use, thereby reversing the mounting health and financial burden attributed to tobacco use...

Centers for Disease Control and Prevention, February 1999

NH Tobacco Prevention Program Accomplishments to Date

- Funds 8 community core coalitions from $3,000 to $14,000
- Statewide Smokefree Coalition
- Speakers Bureau, Youth Network Newsletter
- Held two conferences
- Partnered with the NH Soccer Association, American Lung Association

Accomplishments To Date

- Educational programs related to Environmental Tobacco Smoke
- Provide Information re Smokefree Dining
- Health and Dental Care "How to Kits"
- Support of Coalitions in their efforts to promote No Butts About It and Tale of Samantha Skunk
- Limited Public Service announcements
- Anti tobacco promotional items

Accomplishments to Date

- Media Trainings
- Tobacco Free Teens and Smokeless Saturdays programs
- Information and referral to statewide programs

American Lung Association Efforts

- Tale of Samantha Skunk... 350 appearances, provided five scholarships ($1,000 each) for towns to purchase programs
- No Butts About It... 100 schools in state 2,700 4th and 5th graders
- Tobacco Free Teens... 11 programs, 66 participants
- Freedom From Smoking (FFS) last ten years... 329 sites, 3,730 participants 50.27% end of session quit rate
- When You Can't Light Up... 12 worksite programs followed by 50% having FFS program

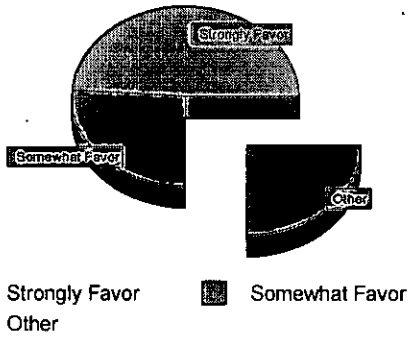
American Lung Association Efforts

- Nicotrol Patch Program... 650 six week supply provided free of charge
- Telephone Counseling.... 135 individuals received multiple session counseling
- Tobacco Awareness presentations... 20 presentations to approximately 3,325 students

American Cancer Society Efforts

- Great American Smoke Scream... Youth smoking prevention effort
- Literature Distribution... Large quantities of informational material distributed throughout the state
- Great American Smokeout... National effort to promote a tobacco free lifestyle
- New England Cessation Hot Line... To provide a resource for people who want to quit smoking
- Extensive focus on local and national legislative efforts

Allocate 25% of Tobacco Funds



Current State Allocation to Tobacco Prevention and Education

ZERO

We Need Financial Support to do the Job Right

- Current programs are good but insufficient
- We need a funded, coordinated, comprehensive approach to tobacco education and prevention
- The Bureau of Health and Human Services should be fighting for this increased funding level to do their job of protecting the public's health
- There is no better time

The Tobacco Industry Spent $22,000,000 Advertising Dollars in New Hampshire last year...

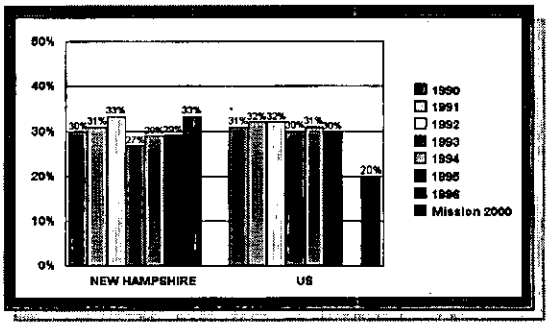
The Department of Health and Human Services Spent $350,000...



NEW HAMPSHIRE

TOBACCO CONTROL

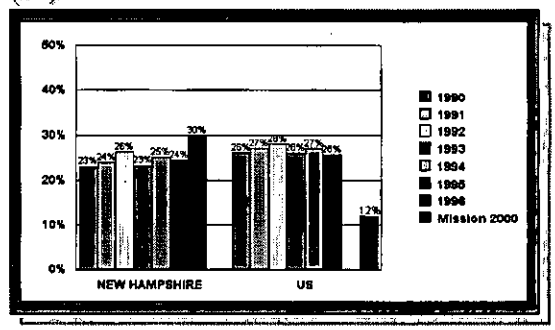
Goal: Reduce overall smoking prevalence among adults with high school education or less.



NEW HAMPSHIRE

TOBACCO CONTROL

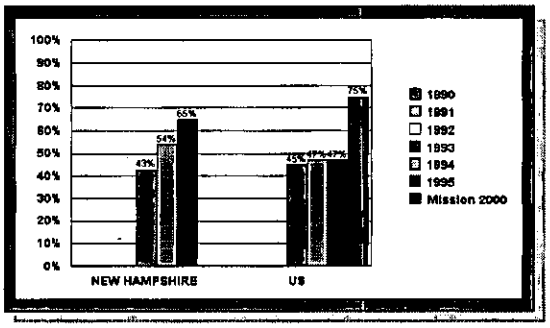
Goal: Reduce overall smoking prevalence among women of reproductive age (18-44).



NEW HAMPSHIRE

TOBACCO CONTROL

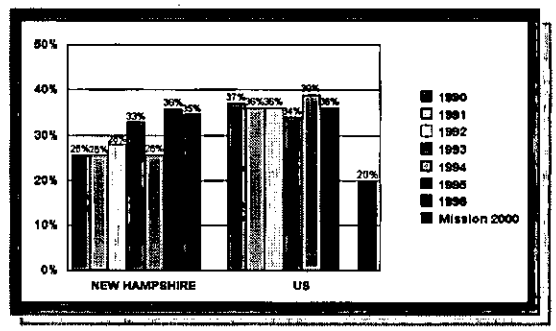
Goal: Increase the proportion of adult smokers seeing a health care provider in last 12 months who received cessation assistance.



NEW HAMPSHIRE

TOBACCO CONTROL

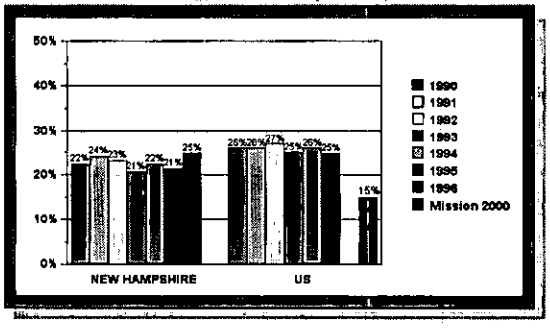
Goal: Reduce overall smoking prevalence among blue collar/low income adults.



NEW HAMPSHIRE

TOBACCO CONTROL

Goal: Reduce overall smoking prevalence among adults 18 years or older.



We Need to do More....

Tobacco is a gateway drug to other forms of substance abuse..

JANUARY 1999 CDC RECOMMENDATIONS FOR PROGRAM COST ALLOCATION

in New Hampshire

Lower Estimate	Upper Estimate		
Amounts in Millions		Percentage for Program Component, Assuming Lower Estimate)	Assuming 9.5m from Tob. Tax
			$ 9,500,000
Cessation Programs			
$ 1.22	$ 5.01	11%	$ 1,026,572
Program Area			
Community Programs to Reduce Tob Use			
$ 2.15	$ 4.37	19%	$ 1,809,123
Community Prog to Reduce Burden of Tobacco Related Disease			
$ 2.80	$ 4.17	25%	$ 2,356,067
School Programs			
$ 1.38	$ 2.07	12%	$ 1,161,205
Enforcement			
$ 0.75	$ 1.50	7%	$ 631,089
Statewide Programs			
$ 0.46	$ 1.15	4%	$ 387,068
Counter Marketing			
$ 1.15	$ 3.44	10%	$ 967,671
Surveillance & Evaluation (10%)			
$ 0.99	$ 2.17	9%	$ 833,038
Administration& Management (5%)			
$ 0.50	$ 1.09	4%	$ 420,726
Total Program Costs			
$ 11.29	$ 24.97	101%	$ 9,592,560
Per Capita Costs			
$ 9.92	$ 21.74		

New Hampshire Tobacco Prevention Task Force

Mission Statement

The New Hampshire Tobacco Prevention Task Force is dedicated to ensuring that 25-percent of the tobacco settlement money is utilized to reduce smoking in New Hampshire. We support using tobacco settlement funds to create public health efforts that combat tobacco addiction, the leading cause of preventable death and disease in New Hampshire.

Supporting Members:

American Cancer Society
American Lung Association of NH
American Heart Association
NH Medical Society
NH Public Health Association
NH Family Practitioners
NH Hospital Association
Norris Cotton Cancer Center
National Center for Tobacco Free Kids
NH Family Practice Association
NH Dental Hygienists' Association
New Futures
NH Smoke-free Alliance
NH Nurses Association
NH Pediatrics Society
NH Nurse Practitioners Association
NH Soccer Association
NH Respiratory Therapists
Governor's Advisory Council on Cancer & Chronic Disease

PRESS RELEASE

VOREL & ASSOCIATES • P. O. Box 7101 - 40 Skyline Drive • Gilford, NH 03246 • (603) 528-2219 • Fax: (603) 524-2034

For Immediate Release

Date: March 10,1999
Contact: John A. Vorel, Communications Consultant
Phone: (603) 528-2219
Fax: (603) 524-2034

"Voters Support Funding of State Tobacco Prevention Program"

Concord, NH—

The New Hampshire Tobacco Prevention Task Force and New Futures unveiled a powerful new survey of New Hampshire voters at a Press Conference on Wednesday, March 10,1999. According to John F. Bunker, Executive Director of New Futures, "The results of this survey showed astonishingly strong support for a substantial amount of NH's share of the National Tobacco Settlement Funds being allocated for programs designed to prevent our youth from forming life long addictions to tobacco."

The New Hampshire Tobacco Prevention Task Force is made up of more than 20 nonprofit organizations of New Hampshire. They commissioned this poll of NH voters to determine the level of support for anti-smoking campaigns, and the appropriateness of using future funds from the National Tobacco Settlement to underwrite the cost of lowering the nationally high rates of smoking among NH youth especially among teenage girls whose smoking rates are 4th highest in the entire country.

The survey, conducted by the University of New Hampshire's Institute for Policy and Social Science Research, showed that 73% of NH voters feel that more has to be done within our state to stop the increased use of tobacco products by our young people. James Gray, Director of Advocacy for the American Cancer Society, stated "The public opinion poll reaffirms the sentiments of the members of the New Hampshire Tobacco Prevention Task Force, that not only does a comprehensive tobacco prevention program need to be put

into action statewide, but that using some of the funds from the National Tobacco Settlement is the first and best use of those future monies."

"In New Hampshire more than 5,000 kids under the age of 18 become new daily smokers each year." said Doug Barry, President and CEO of the American Lung Association of New Hampshire. He continued, "The greatest testament to a comprehensive tobacco prevention program is the fact that 9 out of 10 kids who do not start smoking before their 18th birthday will never become addicted to tobacco or suffer the horrendous consequences in their long lives."

Andrew E. Smith, PhD, Director of the University of New Hampshire Survey Center, who was responsible for conducting the statewide random study of NH citizens who did vote in the last election said, "Seventy-five percent of voters favor dedicating one quarter of the money the State receives from the Tobacco Settlement to fund Tobacco Prevention Programs and programs to help smokers quit."

Not only are New Hampshire voters supportive of spending at least one-quarter of the Tobacco Settlement on anti-smoking programs, They say they will remember candidates who support this proposal at the ballot box. John Vorel, Communications Consultant for the NH Tobacco Prevention Task Force, summarized the report by saying, "The overwhelming message delivered by the voters, is that NH must act now for the benefit of it's next generation and that the voters will remember and support those legislators who step forward to protect the health of our children."

For more information please contact:

John A. Vorel	@ 528-2219
James Gray	@ 472-8899 - Ext. 104
John F. Bunker	@ 862-3706

Attachment K

DARTMOUTH MEDICAL SCHOOL
OFFICE OF STUDENT AFFAIRS
HANOVER · NEW HAMPSHIRE 03755-3837
TELEPHONE: (603) 650-1755, 650-1509
FAX: (603) 650-1169

Governor's Advisory Panel on Cancer and Chronic Disease

Testimony on SB 206, establishing the Tobacco Use Prevention Fund
and continually appropriating a special fund

Senate Public Institutions, Health and Human Services Committee
March 22, 1999

Good afternoon, Mr. Chairman and members of the Committee. My name is Leslie Melby. I'm here today as a member of the Governor's Advisory Panel on Cancer and Chronic Disease to testify in support of SB 206.

The Governor's Advisory Panel was created with the enactment in 1985 of RSA 141-B, which established the New Hampshire Cancer Registry. The mission of the Advisory Panel is to "identify issues relative to, promote programs for, and provide technical assistance for the assessment, prevention and control of cancer and chronic diseases in order to significantly improve and positively influence conditions which affect the health and quality of life for the citizens of the State of New Hampshire".

It's in the spirit of this mission that I appear before you today. The Advisory Panel is comprised of healthcare practitioners, cancer specialists, public representatives, and organizations involved in the prevention of cancer and other chronic diseases.
We are very fortunate to have the Advisory Panel chaired by Dr. Joseph O'Donnell, Associate Director for Education and Information Services of the Norris Cotton Cancer Center at Dartmouth Hitchcock Medical Center. Dr O'Donnell is also the Chief of Oncology at the VA Medical Center at White River Junction.

The Governor's Panel strongly supports the recommendations of the Centers for Disease Control and Prevention (CDC) to states to carry out comprehensive and effective tobacco prevention programs. The tobacco settlement provides New Hampshire with the funds necessary to establish effective programs to reduce smoking, particularly among our youth. Why do we need tobacco prevention programs?

Here are the facts:

- ✓ **40% of New Hampshire's high school students smoke cigarettes**
- ✓ **New Hampshire ranks 4th in the nation in the number of teenage girls smoking**
- ✓ **Each year 5,000 kids in New Hampshire become daily smokers**
- ✓ **$340 million dollars is spent *each* year in NH on health care directly related to smoking**

- ✓ **Tobacco use is the single most preventable cause of death and disease in the nation**
- ✓ **New Hampshire spends no money on anti-tobacco education (only $375,000 in federal funds (no state funds) is used for tobacco prevention and control)**

You have a critical decision to make. You can allocate funds from the tobacco settlement to tobacco prevention programs which will allow people to live free from the premature death and disease associated with tobacco use. By allocating tobacco settlement funds for tobacco prevention, you can ensure that these funds will be used to help people stop smoking, prevent kids from ever starting to smoke, and to dramatically impact the health of the public. This is what the tobacco settlement was intended to do.

The CDC's guidelines are based on programs that have been proven to work. We already know what works based on successful programs carried out in other states. We also know that it requires that all of the following programs implemented as a whole will maximize the success of a statewide program implemented in New Hampshire. These programs are:

- ✓ Public education to counter powerful tobacco marketing messages
- ✓ Community-based programs to implement local tobacco prevention activities where people live and work
- ✓ Cessation programs to help smokers quit smoking
- ✓ School-based programs to prevent and reduce tobacco use among our youth
- ✓ Enforcement of laws prohibiting tobacco sales to teens
- ✓ Monitoring and evaluation to ensure that these programs are carried out properly and meeting their objectives.

I assure you this will be money well spent. The Governor's Advisory Panel on Cancer and Chronic Disease supports a plan based only on those programs proven to effective. We would support a plan of progressive funding sufficient to allow for the implementation of a comprehensive tobacco prevention program based on the CDC recommendations. But we caution that sufficient funds be allocated to allow this to happen. The CDC recommends a minimum of $11 million per year dedicated to accomplish a truly effective tobacco prevention and control effort.

In addition, in Section 2 of SB 206, under 126-K:19, we suggest that the Governor's Advisory Panel on Cancer and Chronic Disease be specifically listed on the Tobacco Use Advisory Committee.

On behalf of the Governor's Advisory Panel on Cancer and Chronic Disease, I urge you to pass SB 206 as presently drafted to allocate 25% of New Hampshire's tobacco settlement money to the Tobacco Use Prevention Fund to support effective tobacco prevention and control programs.

Thank you.

Attachment L

AMERICAN CANCER SOCIETY®
New England Division, Inc.

Testimony of James Gray
American Cancer Society
(603)472-8899

Before the
New Hampshire Senate Public Institutions Committee
Regarding Senate Bill 206

March 22, 1999

Honorable Chair, Members of the Committee, good afternoon. I am James Gray, Director of Advocacy for the American Cancer Society. I am here today in support of Senate Bill 206, which allocates 25-percent of the state's share of the tobacco settlement funds to a comprehensive anti-tobacco education program.

Each year more than 419,000 adults in this country die as a result of a decision to use tobacco, a decision which 89% of the time is made in the teen years. The Centers for Disease Control and Prevention puts our state's death toll from smoking at more than 1,700 citizens each year, which means, that on the average, each Senate Public Institutions Committee member will lose 133 of their constituents to the deadly effects of tobacco during their two-year term. If current trends continue, 23,000 NH kids alive today will eventually die from smoking. These are staggering numbers and far exceed the death toll of any other preventable disease. In New Hampshire, cigarettes kill more citizens than alcohol, car accidents, fires, suicides, homicides, drugs and AIDS **combined.**

The economic toll on New Hampshire taxpayers is enormous. Health care expenditures related to smoking could exceed $340 million in 1999. The average New Hampshire household's State and Federal tax burden from tobacco-related health costs is $430 annually. New Hampshire's State and County Medicaid payments attributed to smoking related illnesses exceeds $90 million per year. Decreases in consumption will offset this

excessive tax burden incurred by all the taxpayers, and in particular the 75% of New Hampshire's taxpayers that do not smoke.

Anti-tobacco programs are not just good health policy. The case for establishing a comprehensive anti-tobacco program is compelling on economic grounds, too. The case is compelling because these programs reduce the economic cost of smoking, while helping our state's economy. Independent economic analysts estimate that in the long run, a 3 percent decrease in smoking would save New Hampshire more than 15 million dollars each year in reduced health care costs and increased economic productivity. A recent report by the State of Oregon on its comprehensive anti-tobacco program showed an 11% reduction in cigarette consumption, and a projected cost savings of $150 million annually in medical expenses and lost economic productivity.

As you know, tobacco generates substantial revenue for New Hampshire's general fund. If we succeed in passing a 25-cent tax increase, estimated to generate $47 million annually, added to a projected $75 million generated by the current 37-cent tobacco tax this fiscal year -- tobacco could provide $130 million to the state. Additionally, the $48 million from the tobacco settlement means that tobacco could generate $175 million annually for the New Hampshire general fund. Seemingly, tobacco revenue is a large component of the state's general fund revenues, however, it equates to only half of the money spent on health care costs that result from tobacco use. Altough, it is tempting to fully utilize this tobacco windfall for immediate priorities, we must invest a portion of the revenue to better lives of our citizens by creating programs that curtail the harmful effects of tobacco.

The New Hampshire legislature has a duty and obligation to the citizens they represent to direct a substanial portion of the tobacco settlement money towards effective tobacco control activities across the state. New Hampshire's lawmakers have the ability to make

the health of their constituents a priority this legislative session. Support of a cigarette tax increase, combined with anti-tobacco educational programs, funded by a portion of the tobacco settlement money will have a dramatic impact on the health of New Hampshire citizens.

Currently, no State money is spent on anti-tobacco programs, the tobacco tax is the only prevention program we have. However, this should only be considered a short-term strategy for reducing tobacco consumption. If New Hampshire is serious about reducing the use of tobacco products, it must be coupled with an aggressive, comprehensive, and sustained approach to preventing tobacco use. Specifically, funds should be allocated according to New Hampshire's Tobacco Prevention Workgroup recommendations, which are as follows:

- community programs that provide grants to community organizations for tobacco prevention and education at the community level.
- partnerships with the Department of Education and local schools for the delivery and support of tobacco prevention education curriculum and the implementation of tobacco-free school campuses.
- provide grants to statewide public and private organizations to address special populations and build resources to assist those communities.
- AN enhanced statewide media campaign utilizing national and local media material to counter tobacco-use appeal.
- Provide support for cessation and treatment programs utilizing existing methods and programs and investigate new interventions.
- Develop and utilize surveillance and evaluation systems to assess the effectiveness of programmatic, policy, media and research efforts.
- Provide education to decision-makers on the importance of public health policies that promote tobacco use reduction.

In summary: tobacco tax increases coupled with an aggressive, comprehensive, and sustained approach to preventing tobacco use funded by tobacco money, will have a tremendous impact on the heath of the citizens of New Hampshire. At the same time, it will greatly reduce the health care cost incurred by the state and its taxpayers.

Honorable Chair and Members of the Committee, thank you for your time. If you have any questions, I would be happy to answer them.

New Hampshire Association of Counties

John M. Disko
Executive Director

95 North State Street, Suite 2
Concord, New Hampshire 03301-4334

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Clerk
Carol Holden
Hillsborough County Commissioner

Treasurer
Suzanne Collins
Coos County Administrator

Executive Director
John M. Disko

MEMO

TO: Public Institutions, Health & Human Services

FROM: Commissioner George Maglaras
Chairman, Tobacco Settlement Committee
John M. Disko, Executive Director
New Hampshire Association of Counties

DATE: April 27, 1999

SUBJECT: Tobacco Settlement Report

The following report was commissioned by the New Hampshire Association of Counties to support their position of entitlement to a portion of the tobacco settlement funds.

The information contained in this report will enable you to make an informed decision regarding this very complex issue.

If you have any questions, please call the New Hampshire Association of Counties Executive Director, John M. Disko at 224-9222.

NURSING HOME EXPENDITURES ATTRIBUTABLE TO SMOKING, NEW HAMPSHIRE COUNTIES: 1970 – 2003

Jeffrey E. Harris MD PhD[1]
March 23, 1999

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Table 5. Range of Estimates of Smoking-Attributable Fraction for Nursing Home Costs

Table 6. Computation of Present Discounted Value of Smoking-Attributable Expenditures by New Hampshire Counties on Nursing Home Care, 1970–2003

[1] The opinions expressed in this report are the author's sole responsibility. They do not necessarily represent the views of the Massachusetts Institute of Technology, the Massachusetts General Hospital, the New Hampshire Association of Counties, the New Hampshire Legislative Budget Assistant Office, New Hampshire HHS, or any other organization.

A. SUMMARY

1. This report estimates county expenditures on nursing home care that are attributable to cigarette smoking.

2. On the basis of data from state appropriations reports and state reports on Medicaid spending, historical expenditures by New Hampshire counties on nursing home care are estimated for fiscal years 1970–1998. Future long-term care expenditures by counties are projected for fiscal years 1999–2003, based upon the expenditure caps in Senate Bill 409 (1998 Session Law Chapter 388:8 (IV)).

3. County expenditures for nursing home care increased from an estimated $723 thousand in 1970, to $8.239 million in 1980, to $28.794 million in 1990, to $51.365 million in 1998. In fiscal year 2003, county expenditures for nursing home care and other forms of home- and community-based long-term care are projected to reach $66 million.

4. Smoking is widely recognized by medical and scientific authorities as a cause of disease and disability. Smokers have been found to have higher health care costs than non-smokers. Economists have estimated that from 1.5 to 25 percent of nursing home costs are attributable to smoking. In this report, a conservative estimate smoking-attributable fraction of 6.6 percent is assumed.

5. Estimated smoking-attributable expenditures by New Hampshire counties increased from $48 thousand in 1970, to $544 thousand in 1980, to $1.9 million in 1990, to $3.39 million in 1998, and are projected to rise to $4.356 million in 2003.

6. Based upon historical and projected interest rates on long-term government securities, the present discounted value of smoking-attributable expenditures by New Hampshire counties during 1970–2003 is an estimated $108.189 million.

7. The present discount value of county nursing home expenditures during 1970–1998 was equal to 8.91 percent of the present discounted value of the state's total computable Medicaid spending during the same time period. If the state's receipts under the Master Settlement Agreement over the next 25 years were allocated in proportion to the counties' share of Medicaid spending, then the counties' expected receipts would equal $116.261 million.

B. INTRODUCTION

This report, prepared at the request of the New Hampshire Association of Counties,[2] estimates county expenditures on nursing home care that are attributable to cigarette smoking.

The analysis proceeds in four main steps:

First, total New Hampshire county expenditures on nursing home care are estimated for the years 1970 through 2003.

Second, the proportion of total nursing home expenditures that is attributable to smoking – often called the "Smoking-Attributable Fraction" or "SAF" – is derived from a review of the literature on smoking in relation to nursing home costs.

Third, smoking-attributable expenditures on nursing home care by New Hampshire counties are computed as total nursing home expenditures multiplied by the applicable smoking-attributable fraction (SAF).

Fourth, the present discounted value of smoking-attributable expenditures for the years 1970–2003 combined is then computed.

C. TOTAL COUNTY EXPENDITURES ON NURSING HOME CARE

This report covers the period from fiscal year 1970 through fiscal year 2003.

A starting year of 1970 has been chosen to approximate the beginning of the state's Medicaid program. A similar starting year was used in most expert reports on financial damages in Attorneys General (AG) lawsuits against the tobacco industry.[3]

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[2] New Hampshire Association of Counties, 95 North State Street, Concord NH 03301. The author's primary contact was John Disko, Executive Director.

[3] See, for example: Miller, Vincent P., *Cigarette Smoking-Attributable Medical Care Costs Incurred by the State of Mississippi, 1970–2000*, December 13, 1996; Max, Wendy. *Estimation of Smoking-Attributable Public Expenditures for the State of Mississippi, 1970–2000*, December 10, 1996; Miller, Vincent M., *Cigarette Smoking-Attributable Medical Care Costs Incurred by the State of Texas, 1967–2007*, June 14, 1997; Max, Wendy. *Estimation of Smoking-Attributable Public Expenditures for the State of Washington, 1970–2001*, November 3, 1997; Harris, Jeffrey E., *Health-Care Spending Attributable to Cigarette Smoking and to Cigarette Manufacturers' Anti-Competitive Conduct: State of Washington Medicaid Program, 1970-2001*, January 5, 1998; Harris, Jeffrey E., *Health-Care Spending Attributable to Tobacco Manufacturers' Anti-Competitive Conduct: State of Connecticut Medicaid Program, 1970-2001*,

Future projections of county expenditures have been extended to fiscal year 2003. This future horizon is consistent with the provisions of 1998 Senate Bill 409.[4] Many expert reports in AG lawsuits included the projection of future damages into the first decade of the next century.[5]

In the analysis of the historical period 1970–1998, this report focuses exclusively on county payments for nursing home care. Other county payments, including Old Age Assistance (OAA) and Aid to the Permanently and Totally Disabled (APTD), have been excluded. For the future period 1999–2003, the report includes payments not only for nursing home care, but also for other forms of home- and community-based long term care, as provided for in Senate Bill 409.

Estimates of county expenditures for the historical period 1970–1998 entailed analyses of two different data sources. Data for the more recent years, 1984–1998, were based upon monthly statements of appropriations, which were compiled by the Legislative Budget Assistant Office (LBAO). Data for prior years, 1970–1983, were based upon quarterly statements of medical assistance payments (now called Form HCFA-64 reports) by the New Hampshire Medicaid program to the federal government. Accordingly, the analysis of the historical period 1970–1998 is divided into two sections below.

1. Historical Expenditures, 1984–1998

June 11, 1998; Cutler, David M., Epstein, Arnold M, Frank, Richard G, et al: *The Impact of Smoking on Medicaid Spending in Massachusetts: 1970–1997*, June 15, 1998; Miller, Leonard S., Wyant, Timothy, Zeger, Scott L., *State Funded Smoking Attributable Medical Expenditures, Maryland, 1970–1996* (including projections to 2025), July 28, 1998; Harris, Jeffrey, E. *Health-Care Spending Attributable to Tobacco Use and Proportion of Health-Care Spending Attributable to Tobacco Manufacturers' Anti-Competitive Conduct:State of Oregon Medicaid Program, 1969-1999*, October 5, 1998; Three exceptions are: Harrison, Glenn W., *Health Care Expenditures Attributable to Smoking in Oklahoma* (covering state charity care payments since 1957), April 27, 1998; Wyant, Timothy, et al. *Estimation of the State of Minnesota's Smoking-Attributable Medical Expenditures, 1978–1996*, June 14, 1998; and Harris, Jeffrey E., *Health-Care Spending Attributable to Cigarette Smoking and to Cigarette Manufacturers' Anti-Competitive Conduct: State of Arizona Medicaid Program, 1983-2001*, February 5, 1998; Harris, Jeffrey E., *Estimates of Smoking-Attributable Medicaid Expenditures in Florida* (covering 1995–1997 only), April 15, 1997. In some states, the starting date of damage claims was controlled by statute of limitations or by the date of enactment of enabling legislation.

[4] SB 409-FN-Final Version (Chapter 388, Long Term Care). Enacted 1998. See 388:8, "Reimbursement of Funds for Persons Eligible to Receive Nursing Home Services; Limitation on County Payments" (Amending RSA 167:18-b), Section IV: "Total Reimbursement by All Counties."

[5] See footnote 3 above.

Table 1 shows computed expenditures by New Hampshire counties on nursing home care for state fiscal years 1984 through 1998. The data in the Table were taken from an analysis of monthly statements of appropriation performed by Mary Jane Turcotte at LBAO in consultation with John Fransway, Medicaid Administrator, HHS. A copy of the LBAO analysis, dated 3/12/99, is attached as an Appendix to this Report.[6]

2. Historical Expenditures, 1970–1983

LBAO could not identify comparable appropriations data on state or county nursing home expenditures for the years prior to fiscal year 1984. Accordingly, for the period 1970–1983, county expenditures for nursing home services were estimated from quarterly form HCFA-64 reports on medical assistance payments filed by the New Hampshire Medicaid program.[7]

Table 2 compares data from HCFA-64 reports with appropriations data on nursing home expenditures during the years 1970 through 1989. Prior to 1980, there were data only on total medical assistance payments by the New Hampshire Medicaid program (the second column of the Table).

From 1980 onward, the available HCFA-64 reports showed a breakdown of medical assistance payments. In particular, two categories of Medicaid payments were most comparable to nursing home expenditures: payments to Skilled Nursing Facilities (SNF); and payments to Intermediate Care Facilities (ICF) other than mental health facilities. Combined payments for these two categories are shown in the third column of the Table. The last column shows

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[6] The expenditures in Table 1 generally fall below those given in the supporting documentation to the recently filed bill S. 206. Thus, for the fiscal years 1986–1998 combined, the LBAO analysis in Table 1 yields total county expenditures of $433,686,670 on nursing home care, while the S.206 analysis yields total county expenditures of $477,788,325 on nursing home care. Accordingly, if the data in the S. 206 analysis had been used in this report instead of the LBAO data, then the estimates of smoking-attributable expenditures in this report would be higher.

[7] Data on Current Expenditures for FFY 1970–1983 derive from tabulations entitled "Medical Assistance Payments," based upon: HCFA Form OA-41 Line 12, Current Expenditures, for federal fiscal year (FFY) 1970 through the first quarter of FFY 1979; and HCFA-64, Line 6, Current Expenditures, for the second quarter of FFY 1979 through FFY 1983. Data for FFY 1984–1987 derive from tabulations entitled "Medical Assistance Payments, Summary of Total Payments Computable for Federal Funding." Data for FFY 1988–1990 derive from Medicaid Financial Management Report, "Medicaid Assistance Payments, Total Computable." Data for FFY 1991–1998 derive from HCFA-64 quarterly reports reported at: Health Care Financing Administration, *Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program HCFA-64*. Internet: http://www.hcfa.gov/medicaid/ofs-64.htm. In FFY 1984, Form HCFA-64 was modified to distinguish between Total Computable Expenditures (line 6) and Total Net Expenditures (line 11). For consistency with prior years, this report relies on Total Computable Expenditures (line 6), where applicable.

data on total nursing home payments, based upon state appropriations data analyzed by LBAO.

During the years 1980–1983, reported combined payments for Skilled Nursing Facilities and Other Intermediate Care Facilities comprised an average of 61.4% of total state medical assistance payments under Medicaid (calculated from Table 2). During 1984–1989, however, total state nursing home payments equaled only 95.0% of combined SNF and Other ICF payments (also calculated from Table 2). The product of 61.4% and 95.0%, which equals 58.3%, represents a best estimate of the proportion of all medical assistance payments devoted to nursing home care in the pre-1983 period.

Accordingly, for the years 1970–1983, county nursing home payments were estimated by the following formula:

County Nursing Home Expenditures	=	HCFA-64 Medical Assistance Payments	×	58.3%	×	Non-Federal Share of Medicaid Spending	×	County Share of Non-Federal Medicaid Spending

The non-federal share of Medicaid spending (that is, the proportion of all Medical Assistance Payments that were not reimbursed by the federal government) was derived from HCFA-64 reports. The county share of non-federal Medicaid spending was taken to be 50% during 1970–1980 (Chapter 423:6, effective 6/30/73) and 62.5% during 1981–1983 (Budget Footnotes).

Table 3 shows the resulting calculations of county expenditures on nursing home care for fiscal years 1970–1983, based upon the formula presented above.

3. Projected Expenditures, 1999–2003

Senate Bill 409 (1998 Session Laws Chapter 388:8 (IV)) provided for caps on the counties' total expenditures for all forms of long-term care, including nursing home care and other forms of home- and community-based care. Table 4 shows the limits on total county payments.

In the analysis below, this Report assumes that total county long-term care payments will reach their maximum values.

D. SMOKING-ATTRIBUTABLE FRACTION

There is a long-standing, world-wide consensus among the medical and

scientific community that tobacco use and, in particular, cigarette smoking causes or exacerbates a number of diseases. The major health effects of cigarette smoke include: cancer (lung, esophagus, oral cavity, larynx, pancreas, kidney, urinary bladder, and other organs); non-cancerous lung diseases (chronic obstructive lung disease and emphysema); diseases of the heart and blood vessels (coronary heart disease, strokes, peripheral vascular disease, aortic aneurysm, and other circulatory diseases); and toxicity to the human reproductive system (low birth weight and complications of pregnancy, early menopause, osteoporosis, and other toxic effects). Cigarette smoking also has well-documented adverse effects on overall morbidity, including absenteeism and disability days.[8]

The diseases caused by cigarette smoke are expensive to treat. Accordingly, it come as no surprise that economists and medical scientists have found that both current and former smokers have higher health-care costs than people who have never smoked.[9]

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[8] *Reducing the Health Consequences of Smoking, 25 Years of Progress: A Report of the Surgeon General.* Washington, D.C.: U.S. Department of Health and Human Services, 1989. See also: Harris, Jeffrey E. "Cigarette Smoke Components and Disease: Cigarette Smoke is More Than a Triad of Tar, Nicotine, and Carbon Monoxide," in *The FTC Cigarette Test Method for Determining Tar, Nicotine, and Carbon Monoxide Yields of U.S. Cigarettes: Report of the NCI Expert Committee.* National Cancer Institute. Smoking and Tobacco Control Monograph 7, 1996: 59–75.

[9] Anderson D, Brink S, Courtney TD. *Health Risks and Their Impact on Medical Costs: A study by Milliman & Robertson, Inc., StayWell Health Management Systems, Inc. in conjunction with the Chrylser Corporation and the International Union, UAW.* Brookfield WI: Milliman & Robertson, Inc., 1995; Bertera, RL. The effects of behavioral risk on absenteeism and health care costs in the workplace. *J Occupational Med* 1991; 33(11):1119–24; Bluhm WF. *Blue Cross and Blue Shield of Minnesota Non-Group Rating Factor Study: Non-Maternity Analysis.* Milliman & Robertson, November 27, 1991; Brink SD. *Health Risks and Behavior: The Impact on Medical Costs. A preliminary study by Milliman & Robertson, Inc. and Control Data.* Brookfield WI: Milliman & Robertson, Inc., 1987; Coronary Drug Project Research Group. Cigarette smoking as a risk factor in men with a prior history of myocardial infarction. *Journal of Chronic Diseases* 1979; 92:415-25; Daviglus, M.L., Liu, K, Greenland, P., et al. Benefit of a favorable cardiovascular risk-factor profile in middle age with respect to Medicare costs. *New England Journal of Medicine* 1998; 339:1122-1129; Freeborn, Donald K, Mullooly, John P., Pope, Clyde R., and McFarland, Bentson H., Smoking and Consistently High Use of Medical Care among Older HMO Members. *American Journal of Public Health* 1990; 80:603–605; Gorski L, Shanklin L. *Results of Field Test of Smoker/Non-Smoker Experience Exhibit.* National Association of Insurance Commissioners (NIAC), (EX5) Subcommittee's Life & Health Actuarial Task Force. Springfield IL: Illinois Dept. of Insurance, June 23, 1987; Halpern, M.T.; Warner, K.E. Differences in former smokers' beliefs and health status following smoking cessation. *American Journal of Preventive Medicine* 1994; 10:31-37; Hammond EC. Smoking in relation to mortality and morbidity. Findings in first thirty months of follow-up in a prospective study started in 1959. *Journal of the National Cancer Institute* 1964; 32:1161–1188; Hodgson TA. Cigarette smoking and lifetime medical expenditures. *Milbank Quarterly* 1992; 70:81–125; Leigh JP, Fries JF. Health habits, health care use and costs in a sample of retirees. *Inquiry* 1992; 29:44–54; Manning WG, Keeler EB, Newhouse JP, Sloss EM, Wasserman J. *The Costs of Poor Health*

The extent to which smoking contributes to health care spending in a particular population can be summarized by the *smoking-attributable fraction* (abbreviated "SAF"). The SAF represents the proportion of all health care expenditures in the population that are caused by cigarette use.[10] The SAF is an application of the well-known concept of population attributable risk, which has been routinely used by medical scientists since the 1950s.[11] Public health specialists have repeatedly employed the concept of attributable risk to estimate smoking-attributable health-care costs in many states[12] (including New Hampshire[13]) and

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Habits. Cambridge MA: Harvard University Press, 1991; Marsden, M.E. Bray, R.M. Herbold, J.R. Substance Use and Health Among U.S. Military Personnel: Findings From the 1985 Worldwide Survey. *Preventive Medicine* 1988; 17(3):366-376; Oakes, T.W., Friedman, G.D., Seltzer, C.C., et al. Health service utilization by smokers and nonsmokers. Medical Care 1974; 12:958–66; Penner M, Penner S. Excess insured health care costs from tobacco-using employees in a large group plan. *J Occupational Med* 1990; 32:521–3; Rice DP, Hodgson TA, Sinsheimer P, Browner W, Kopstein AN. The economic costs of the health effects of smoking, 1984. *Milbank Quarterly* 1986; 64:489–547; Schauffler, H.H.; D'Agostino, R.B.; Kannel, W.B. Risk for cardiovascular disease in the elderly and associated Medicare costs: the Framingham study. *American Journal of Preventive Medicine* 1993; 9:146-154; Vogt TM, Schweitzer SO. Medical costs of cigarette smoking in a health maintenance organization. *Amer J Epidemiology* 1985; 122:1606–6; Wagner EH, Curry SJ, Grothaus L, et al. The impact of smoking and quitting on health care use. *Archives of Internal Medicine* 1995; 155:1789–95; Yen, Louis Tze-ching, Edington DW, Witting P. Associations between health risk appraisal scores and employee claims costs in a manufacturing company. *American Journal of Health Promotion* 1991; 6:46–54.

[10] Bartlett JC, Miller LS, Rice DP, Max WB, et al. Medical care expenditures attributable to cigarette smoking– United States, 1993. *Morbidity and Mortality Weekly Report* 1994; 43:469–72; Shultz JM, Novotny TE, Rice DP. Quantifying the disease impact of cigarette smoking with SAMMEC II software. *Public Health Reports* 1991; 106:326–33.

[11] Harris JE. "Trends in Smoking-Attributable Mortality," *op. cit.*

[12] See, for example: Breukelman FN, Zeitz PS, Novotny TE. Smoking in Delaware: Economic costs and deaths attributable to cigarette smoking in the State, 1985; *Delaware Medical Journal* 1988 (Dec.); 60:735–39; Goldbaum GM, Ostroff SM, Novotny TE. The costs of smoking for Washington State. *Washington Public Health* 1989; 7:37–8; Hinds MW. Medical care costs attributable to cigarette smoking in Kentucky. *Southern Medical Journal* 1986; 79:665–8; Lynch TA, Hopkins RS. Estimating tobacco-related health-care and mortality costs in Florida. *Journal of the Florida Medical Association* 1996; 83:128–33; Vermont Department of Public Health. The public health impact and economic costs of cigarette smoking, Vermont, 1985. *Disease Control Bulletin*, May 1987; Miller LS, Zhang X, Novotny T, Rice DP, Max W. State estimates of Medicaid expenditures attributable to cigarette smoking, fiscal year 1993. *Public Health Reports* 1998; 113:140–151.

[13] Kiely, Marie, and Steiger, Lorie, *Smoking-Attributable Mortality, Morbidity and Economic Costs (SAMMEC): New Hampshire 1991*. Concord NH: Chronic Disease Epidemiology Program, New Hampshire Division of Public Health Services. NHDPHS Publ. #93-019, September 28, 1993. The cited report estimated that New Hampshire nursing home expenditures attributable to smoking were $8.832 million in 1991.

in foreign countries.[14] In the United States, most estimates of the smoking-attributable fraction for all health care spending generally fall in the range of 5 to 9 percent, with a mid-point of approximately 7 percent.[15]

Computation of smoking-attributable expenditures for an entire population does not require a case-by-case determination of the costs of smoking for each individual in the population. The computation takes advantage of the well-known "law of large numbers" in the mathematical theory of probability.[16] For example, 2 percent of people who receive penicillin become sensitized to the drug. While it may be difficult or impractical to identify each and every individual who has developed drug hypersensitivity, one can confidently estimate that 2 percent of every one million recipients of penicillin has a drug allergy. Similarly, the scientific validity of the estimate that 7 percent of health-care expenditures are caused by smoking does not hinge upon the ability to name the names of each person who ran up medical bills from smoking-related diseases.

1. Smoking-Attributable Fraction for Nursing Home Care

The diseases caused or aggravated by smoking comprise a significant proportion of the admission diagnoses to nursing homes in this country. In an analysis of the distribution of primary diagnoses among 5,726 nursing home residents in the 1987 National Medical Expenditure Survey, Harris found that 32.5% of the person-days and 36.7% of the admissions to nursing homes represented individuals with smoking-related diagnoses.[17]

Recently published econometric studies and expert reports in AG law suits have supported the finding that smokers are more likely to be admitted to nursing homes than non-smokers. The estimated smoking-attributable fractions, however, have varied considerably. The range of estimates is shown in Table 5 below.

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[14] See, for example: Health Department of Western Australia. *Smoking-Attributable Economic Costs in the Australian States and Territories, 1984.* Perth, Australia: Health Department of Western Australia, 1987.

[15] Bartlett JC, Miller LS, Rice DP, Max WB, et al. Medical care expenditures attributable to cigarette smoking– United States, 1993. *Morbidity and Mortality Weekly Report* 1994; 43:469–72. Smoking-attributable fractions for persons aged 19+ were estimated to be: 7.1% for physician services; 2.6% for prescription drugs; 7.5% for hospital care; 7.0% for home health care; 6.6% for nursing home care; and 7.1% overall (Table 1).

[16] Mosteller F, Rourke R.E.K, Thomas, G.B. Jr. *Probability with Statistical Applications*, 2nd Edition. Reading, Ma.: Addison-Wesley, 1970; p. 231.

[17] Harris, Jeffrey E., *Distribution of Primary Diagnoses Among 5,726 Nursing Home Residents in the 1987 National Medical Expenditure Survey (Public Use Tape 8)*, unpublished, October 1998.

In an expert report in the Maryland case, Leonard Miller, Timothy Wyant and Scott Zeger estimated that 1.59 percent of that state's nursing home expenditures during 1970–1997 were attributable to smoking.[18] In testimony in the Minnesota case, Wyant estimated smoking-attributable nursing home expenditures to be 3 percent of all Medicaid nursing home costs in that state during 1978–1996.[19] In an expert report in the Massachusetts Case, Cutler and colleagues estimated that smoking caused 5.3 percent of nursing home stays.[20] In a 1994 article published in the Center for Disease Control's weekly *MMWR*, Barlett and colleagues estimated a SAF for nursing home care of 6.6 percent nation wide.[21] In an expert report in the Oklahoma case, Harrison, based upon an analysis of data from the National Health and Nutrition Examination Survey (NHANES),[22] estimated a SAF for nursing home care of 6.8 percent.[23] In a recent paper in *Public Health Reports*, Leonard Miller and colleagues estimated a SAF of 18.92 percent for nursing home care in New Hampshire and 15.91 percent nationwide.[24] Their 95% confidence interval on the nationwide SAF was

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[18] Miller, Leonard S., Wyant, Timothy, and Zeger, Scott L. *State Funded Smoking Attributable Medical Expenditures: Maryland, 1970–1997. Updated Calculations*, October 22, 1998, Table 1. In their original Maryland report, Len Miller and colleagues estimated a nursing home smoking-attributable fraction of 2.5 percent. See: Miller, Leonard S., Wyant, Timothy, and Zeger, Scott L. *State Funded Smoking Attributable Medical Expenditures: Maryland, 1970–1996.*, July 28, 1998, Table 5.

[19] *State of Minnesota, et al. v. Philip Morris, et al.*, Testimony of Timoth S. Wyant, February 26–27, 1998 (Volumes 28–29). See, in particular, Trial Exhibit 30,203, "State Expenditures Attributable to Smoking by Disease Category. Full Model, 1978–1996." No details of the nursing home analysis, including uncertainty ranges, are given.

[20] Cutler, David M., Epstein, Arnold M, Frank, Richard G, et al. *The Impact of Smoking on Medicaid Spending in Massachusetts: 1970–1998: Results from the Inclusive Approach for Adults*, July 1, 1998. The estimate in the text is based on: the authors' estimate that smoking was responsible for 7.4 percent of nursing home stays among men and 4.6 percent of nursing home stays among women (Table I.9); and their calculations of Medicaid smoking-attributable expenditures for long-term care during 1991–1998 (Table I.12).

[21] Bartlett JC, Miller LS, Rice DP, Max WB, et al. Medical care expenditures attributable to cigarette smoking– United States, 1993. *Morbidity and Mortality Weekly Report* 1994; 43:469–72, Table 1. The SAF for home health care was 7.0 percent.

[22] Harrison, Glen W. *Medicaid Expenditures Attributable to Smoking in Oklahoma*. April 27, 1998, Department of Economics, College of Business Administration, University of South Carolina, April 27, 1998, 51 pp.. A one-equation probit model of the probability of nursing home admission was estimated. In addition to smoking practices, the independent variables included body weight, history of arthritis, gout, heart attack, activity limitation, and alcohol use (pp.31–32).

[23] Harrison, op. cit., p. 41.

[24] Miller LS, Zhang X, Novotny T, Rice DP, Max W. State estimates of Medicaid expenditures attributable to cigarette smoking, fiscal year 1993. *Public Health Reports* 1998; 113:140–151, Table 3. The respective SAF's for home health services were 9.64% for New Hampshire and 8.02% nationwide.

8.44 to 21.58 percent.[25] In a report to the Robert Wood Johnson Foundation, Vincent Miller and colleagues estimated a smoking-attributable fraction of 19.29 percent for nation-wide Medicaid expenses and 24.68 percent specifically for New Hampshire Medicaid expenses.[26]

The present report uses the median SAF of 6.6 in Table 5. As previously noted, this conservative estimate closely approximates the estimated smoking-attributable fraction for all health care services.

E. PRESENT DISCOUNTED VALUE OF COUNTY EXPENDITURES ON NURSING HOME CARE THAT ARE ATTRIBUTABLE TO SMOKING

Table 6 shows estimates of smoking-attributable spending, based upon the estimates of total spending derived in Sections B and C and the smoking-attributable fraction derived in Section D. In conformity with expert reports filed in AG cases against the tobacco industry, this report computes the present discounted value of smoking-attributable expenditures by New Hampshire counties. For this purpose, the historical annual rates of return on long-term US government bonds were used.

The right-most column of Table 6 shows the computed present discounted values. The cumulative present discounted value of smoking-attributable expenditures during 1970–2003 (that is, the sum of the entries in the right-most column of the Table) equals $108.189 million.

F. COMMENT

The present analysis assumed that 6.6 percent of county nursing home costs were attributable to smoking. On the basis of this assumption, the present discounted value of smoking-attributable nursing home spending by New Hampshire counties totaled $108.189 million. By way of sensitivity analysis, if the recently estimated smoking-attributable fraction of 18.92% for New Hampshire nursing home care[27] had been assumed instead, then the present

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[25] Miller LS, Zhang X, Novotny T, Rice DP, Max W. 1998, op. cit. Table 5.

[26] Miller VP, James CR, Ernst C, Collin F. *Smoking-Attributable Medical Care Costs: Models and Results.* Berkeley CA: Berkeley Economic Research Associates, September 3, 1997, Tables 5.5, 5.6 and 5.7 Revised. The 95% confidence range around the New Hampshire estimate was ±4.6% (based upon Table 5.6). In 1993, the estimated smoking-attributable Medicaid nursing home expenses in New Hampshire was $36.41 million (Table 5.8 Revised).

[27] Table 5, note A.

discounted value smoking-attributable nursing home spending by New Hampshire counties would be $310.141 million.[28] Alternatively, if the extremely conservative SAF of 1.59 percent had been used, then the present discounted value of smoking-attributable expenditures would equal $26.064 million.[29] The median estimate of $108.189 million thus falls much closer to the conservative end of the range of possible estimates.

The present discounted value of New Hampshire's total computable Medicaid expenditures during 1970–1998 was $15.278 billion, while the corresponding present discounted value of county spending on nursing home care during the same period was $1.370 billion. (Details of calculations not shown.) Thus, historical spending by counties constituted 8.91 percent of total Medicaid spending. New Hampshire's receipts from the Master Settlement Agreement over 25 years have been reported to total $1,304.689 million.[30] If counties' share of settlement payments were computed solely on the basis of their share of Medicaid spending, then their expected share over 25 years would equal $116.261 million,[31] an estimate that is quite close to the value of smoking-attributable spending reported above.

[28] Computed as $108.189 million × 18.92% ÷ 6.6%.

[29] Computed as $108.189 million × 1.59% ÷ 6.6%.

[30] New Hampshire Attorney General's Office, Tobacco Settlement Briefing, March 1999.

[31] That is, 8.91% multiplied by $1,307.357 million.

Table 1. Expenditures on Nursing Home Care by New Hampshire Counties, State Fiscal Years 1984–1998

State Fiscal Year	County Expenditures on Nursing Home Care ($ 000)
1984	14,510
1985	15,103
1986	16,206
1987	18,496
1988	21,523
1989	24,708
1990	28,794
1991	34,634
1992	39,816
1993	20,848
1994	36,123
1995	42,030
1996	52,144
1997	46,999
1998	51,365

Source: Analysis by Mary Jane Turcotte (LBAO) in consultation with John Fransway (Medicaid administrator, HHS), 3/12/99.

Table 2. Comparison of HCFA-64 and New Hampshire Appropriations Data on Total Nursing Home Expenditures, 1970–1989

Fiscal Year [a]	HCFA-64 Medical Assistance Payments ($ 000) [b]	HCFA-64 SNF plus Other ICF Payments ($ 000) [c]	Appropriations Total State Nursing Home Payments ($ 000) [d]
1970	6,074		
1971	7,072		
1972	9,675		
1973	11,518		
1974	22,689		
1975	28,597		
1976	43,589		
1977	45,891		
1978	50,249		
1979	61,485		
1980	72,820	44,504	
1981	84,610	50,351	
1982	87,965	56,129	
1983	96,914	59,138	
1984	110,967	57,374	52,177
1985	120,607	59,480	55,190
1986	134,987	49,986	59,893
1987	143,663	71,746	63,278
1988	169,132	78,301	72,856
1989	194,575	88,983	82,105

a. For HCFA-64 reports, federal fiscal year; for appropriations data, state fiscal year. For 1976, HCFA-64 data include transition quarter.
b. Derived from HCFA-64 Line 6 (Total Computable Expenditures).
c. Derived from HCFA-64 Line 2 (Skilled Nursing Facility Payments) plus HCFA-64 Line 3C (Intermediate Care Facility Payments, Other).
d. Derived from LBAO analysis of appropriations data.

Table 3. Computations of New Hampshire County Expenditures for Nursing Home Care, Fiscal Years 1970–1983

Fiscal Year	Nursing Home Expenditures ($ 000) [a]	Non-Federal Share (%) [b]	Non-Fed. Nursing Home Expenditures ($ 000) [c]	County Nursing Home Expenditures ($000) [d]
1970	3,541	40.8	1,446	723
1971	4,123	40.8	1,683	842
1972	5,641	40.6	2,292	1,146
1973	6,715	40.6	2,729	1,365
1974	13,228	38.0	5,020	2,510
1975	16,673	38.0	6,328	3,164
1976	25,413	39.6	10,076	5,038
1977	26,756	39.6	10,591	5,296
1978	29,296	37.1	10,856	5,428
1979	35,847	37.1	13,292	6,646
1980	42,456	38.8	16,479	8,239
1981	49,329	38.9	19,184	11,990
1982	51,286	40.6	20,817	13,011
1983	56,503	40.6	22,912	14,320

a. HCFA-64 Medical Assistance Payments (Table 2) multiplied by 58.3%.
b. Derived from HCFA-64 reports.
c. Nursing Home Expenditures (2nd column) multiplied by non-Federal share (3rd column).
d. Non-Federal Nursing Home Expenditures (4th column) multiplied by 50% for 1970–1980 and by 62.5% for 1981–1983.

Table 4. Limits on Total County Spending for Nursing Home Care and Other Home- and Community-Based Long Term Care, Fiscal Years 1999–2003.

Fiscal Year	Maximum County Payments ($ 000)
1999	54,000
2000	57,000
2001	60,000
2002	63,000
2003	66,000

Source: SB 409-FN-Final Version (Chapter 388, Long Term Care). Enacted 1998. (See footnote 4.)

Table 5. Range of Estimates of Smoking-Attributable Fraction for Nursing Home Costs.

Authors	State (or US)	Smoking-Attributable Fraction (%)
L. Miller, Wyant and Zeger	MD	1.59
Wyant	MN	3.00
Cutler et al.	MA	5.30
Bartlett et al.	US	6.60
Harrison	OK	6.80
L. Miller, Zhang et al.[a]	US	15.91
V. Miller et al.[b]	US	19.29

Sources: See text.
Notes:
a. Estimated SAF for New Hampshire was 18.92%.
b. Estimated SAF for New Hampshire was 24.68%.

Table 6. Computation of Present Discounted Value of Smoking-Attributable Expenditures by New Hampshire Counties on Nursing Home Care, 1970–2003.

Fiscal Year	Expenditures on Nursing Home Care ($000) [a]	Smoking-Attributable Expenditures ($000) [b]	Long Term Rate on Government Bonds (%)	1999 Present Discounted Value of Smoking-Attributable Expenditures ($ 000) [c]
1970	723	48	6.48	295
1971	842	56	5.97	282
1972	1,146	76	5.99	364
1973	1,365	90	7.26	557
1974	2,510	166	7.60	1,034
1975	3,164	209	8.05	1,339
1976	5,038	333	7.21	1,649
1977	5,296	350	8.03	1,912
1978	5,428	358	8.98	2,180
1979	6,646	439	10.12	3,016
1980	8,239	544	11.99	4,676
1981	11,990	791	13.34	7,538
1982	13,011	859	10.95	5,023
1983	14,320	945	11.97	5,769
1984	14,510	958	11.70	5,035
1985	15,103	997	9.56	3,579
1986	16,206	1,070	7.89	2,871
1987	18,496	1,221	9.20	3,510
1988	21,523	1,421	9.18	3,733
1989	24,708	1,631	8.16	3,573
1990	28,794	1,900	8.44	3,941
1991	34,634	2,286	7.30	4,016
1992	39,816	2,628	7.26	4,292
1993	20,848	1,376	6.54	2,012
1994	36,123	2,384	7.99	3,501
1995	42,030	2,774	6.03	3,506
1996	52,144	3,441	6.73	4,184
1997	46,999	3,102	5.92	3,480
1998	51,365	3,390	5.50	3,577
1999	54,000	3,564	5.50	3,564
2000	57,000	3,762	5.50	3,566
2001	60,000	3,960	5.50	3,558
2002	63,000	4,158	5.50	3,541
2003	66,000	4,356	5.50	3,516

a. From Tables 1, 3, and 4.
b. Total expenditures (2nd column) multiplied by SAF of 6.6%.
c. For 1970–1996, the source is Ibbotson Associates, *SBBI 1997 Yearbook*, Table A-9, "Long Term Government Bonds: Yields," pp. 196-197. The year-end closing value for 1997 is from Bloomberg Business News. The rate of 5.50% for all remaining years is based on 3/19/99 close for 30-year treasury notes.
d. Smoking-attributable expenditures (3rd column) multiplied by $(1 + r)^T$, where r is the interest rate and T is the number of years since 1999.

LBAO (mjt) 3/18/99

County Expenditures for Nursing Homes
FY 84-FY 98

BACKGROUND:

RSA 167:18a addresses county payments for Aid to the Permanently and Totally Disabled (APTD) and Old Age Assistance (OAA)

RSA 167:18b addresses county payments for Nursing Homes

Changes to RSA 167a and b:

Year	Chapter	APTD	OAA	Nursing Homes	Federal Share	Effective
1973	423:6	35%	25%	50% of non federal share=25%	FY 84-87=54.92	6/30/73
		50%	50%		FY 88-98=50%	1/1/74
1985	380:33, 394:10	50%	50%	61.5% of non-federal share=30.75%		7/1/85
1993	358:99			61.1% of non-federal share=30.55%		12/1/93

Appropriation Numbers from the Statement of Appropriations, Dept. of Administrative Services, FY 1984 THROUGH FY 1998

FY	APTD, OAA	Nursing Homes
84-87	025-045-1460	025-045-1470
88-97	025-045-6170	025-045-6173
'98	025-045-6170	025-048-6173

County Revenues/Expenditures **is reflected in Private/Local Funds below.** Base numbers were from the Statement of Appropriations, Dept. of Administrative Services, FY 1984 through FY 1998, 005 Private/Local Funds actual revenues, **adjusted for audit funds and Proshare.**

	FY 1984	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
005 Private/Local Funds	$ 14,509,698	$ 15,103,379	$ 16,206,367	$ 18,495,708	$ 21,523,323	$ 24,708,160	$ 28,794,343	$ 34,633,626
Nursing Homes Total	$ 52,177,235	$ 55,190,284	$ 59,893,060	$ 63,277,825	$ 72,855,929	$ 82,104,943	$ 91,831,487	$ 112,505,532
Federal Share	28,655,737	30,310,504	32,893,269	31,638,912	37,324,072	41,039,990	45,915,744	56,260,092
Total minus Federal	$ 23,521,497	$ 24,879,780	$ 26,999,792	$ 31,638,912	$ 35,531,857	$ 41,064,953	$ 45,915,743	$ 56,245,440
times % Cty	$ 11,760,749	$ 12,439,890	$ 16,604,872	$ 19,457,931	$ 21,852,092	$ 25,254,946	$ 28,238,182	$ 34,590,945
% CTY	61.69%	60.71%	60.02%	58.46%	60.57%	60.17%	62.71%	61.58%
Federal =					-audit funds	-audit funds	-audit funds	-audit funds

	FY 1992	FY 1993	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997	FY 1998
005 Private/Local Funds minus Proshare	$ 39,815,869	$ 20,848,268	$ 20,848,268	$ 36,123,479	42,029,510	52,143,516	46,999,087	51,365,414
		$	41,696,535					
Nursing Homes Total	$ 129,482,447	$ 135,829,177	$ 135,829,177	$ 144,392,858	158,065,413	168,467,373	163,455,395	170,270,191
Federal Share	68,920,635	72,493,180	72,493,180	85,261,278	90,694,604	90,273,296	84,849,126	81,609,090
Total minus Federal	$ 60,561,812	$ 63,335,997	$ 63,335,997	$ 59,131,580	$ 67,370,810	$ 78,194,077	$ 78,606,269	$ 88,661,101
times % Cty	$ 37,245,514	$ 19,475,819	$ 19,475,819	$ 36,365,922	$ 41,433,048	$ 48,089,357	$ 48,342,856	$ 54,526,577
		$ 38,951,638						
% CTY	65.74%	61.40%		61.09%	62.39%	66.68%	59.79%	57.93%
Federal=	-audit funds			-audit funds-1/2 PSP	-audit funds-1/2 PSP	-audit funds-1/2 PSP	-audit funds-1/2 PSP	-audit funds-1/2 PSP

JANUARY 1999 - CDC RECOMMENDATIONS FOR COMPREHENSIVE TOBACCO CONTROL NEW HAMPSHIRE MODEL

Recommended Components for Comprehensive Tobacco Control Program	Recommended Percentage for NH	Amount Available Assuming 2 cents to Tobacco Prevention	Amount Available Assuming 1.54 cents to Tobacco Prevention
		$ 3,896,000	$ 2,999,920
Community Programs to Reduce Tobacco Use	19%	$ 741,931	$ 571,287
Community Programs to Reduce Burden of Tobacco Related Disease	25%	$ 966,236	$ 744,001
Community School Programs	12%	$ 476,216	$ 366,686
Cessation Programs	11%	$ 421,003	$ 324,172
Counter Marketing	10%	$ 396,847	$ 305,672
Surveillance & Evaluation	9%	$ 341,633	$ 263,058
Enforcement	7%	$ 258,813	$ 199,286
Statewide Programs	4%	$ 158,739	$ 122,229
Administration & Management	4%	$ 172,542	$ 132,857
Total Program Costs	101%	$ 3,933,959	$ 3,029,149
Per Capita Cost		$ 3.46	$ 2.66

Speakers

Fill in ONLY if Speaking on Bill

Bill # SB206 Date March 22

Committee Public Inst.

I support the bill X

I oppose the bill _____

I have written testimony X

(Number of copies) _____

Time needed to speak: 30 Seconds

Name James Gorey

Address 9 Myrtle St
Concord, NH

Phone 1-800-640-7101

Representing American Cancer Society

Fill in ONLY if Speaking on Bill

Bill # SB 206 Date 3/22/99

Committee Senate Health

I support the bill ✓ w/ 25% used for tobacco Prevention

I oppose the bill _____

I have written testimony _____

(Number of copies) _____

Time needed to speak: _____

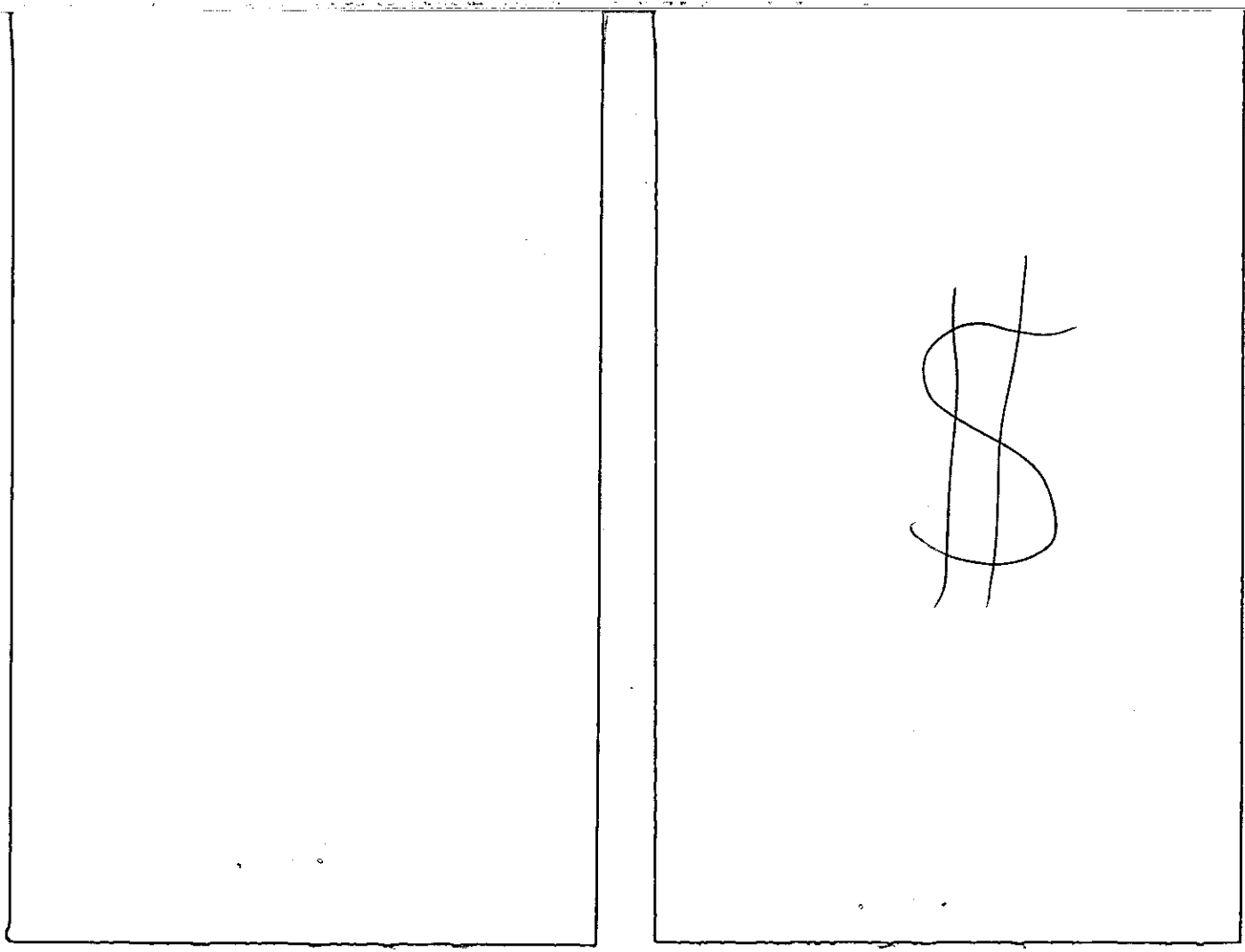
Douglas Barry, Pres.

Name Diane Smogor, (Children's Smoking Program)

Address 456 Beech St
Manchester NH

Phone 1-800-835-8647

Representing Am. Lung Assn of N.H.



SENATE PI-HHS COMMITTEE

Date 3/22/99 Time 1:00 PM Public Hearing on SB206-FN-A-L

Appearing in FAVOR: (Please print) **Please check box at left to speak.**

Speaking?	Name	Address	Representing
☑	Rep Bonnie Ham	Woodstock	Tri C Coop / self
☑	George Maglaras	Dover, NH	NH Assn of Counties
☑	John M. Disko	Concord, NH	NH Assn of Counties
☑	Nicole Cann, 14	Franklin, NH	Franklin-Winnisquam
☑	Brendan Driscoll 11	Dover NH	Smoke Free Coalition → Dover Youth 2 Youth
☐			
☑	Tina Wisell	Williston, VT / Manchester, NH	American Heart Assoc.
☑	ANDREW J. SMITH	4 OLD MILL, LEE	UNH SURVEY CTR
☐	Mary Lee Hinman	MAN NH	NH VOICE OF NH
☐	Mary Cook	Franklin NH	Franklin Reg. Hosp.
☑	Jon Wahrenberger, MD	Lebanon, NH	Dartmouth Hitchcock Med Ctr / American Heart Assoc.
☐	John Vorel	40 Skyline Dr. Gilford NH	NH Tobacco Prevention Task Force

Appearing in OPPOSITION: (Please Print) **Please check box at left to speak.**

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SENATE PI-HHS COMMITTEE

Date 3/22/99 Time 1:00 PM Public Hearing on SB 206-FN-A-L

Appearing in FAVOR: (Please print) **Please check box at left to speak.**

Speaking?	Name	Address	Representing
☐	Janet Monahan	Concord	NH Medical Society
☑	Darrell Niemeyer		Centers for Disease C
☑	Russell Jones		NH Public Health Assoc.
☑	Leslie Melby		Governor's Advisory Panel on Cancer
☑	"	"	New Hampshire Hospital Assoc
☑	Don Shumway	Commissioner	DHHS.
☑	Senator Fred King		District 1
☑	Adar Cohen	46 old Jaffrey Rd.	Peterborough NH 03458
☑	Ellen-Ann Robinson	19 Temple St.	Nashua, NH 03060
☐	Rep Pilliod		Belmont.

Appearing in OPPOSITION: (Please Print) **Please check box at left to speak.**

☑	Phil Morland MD		Rep Therapist
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Committee Report

Date: March 22, 1999 Time: 1:00PM

The Senate Committee on Public Institutions/Health Human Services held its hearing in Room 102, LOB, Concord, New Hampshire.

BILL NO.: SB 206-FN-A-L TITLE: establishing the tobacco use prevention fund and continually appropriating a special fund.

Members of the Committee present: Senator Squires
Senator Wheeler
Senator McCarley
Senator Pignatelli

Those appearing in favor:

Name and Address	Representing
See Attached.	

Those appearing in opposition:

Name and Address	Representing
See Attached.	

REPORT OF THE COMMITTEE:

- ☐ Ought to Pass
- ☒ Ought to Pass w/ Amendment
- ☐ Inexpedient to Legislate
- ☐ Rereferred
- ☐ Interim Study
- ☐ Continued Hearing
- ☐ Postponed Hearing

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date:

THE COMMITTEE ON Public Institutions/Health Human Services

to which was referred Senate Bill 206-FN-A-L

AN ACT establishing the tobacco use prevention fund and continually appropriating a special fund.

VOTE: 6 - 0

amendment #1999-1005s

Having considered the same, report the same with the following amendment and recommend that the bill: **AS AMENDED OUGHT TO PASS.**

Senator James Squires
For the Committee