Approved: 4-30-99
Date

MINUTES OF THE HOUSE APPROPRIATIONS COMMITTEE.

The meeting was called to order by Chairperson Phill Kline at 9:00 a.m. on March 17, 1999 in Room 514-S of the Capitol.

All members were present except: Rep. Jeff Peterson

Committee staff present: Legislative Research - Conroy, Little, Waller, Hallon, Nogle, Davis, Sparks, Campbell, Robinson
Revisor of Statutes - Wilson, Corrigan
Secretary - Ann McMorris

Conferees appearing before the committee:
University of Kansas Chancellor Robert Hemenway
Gary Brunk, Kansas Action for Children
John Pepperdine, American Cancer Society
Doug Wright, American Lung Association of Kansas
Sally Finney, Kansas Public Health Association
Melissa Ness, Kansas Children's Service League
Jim Redmon, Kansas Children's Service League
Del Meier, RN-DSN, Salina Health Department, Salina
Rev. Maxine Burch, Marion County Health Department
Jim Rast, KAN FOCUS, Parsons

Others attending: See attached list.

PUBLIC INPUT AND COMMENT ON CREATING A CHILDREN'S INITIATIVE TRUST FUND TO BE FUNDED FROM TOBACCO SETTLEMENT PROCEEDS

Conferees:

1. University of Kansas Chancellor Robert Hemenway (Attachment 1)
2. Gary Brunk, Kansas Action for Children (Attachment 2)
3. John Pepperdine, American Cancer Society (Attachment 3)
4. Doug Wright, American Lung Association of Kansas (Attachment 4)
5. Sally Finney, Kansas Public Health Association (Attachment 5)
6. Melissa Ness, Kansas Children's Service League
7. Jim Redmon, Kansas Children's Service League (Attachment 6)
8. Del Meier, RN-DSN, Salina Health Department, Salina (Attachment 7)
9. Jim Rast, KAN FOCUS, Parsons (Attachment 8)
10. Rev. Maxine Burch, Marion County Health Department (Attachment 9)

Written testimony only
Terri Roberts, Tobacco Free Kansas Coalition, Inc. (Attachment 10)

Conferees offered following suggestions for use of tobacco settlement proceeds: 1. Improve health of Kansas by investing in bio-medical research; 2. Implement a tobacco control program; 2. Include health care organizations when setting up mechanism for use of tobacco settlement funds; 3. Provide critical services in local communities; 4. Set up community funding to develop plans for communities to take responsibility for their own children; 5. Protect our children by tobacco use prevention programs in the counties.

Chair closed hearing on public comments.

CONTINUATION SHEET

MINUTES OF THE HOUSE APPROPRIATIONS COMMITTEE, Room 514-S, Statehouse, at 9:00 a.m. on March 17, 1999.

Chair recognized Rep. Farmer for discussion concerning introduction of proposed legislation to establish a trust fund for tobacco settlement funds. (Attachment 11)

Moved by Representative Farmer, seconded by Representative Reardon, amend **SB 156** by deleting all portions and substituting text from **HB 2558,** as a substitute bill. Motion carried.

Representative Nichols recommended the Revisor of Statutes work with KPERS representatives to strengthen the language regarding KPERS in **SB 156.**

Moved by Representative Farmer, seconded by Representative Landwehr, to report **SB 156** out favorably as amended. Motion carried.

Next meeting will be held on March 18, 1999.

Adjournment.

Respectfully submitted.,

Ann McMorris, Secretary

Attachments - 11

HOUSE APPROPRIATIONS COMMITTEE
GUEST LIST

DATE: March 17, 1999

NAME	REPRESENTING
Randy Scott	KCVA
Donna Dock	KCVA
Maxine M. Busch	Marion County Health Dept.
Mike Hollar	KS. HRC
Del Meier	Salina - Saline Co Health Dept
Jon Josserand	KU
Bob Harder	LWV-KS
Gary Brunk	KAC
Paul Johnson	PACK
Marjorie Hellekurst	KSKI
Lea Steele	KCVA
Jack Strukel	KCVA
Robin Lehman	Kansas Action for Children
Bill Minner	KS. Human Rights Commission
Bob Lay	KS Human Rights Commission
Carye Hanes	KS Human Rights Comm.
Shannon LaShell	University of Kansas

The University of Kansas

Office of the Chancellor

March 17, 1999

Mr. Chairman and members of the Committee:

Good morning. I am Bob Hemenway, Chancellor of the University of Kansas. The committee calendar indicates that this hearing has been convened to seek public input and comment on the creation of a Children's Initiative Trust Fund to be funded from tobacco settlement proceeds. I presume that the testimony of most of the conferees will bear directly on House Bill 2558 which creates such a Fund.

From earlier discussions with committee staff and Legislative Research Department staff we understood that the purpose of this hearing was a global one aimed at exploring alternative uses of the tobacco settlement monies. It is to share my views regarding that important topic, Mr. Chairman, that I appear here today.

As you all know, Governor Graves recommended that $255,541 from the tobacco settlement monies be used to expand the University of Kansas Medical Center's Tele-Kidcare initiative to rural parts of the state.

This seems a highly appropriate use of those tobacco settlement dollars. When boiled down to its essence, the landmark litigation against the tobacco companies has been about health. The lawsuit sought to hold the tobacco companies accountable for the damaging effect cigarettes have had on the health of Kansans and the concomitant cost that those health effects have imposed on the state. Given the health purpose which lies at the core of the tobacco litigation, it is wholly appropriate to use some of the funding produced by that effort to expand a children's health program like Tele-Kidcare, and I strongly support the Governor's recommendation to do so. It would be equally appropriate to fund this important service program from State General Revenue Fund monies, as the University suggested in its request.

I would like to turn now to the broader topic of how the state could use an additional portion of the tobacco settlement fund to capitalize on an important investment opportunity.

I am convinced that the State of Kansas presently stands at the threshold of an incredibly rich investment opportunity that will produce substantial dividends for the people of this great state. As you and other important state leaders consider how to optimize the use of the tobacco settlement dollars that are set to come into the state over the next twenty-five years, I strongly encourage you to embrace the opportunity to invest

Attachment 1-1
House Appropriations Committee
March 17, 1999

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Main Campus, Lawrence • Medical Center, Kansas City and Wichita • Edwa

in biomedical research. Let me quickly tell you why I believe such an investment makes sense for Kansas.

Biomedical research has been at the heart of the improvements in health and quality of life we have all experienced in the last generation. Given its value in that regard, I believe that an investment in biomedical research provides an ideal use for dollars derived from the historic health-driven tobacco litigation. The nexus between the litigation that produced these dollars and a biomedical research agenda that promotes health and seek to identify causes and cures for disease is powerful. The health benefits to be derived alone would more than justify an investment in biomedical research.

In addition, it is clear that such an investment would yield not only health benefits for Kansans, but economic development benefits as well. An array of studies has demonstrated clearly that investment in research produces direct and positive economic impact. The Congressional Budget Office concluded recently that the rate of return from public investment in research ranges from 30 to 80 percent. This point is particularly noteworthy when we recognize that biomedical research drives much of the growth of the health care industry, which is among the fastest growing industries in the current economy. In addition, such an investment can be leveraged to bring increased federal research dollars into the state's research universities.

The federal government has increased significantly its funding for research, and is in the midst of a plan to continue those substantial increases into the future. The research budget for the National Institutes of Health, for example, will double from $13.5 billion to $27 billion annually over the next seven years. If Kansas invests seriously in biomedical research now the state will be well-positioned to leverage that investment into robust increases in the federal dollars its research universities receive to engage in that research.

This investment makes sense for Kansas. The dividends to be gained for Kansans will be significant both in terms of improved health and economic development. As you and other important state leaders consider how to optimize the use of tobacco settlement dollars, I encourage to work with us to explore this very important option.

I want to make one very important point before I close. The availability of the tobacco settlement monies presents the state with a unique set of opportunities to make investments that will produce meaningful dividends in the long run for Kansans. I have suggested that an investment in biomedical research is a particularly important and far-reaching opportunity that should be seized, and I believe very strongly that it is. I also recognize that many around the state, and many you will hear from today, are very committed to ensuring that those settlement dollars be used in a way that provides long-term benefits for this state's children. I certainly would not oppose such a use; in fact, I am convinced that an investment in biomedical research is consistent with that very important goal. As you consider how to optimize the monies that this landmark settlement has produced, I encourage you to work together with children's advocates and higher education leaders to make the best investment in Kansas and its future. There is

much that we can achieve with this funding if we work together, think creatively, and remain focused on the long-term interests of this state and its citizens.

Thank you very much for your time. It has been a pleasure to be with you here this morning.

BEFORE THE HOUSE APPROPRIATIONS COMMITTEE

Gary Brunk
Executive Director
Kansas Action for Children

March 17, 1999

I am here to urge that you dedicate 100 percent of the Kansas tobacco settlement to improving the health and well-being of our children and youth.

The Kansas portion of the master tobacco settlement gives us an unprecedented opportunity to invest in the future of our state by investing in our children. While it is often said that there is no more important investment than the one we make in our children, we also know there are good investments and bad investments. I would like to talk briefly about how we can use the tobacco settlement to make a good investment in children.

- We should balance immediate needs and long-term opportunities. I believe we should use part of tobacco settlement revenues to support programs and services our children need now. But we should also look to the future by ensuring that two decades from now we have built up a substantial endowed trust fund that will be a resource for generations to come.

- Tobacco settlement funds should support prevention-oriented approaches. While increasingly we have solid data demonstrating the cost effectiveness of investments in prevention, it has been almost impossible to allocate resources to pay for prevention. We are always in the box of having to pay for essential services such as foster care and not having enough to pay for those things we know could dramatically reduce the need for foster care. We will never have a better opportunity to make the investment we need to make in prevention.

- Tobacco settlement funds should go to communities, not to state agencies. Communities are in the best position to implement prevention plans that are responsive to local needs. Let's give them the resources to do so.

- Generally we should use the tobacco settlement to fund demonstrated progress toward measurable outcomes—not to fund categorical programs. Communities need the flexibility that comes from not being tied to categorical programs that someone in Topeka decided they needed. In turn, communities need to show that what they are doing works.

- In order for communities to show that what they are doing works we need to be willing to pay for solid evaluation studies.

- Finally, we should not use the tobacco settlement to supplant existing funding.

I believe that the citizens of our state will greet investing all of the tobacco settlement in the future of our children with overwhelming support. Last February 9, over 400 persons from across the state came to Topeka to voice their support for increasing our investment in children. No issue was of more interest to them than the use of tobacco settlement funds to improve child well-being.

But that interest is not restricted to persons who think of themselves as child advocates, as many in that group did. Kansans overwhelmingly believe that caring for children ought to be the number one priority for their communities, as demonstrated in a scientific survey of over 1,000 adults this past Fall. Your decision to allocate 100 percent for kids can give communities vital additional resources they need and want.

But you should not decide to allocate all of the tobacco settlement to children just because communities would like you to do so. You should do it because it is fiscally prudent.

I said earlier that we increasingly have good data demonstrating the cost effectiveness of investments in prevention. In 1998 RAND completed a major study of the cost and benefits of early childhood interventions, and I want to share with you their key findings. RAND is known for their rigorous analysis, and I believe their findings are significant. In the programs they examined RAND found that participants when compared to the control group had one or more of the following:

- Gains in emotional or cognitive development for the child, typically in the short-run, or improved parent-child relationships.
- Improvements in educational process and outcomes for the child.
- Increased economic self-sufficiency, initially for the parent and later for the child, through greater labor force participation, higher income, and lower welfare usage.
- Reduced criminal activity.
- Improvements in health-related indicators, such as child abuse, maternal reproductive health, and maternal substance abuse. (From the Executive Summary of: *Investing in Our Children: What We Know and Don't Know About the Costs and Benefits of Early Childhood Interventions,* RAND, 1998.)

I think we would all agree that these are desirable outcomes. But RAND went beyond those findings and measured program costs against savings to taxpayers for two of the programs they analyzed. They found that savings were much higher than costs: in one case savings of $25,000 versus a cost of $12,000, in the second case savings of $24,000 versus a cost of $6,000.

We have an unprecedented opportunity to make a fiscally prudent long-term investment using tobacco settlement funds. Kansas kids count: let's give them 100 percent.

March 17, 1999

testimony by John Pepperdine
Manager of Government Relations
American Cancer Society, Heartland Division

REVIEW OF TOBACCO TRUST FUND BY THE HOUSE APPROPRIATIONS COMMITTEE

"I'll tell you why I like the cigarette business. It cost a penny to make. Sell it for a dollar. It's addictive. And there's fantastic brand loyalty."
- R.J. Reynolds Tobacco stockholder

My name is John Pepperdine and I am Manager of Government Relations for the American Cancer Society as well as a member of the Tobacco Free Kansas Coalition's Policy Task Force Committee. Representing over 270,000 volunteers and supporters in Kansas for the American Cancer Society and an even greater number for the coalition, I am here today to urge you to invest in a comprehensive, sustainable, and accountable tobacco control plan that will save lives and money.

A comprehensive statewide tobacco control policy would substantially reduce smoking and other tobacco use, save thousands of lives and millions of dollars, dramatically improve public health, and do more to help Kansas and its citizens than any other option.

Examine the facts:

- Tobacco killed 4,326 Kansans last year, more than AIDS, alcohol, car accidents, fires, cocaine, heroin, murders, and suicides COMBINED or nearly 1 out every 5 deaths. (Kansas Department of Health and Environment, 1997).
- 11,000 kids (under 18) in Kansas became new daily smokers in 1997 (Centers for Disease Control, Morbidity and Mortality Weekly Report, 1998).
- 90% of smokers began smoking before the age of 18 (Report by the Surgeon General, U.S. Department of Health and Human Services, 1997).
- Smoking among high school students is at a 19 year high from a low of 27.8 in 1992 to a high of 36.5% in 1997 (University of Michigan, 1998).

Continued -

Attachment 3-1
House Appropriations Committee
March 17, 1999

- Annual health care expenditures in Kansas directly related to smoking: $630 million (U.S. Department of Treasury, 1998).

What can you as lawmakers do about this major health problem? Establish tobacco programs that are comprehensive, sustainable, and accountable. In Kansas there is no such tobacco program.

Do these programs work, yes. Indeed, data from California and Massachusetts have shown that implementing comprehensive tobacco control programs produce substantial reductions in tobacco use. And while youth smoking rates in the nation rose steadily, California and Massachusetts had their rates either decrease or increase at a much slower rate.

- In California during the first three years of the program, cigarette consumption fell by more than 40 percent - more than 1.3 million Californians quit smoking.

- In Massachusetts, the cigarette consumption rate fell more sharply than the rest of the nation - 20 percent since 1992, compared to 6 percent nationally. Young adult smoking rates fell from 29.4 percent to 21.6 percent.
  * 46 percent of 7th-8th grade smokers said they quit because of the anti-smoking messages.

And the most recent figures from Oregon, a state that implemented a comprehensive tobacco prevention and education program in 1996, indicate that cigarette consumption has been reduced by 11.3 percent between 1996 and 1998. In fact, this reversed a four-year period of cigarette consumption increases of 2.2 percent.

- In 1998, 25 million fewer cigarette packs were sold in Oregon compared to 1996, despite a population increase of 2.7 percent.

- Preliminary adult smoking prevalence data show a 6.4 percent decline from 1996-1998, representing 35,000 fewer smokers in Oregon.

Even Florida, after less than five months of implementation of their pilot program, more than 90 percent of teens in the state were aware of the program, and over half were aware of the campaign logo. The program has already had an impact, as evidenced by the following:

- From April to September of 1998, the proportion of Florida teens who "strongly agree" that smoking has nothing to do with a person is cool increased from 45 to 59 percent.

- From April to September of 1998, the proportion of Florida teens who "strongly agree" that tobacco companies try to get young people to smoke because older people quit smoking or die increased from 29 to 42 percent.

Continued -

Does Kansas have a comprehensive tobacco control plan? Yes, the Tobacco Free Kansas Coalition has developed the Kansas Tobacco-Use Prevention and Cessation Plan. This plan was developed following the Centers for Disease Control and Prevention guidelines along with the collaboration of 43 member organizations and partners (refer to Appendix C of the plan for a complete list).

The components of this plan are divided into five areas:	funding percentage:
1. Community Interventions for Tobacco-Use Prevention	69%
2. Counter Marketing	14%
3. Policy Regulation and Enforcement	4.1%
4. Surveillance and Evaluation	8.7%
5. Administration and Management	4.3%

* Notice the majority of the funding, 69 percent, is for use by local communities for specific programs.

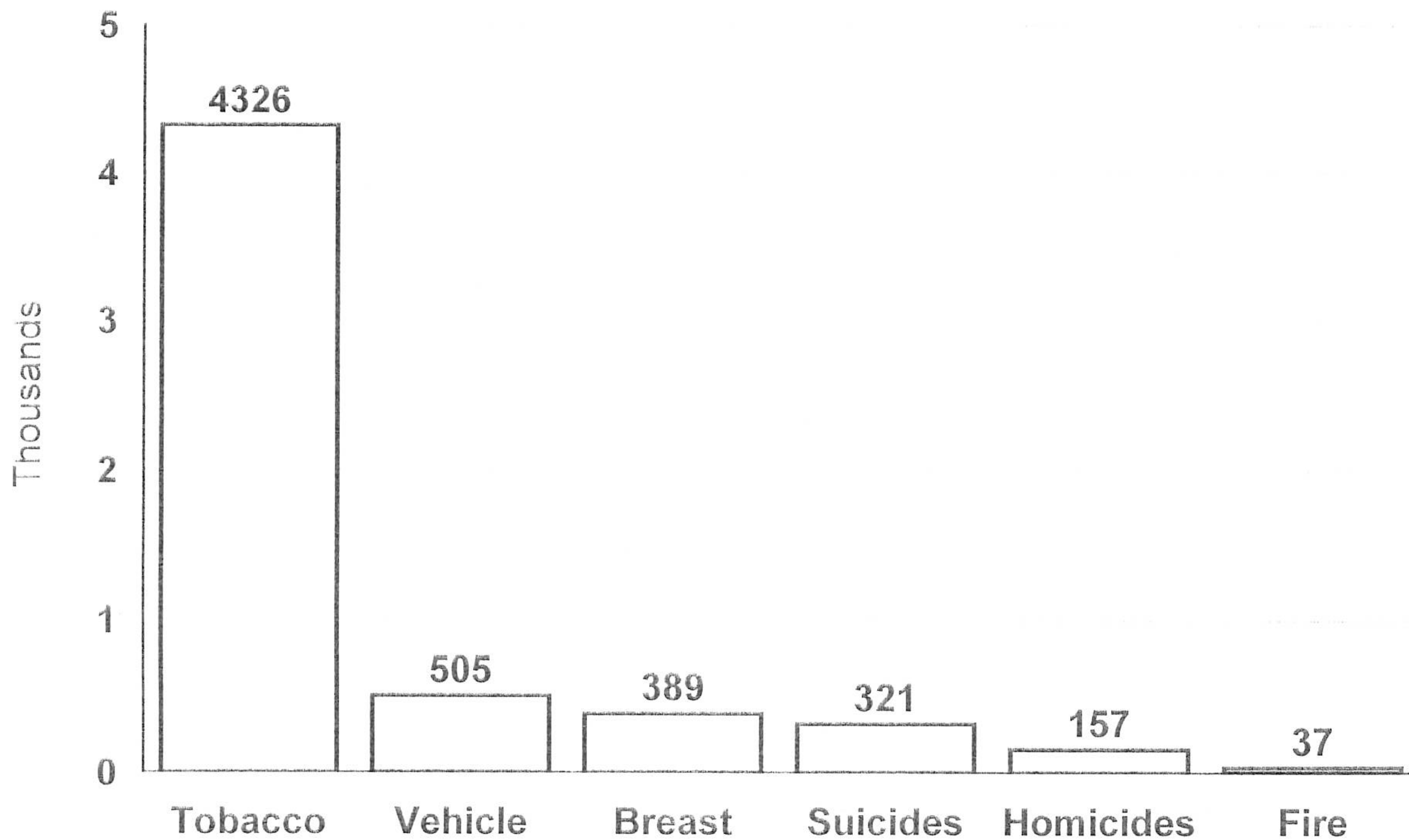
Funding levels for this program are recommended to be $7 to $20 per capita or $18 to $44 million for the annual budget of the program.

Again, the Tobacco Free Kansas Coalitions strongly urges that a significant portion of the tobacco settlement be used to combat the state's leading cause of death, tobacco.

If you choose not make a significant investment in tobacco control, this settlement will be no more than a financial transaction between the tobacco industry and the state of Kansas. The results, thousands of Kansans dying every year from something that could have been prevented.

It's time our kids grew up tobacco free.

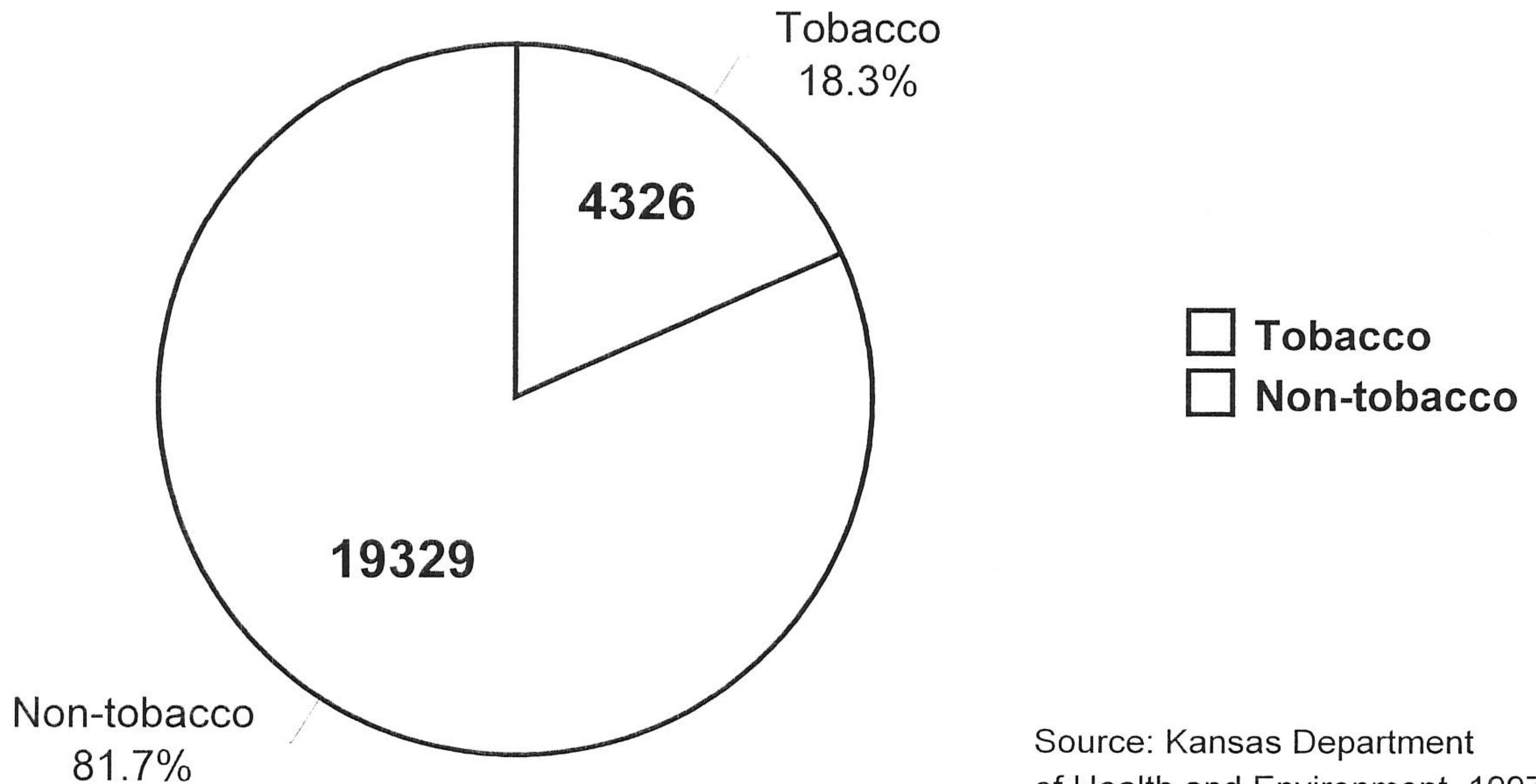
Deaths in Kansas: Why single out tobacco?



Source: Kansas Department of Health and Environment, 1997

Nearly 1 in 5 Deaths in Kansas are Tobacco Related

3-5



Independent Evaluation of the Massachusetts Tobacco Control Program

Fourth Annual Report

January 1994
to
June 1997

Prepared for:
The Massachusetts Department
of Public Health

Prepared by:
Abt Associates Inc.
William Hamilton

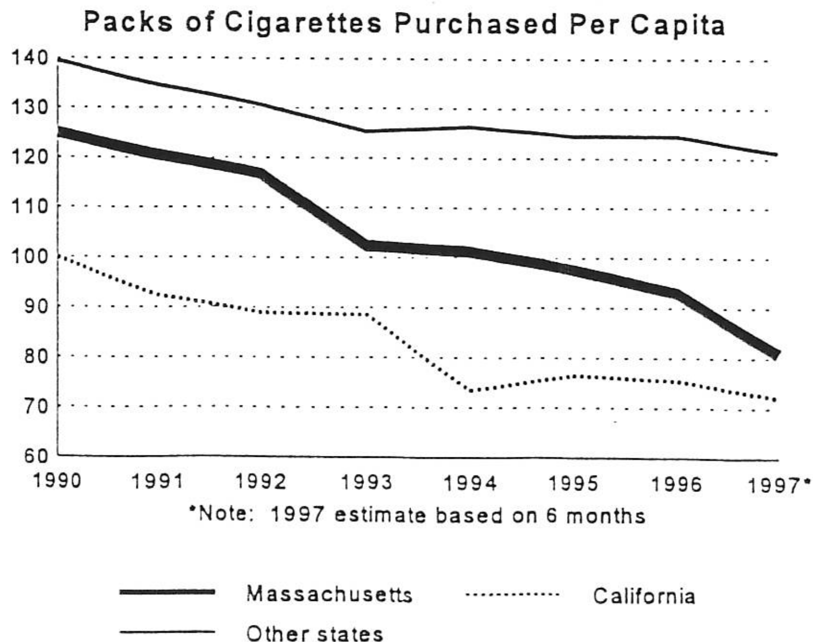
3-6

REDUCING OVERALL SMOKING

The Question 1 campaign, the cigarette price hikes resulting from the tobacco tax increases, and the efforts of the Massachusetts Tobacco Control Program have accelerated the trend toward reduced tobacco use in Massachusetts. Since Question 1 passed, tobacco sales in the Commonwealth have declined much faster than in the prior period, and faster than the national rate.

Cigarette consumption has dropped by 31 percent since 1992. Data from the Tobacco Institute show that cigarette purchases in Massachusetts in 1992 totaled 117 packs per person aged 18 or older. By the first half of 1997, purchases had dropped by 31 percent, to 81 packs per capita.[1] The steepest declines occurred in the two years following new excise taxes (1993 and 1997).

Cigarette consumption continues to fall more sharply in Massachusetts than in the rest of the nation. In California, which implemented a tobacco tax and tobacco control program in 1989 similar to the Massachusetts initiative, per capita cigarette purchases shrank by 19 percent from 1992 to 1997. Cigarette purchases declined much more slowly in the rest of the nation than in Massachusetts and California. Excluding these two states, the national consumption rate declined 7 percent from 1992 to 1997.[2]



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When You Can't
Breathe,
Nothing Else
Matters®

Testimony on Children's Initiative Trust Fund
Before the House Committee on Appropriations
Douglas S. Wright
March 17, 1999

Mister Chairman and members of the Committee, thank you for the opportunity to speak with you today.

My name is Doug Wright. I represent the American Lung Association of Kansas, where I am a volunteer and past president of the Board of Directors. I am here today to applaud your effort to assure that the tobacco settlement dollars Kansas will receive will be put to use now and in the future to improve the health of Kansas children.

However, we hope that when determining the ultimate disposition of these funds you do not forget the important health issue that is at the heart of the settlement — the deadly hazard of tobacco use. False advertising and targeted marketing of tobacco to children is what the lawsuits were all about.

Therefore, we believe the first priority use of settlement funds should be tobacco-use prevention and cessation. This makes good public health sense and it also makes good financial sense. Tobacco related illnesses cost the state $87 million[1] annually. By seizing this opportunity to implement a comprehensive tobacco control plan we will save lives and reduce demand on the state for health care payment.

Tobacco use is an epidemic among our youth. The most recent *Communities That Care Youth Survey* (attached) found that 36.2 percent of Kansas 12th graders smoked at least once in the last 30 days. We also know that more than 90 percent of adult smokers took up the habit before they were 18 years old. Smoking and the use of tobacco may be an adult choice, but it is kids who are making the decision to start.

Decisions to use tobacco settlement funds, with current allocations or trust fund proceeds, for future and continuing use must include tobacco-use prevention and cessation for **all** Kansans.

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[1] Kansas Medicaid Costs for 1998. Developed by the Kansas Department of Social and Rehabilitation Services from estimates based on Centers fo
1993 data, with adjustments for inflation and the number o

This money will buy results. Proven tobacco control programs translate into reduced tobacco consumption. According to *Best Practices for Comprehensive Tobacco Control Programs (*produced by the Centers for Disease Control and Prevention*)*, California and Massachusetts, two states with well-funded tobacco control programs, saw tobacco consumption decline by 17 and 20 percent respectively, between 1992 and 1996.

The *Kansas Tobacco-Use Prevention and Cessation Plan* is such an opportunity for Kansas. It was developed by public health and tobacco control experts in Kansas, specifically for Kansas. Copies have been provided to you. It is a research-based, comprehensive approach that relies on programs proven effective.

Given the chance we can reduce tobacco-related illnesses and costs in our state and keep kids tobacco free. Tobacco settlement funds are that opportunity. It would be a tragedy if, when we have the opportunity, we do nothing and our children and their children continue to die from tobacco use – the single most preventable cause of death in Kansas.

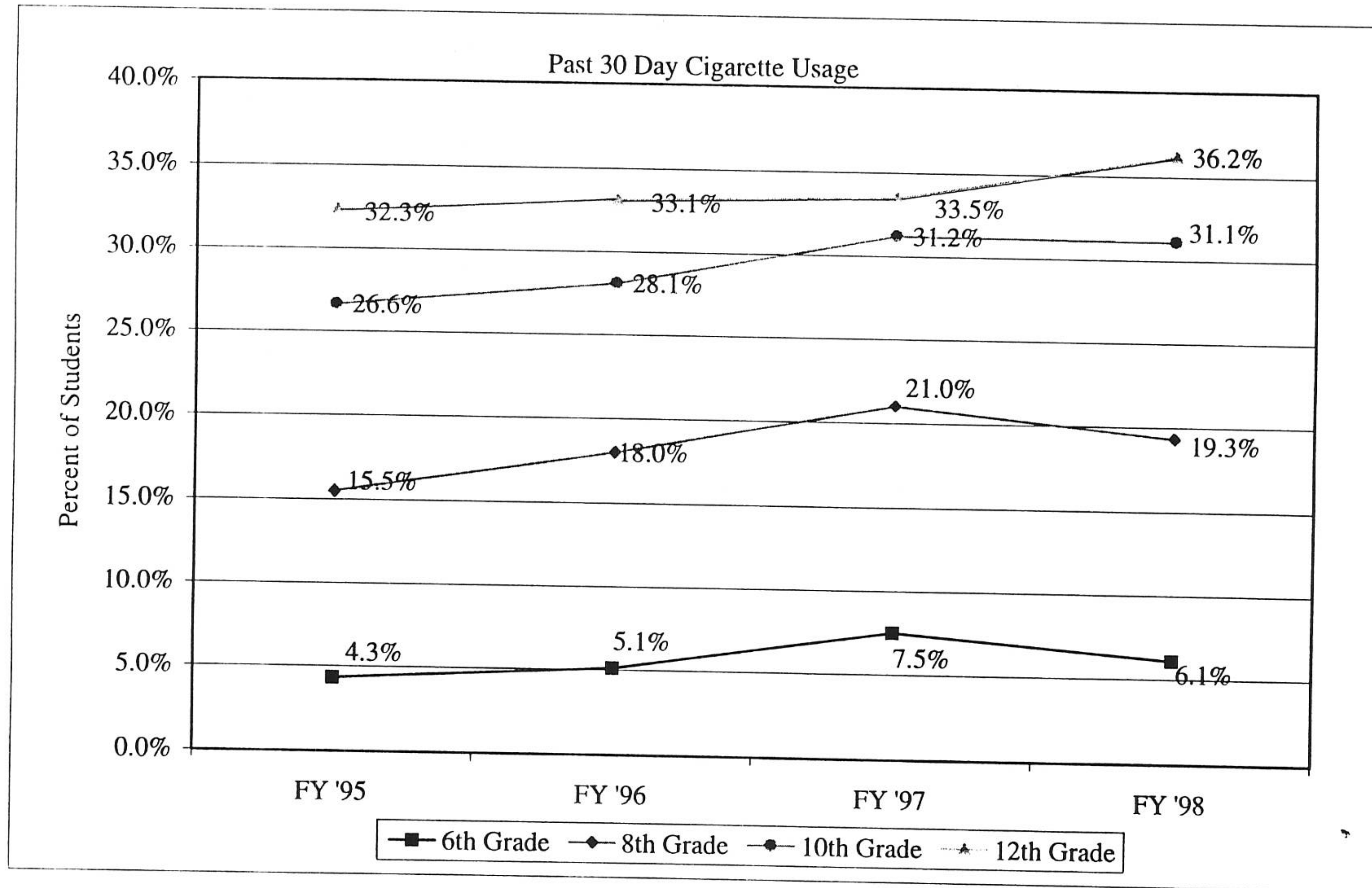
Thank you for your attention and we look forward to working with you in the future to assure that a comprehensive tobacco control plan is funded in Kansas; one that protects the health of all Kansans.

Kansas Youth Trends 1995 - 1998

4-3

USAGE LEVELS OF CIGARETTES BY STUDENTS

Kansas Communities That Care Student Survey of 6th, 8th, 10th, and 12th Graders, Public and Private School Students



Percent of 6, 8, 10, and 12th graders who indicated that they have smoked cigarettes in the past 30 days.

KANSAS
PUBLIC
HEALTH
ASSOCIATION, INC.

KANSAS PUBLIC HEALTH ASSOCIATION, INC.
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Public Comments Presented by
Sally Finney, Executive Director on
March 17, 1999

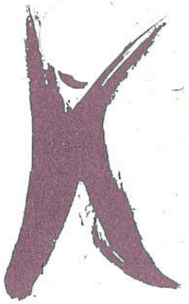
Mr. Chairman and members of the House Committee on Appropriations, I am here today on behalf of members of the Kansas Public Health Association to provide our input on the disposition of funds from the State's allocation from the tobacco settlement.

We believe any plan dealing with these dollars should include the following elements:

1. Use of 100 percent of the award for programs proven to help children lead healthier lives.
2. Helping our children grow up tobacco free is first priority. This means tobacco prevention programs for children. Children who live in homes where adults use tobacco are more likely to use it themselves, so cessation programs for adults are also important.
3. Investment of a portion of each year's allocation in a trust to provide a "safety net" and insure future availability of funds from the settlement. Investment may include moderate risk, using a combination of stocks and bonds to generate returns for re-deposit to the fund.
4. Expenditure of a portion of funds from the trust to address current needs for children's programs.
5. Guidance from a wide variety of organizations familiar with public health, children's health, and children's services to aide the Kansas Legislature and the Governor in formulation their annual budget recommendations.

I must emphasize again that the Kansas Public Health Association firmly believes that funding for tobacco prevention and cessation to help our children grow up tobacco free must be first priority. Without addressing the underlying problem of tobacco use, we are guaranteed to see more of the kind of health problems that caused states to file the original lawsuit.

Thank you for your time.



Presentation before
House Appropriations Committee

March 17, 1999

Investing in Prevention

Good Morning. My name is Jim Redmon and I am the Program Development Manager for the Kansas Children Service League's Healthy Families Olathe Program. I hold a Master's Degree from UC Berkeley in Public Health with an emphasis on maternal and child health and a Master's Degree from the University of Michigan in Social Welfare with an emphasis on children and families. I now have over 20 years of experience directly working with, teaching courses on and developing policies for children and families. If there is one thing that I have learned in those 20 years it is that programs that prevent child abuse, prevent illnesses, prevent violence, and promote wellness, rather than simply (or not so simply) treating symptoms is where much of the focus needs to be in children's services. My first job in human services was working with children who had severe disabilities. Infants with fetal alcohol syndrome, who had been severely shaken and had brain damage as a result, with spina bifida whose moms and dads did not know about taking folic acid before and during pregnancy, who failed to thrive because the adults in their lives did not know how to take care of them—these were the kids I worked with every day. So many of the problems I saw and worked with were preventable. Since that experience my professional life has focused on prevention.

Simply put, research based, outcomes oriented prevention programs like Healthy Families work. A decade ago I developed a home and center based infant development program in a high crime, low income neighborhood that was extensively researched. We witnessed and documented improvements in almost all areas of infant development and parenting skills. More rigorous research over the last two decades of other, much larger programs has consistently confirmed that providing supportive services and education to at-risk parents around the time of a baby's birth—and continuing for months or years afterwards—significantly reduces the risk of child abuse and, as important, contributes to positive, healthy parenting practices. Families receiving supportive home based services show positive changes such as consistent use of preventive health services, increased high school completion rates (for teen parents), higher employment rates, lower welfare use and fewer pregnancies. Current research also shows that programs that work with new parents stand the greatest chance of success for several reasons: 1) new parents are eager and excited to learn about caring for their babies; 2) they work with parents before abusive or neglectful patterns are established; 3) most physical abuse and neglect occur among young children under the age of two; 4)

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EMERGENCY
CHILDREN'S SHELTER
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913-232-8282
913-232-4142 (FAX)

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ULYSSES
WICHITA

Attachment 6-1
House Appropriations Committee
March 17, 1999

almost all child fatalities due to child maltreatment occur among children under the age of five with 44 % occurring to infants under the age of one; 5) from a public health perspective it is when most immunizations should occur and 6) we are learning every day about the importance of early brain development.

Research into programs to prevent child abuse and neglect and promote wellness point also point to certain critical elements that make them successful. Successful prevention programs are intensive, that is, they work with families on a regular basis. They are comprehensive, addressing a range of issues related to parenting and other stressful issues in families' lives. They are long term, working with at risk families for 3 to 5 years. Finally, they are flexible in responding to families needs. What you think you may be doing with a family one week may turn into something very different when you are at the door. However, in that flexibility is the trust that is needed to develop the relationship with the hard to reach family.

Why invest in prevention? I have to preface this by saying that the cost savings for funding prevention are not always immediate. Research suggests those programs to prevent child abuse and neglect can pay for themselves in reducing the need for a wide range of services including health care, foster care, child welfare, juvenile facilities and special education. For every $3 spent on prevention, research shows we save at least $ 6 that might have been spent on tertiary services. However, it may be years before the savings are visible.

Cutting edge research in brain development show the devastating effects of abuse and neglect. Professionally, I have seen the results of not providing preventive services for infants and children. At this point <u>we know</u> what works to prevent child abuse and neglect. Programs like Healthy Families have done the research to demonstrate what works and how to get successful outcomes for at risk families. After 20 years in the field, I believe now more than ever that investments in early childhood programs are investments in a better future for Kansas.

Presented by Jim Redmon, Kansas Children's Service League

Testimony

HB 2558: Disposition of tobacco litigation proceeds

I would like to thank the committee for hearing and considering my testimony. My name is Del Meier, and I am a registered nurse and health educator at the Salina-Saline County Health Department, and the mother of two teenagers. I am here to support the 100% dedication of tobacco settlement funds for children's initiatives, especially those that are designed to prevent or stop youth from using tobacco. I think that it is entirely appropriate to use tobacco litigation proceeds to address tobacco use.

Tobacco-related illness is the number one cause of preventable death in Kansas, killing one in five of our citizens. This does not even take into account the disability that accompanies many tobacco-related diseases. Yet we still see over 11,000 Kansas children start smoking every year, and about a third of them will die from it. Our resources are strained beyond their limits. With a comprehensive tobacco control program, using data-driven and research-based tobacco prevention strategies, we could make an impact on tobacco use in Kansas. I see such programs fitting in to Section 2(b) of the bill.

The Tobacco Free Kansas Coalition's Comprehensive Tobacco Prevention and Cessation Plan would require about 25% of the settlement proceeds to fund a truly comprehensive program. Of that amount, approximately two-thirds is dedicated to local community and school programs to prevent and stop tobacco use.

Local health departments are woefully underfunded for the jobs they need to do to protect the public health. Tobacco prevention is only a small part of my position as health educator. Other responsibilities include communicable disease prevention, health promotion, AIDS/STD education, safety education, coalition building, consulting for businesses and local government, school presentations, special projects, media spokesperson, biological threat planning, crisis intervention and much more. Each of these duties could easily be a full-time job in itself.

Currently, our local tobacco prevention program activities have been funded by a variety of small short-term grants. In Salina, we have a local coalition of committed health, school, law enforcement, and drug prevention specialists all doing what they can "on the side" in addition to their regular duties, because they see the importance of tobacco prevention and cessation activities on the health of our community. As locals, we know the needs and norms of our community, and understand how best to implement prevention programs at the local level.

Our local coalition has presented educational programs and displays on the effects of tobacco at schools, fairs, and businesses; partnered with the American Lung Association on a free nicotine patch distribution; recruited youth to attend tobacco prevention/education rallies; presented school and community lectures; assisted businesses with drafting and implementing policies; conducted poster contests for grade schoolers; started a billboard campaign; published a smoke-free dining guide; promoted Great American Smokeout; provided radio public service announcements; recognizes smoke-free restaurants; and more. It is our fervent hope that these activities will improve the health of citizens in our county.

Using "best practices"--proven, research-driven programs that work, such as those outlined by the Centers for Disease Control and Prevention, could have a tremendous impact on the health of our residents. Dedicated staffing, and adequate and consistent funding, would strengthen our efforts considerably, and allow us to coordinate and evaluate our programs more effectively. Several states that have implemented comprehensive tobacco control plans have reduced overall smoking rates within their borders at a faster rate than elsewhere in the country.

Our youth are easily our most precious asset. If 100% of the tobacco settlement funds could be dedicated to a children's initiatives fund, intervention programs for children of all ages would benefit Kansas. Investing in them now will provide huge rewards in the future.

This is our opportunity to make profound changes to public health in Kansas. Please consider dedicating 100% of the tobacco settlement funds to children's health programs. The children can't speak for themselves, so we must advocate for them. It would be a tragedy if we do nothing, and our children and grandchildren continue to die prematurely because of tobacco use. We have the chance, and a responsibility to make a difference for the health of our Kansas children.

If not now, when?

Thank you so much for your time and attention,

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PROJECT BEFORE

(Bridging Empowers Families to Overcome Risks and Excel)
Cherokee, Crawford, Labette, and Montgomery Counties, Kansas

Project Before illustrates how a behavioral health home visiting program supporting families with substance abuse and mental health disorders and very young children has evolved in response to welfare reform. The Before intervention combines case management/home visiting with a whole family wraparound process. The case management approach is family-centered and strength-based. The whole family wraparound process supports family developed goals. Welfare reform has focused family priorities on goals for employment and education.

Project Before Evolution and Description

Southeast Kansas families, community leaders and providers of health, behavioral health, education, social, and juvenile justice systems have been developing a rural integrated system of care since 1991. The initial focus of this system of care was children with severe emotional or behavioral disorders. In 1994 concentrated efforts began to focus on early intervention and prevention and to include the providers of services and supports for very young children. **BEFORE** (**B**ridging **E**mpowers **F**amilies to **O**vercome **R**isks and **E**xcel) Home Visiting/Case Management is one of the evolving interventions within this developing system of care. Prevention and early intervention efforts within the system of care are based on a risk and resiliency model. Families in which a care giver is substance dependent or has a mental illness are overburdened with the complex demands of today's society. Very young children within these families have the highest levels of risk for future school failure, mental illness, juvenile crime, and violence. These are the families targeted for support through Project Before. During the past three years 205 families with child(ren) under six years of age and at least one care giver has problems with substance abuse or mental illness, have received services through this project.

The Before intervention combines case management (home visitation) with individual whole family wraparound planning. Before case management is based on the principles of home visiting of the Healthy Families America program. This intervention has been adapted to meet the unique needs of caregivers with substance dependency and mental illness. The strength based model begins with the strengths of each family member and the needs and goals they rate most important. This approach is building rapport and engaging families more consistently than comparable interventions. As families are engaged they begin to address changeable risks and protective factors for the children. This process focuses on problem solving and parenting skills in those areas most important for the child(ren) and family. In these families services are provided in a way that is based on the strengths and needs of every member of the family and encourages each family member to participate in the intervention process. Service plans are developed and coordinated through a family driven wraparound process that coordinates professional and natural supports as needed. Specific goals and objectives are developed and evaluated by the family and home visitor/case manager to ensure that services meet their needs. Natural family supports (relatives, friends, and neighbors) and community organizations (12 step programs, support groups, and other community support systems)

are integral parts of each plan. Overall program direction and success will be under the auspices of local coalition's and regional advisory boards consisting of families, community leaders, and key service providers.

Whole Family Wraparound Planning (WFWP) is the cornerstone for services delivery. The WFWP process begins with strength-based assessment and evaluation. This part of the process determines the strengths, preferences, and cultural practices of the child and family. Risks, needs and protective factors are identified and each person, particularly the parents, suggests recommendations for goals and services. The multi-disciplinary team consisting of the family and people identified by the family generally consists of the parents, home visitor, and only one or two other people. Large teams are often intimidating to the families and coordination can often be handled most cost efficiently through collaborative contacts. The team develops a vision of the future for the family based on the their interests, preferences, and strengths. Based on this vision the team develops a system of services and supports to help the family achieve the vision. Each WFWP describes the specific mixes of services, levels of intensity for each service, persons responsible for each service, and provide a forum for consensus or disagreement. Experience has shown that families (especially single teenage mothers) prefer less formal processes and meetings and that plans change more often than for more established families with SED children.

Experience has shown that many of the parents targeted for this project have economic, health, housing, transportation, dental, vocational, education, and legal problems. In addition, the children in these families also have educational, developmental, nutritional and mental health needs. To provide holistic support we must be able to coordinate with the providers of support and services in each of these areas. One of the real strengths of this project is the strong interagency, inter-community integration of services. This level of support can be seen in the over 30 agencies who meet on a monthly basis to plan and implement the system of care. All families receiving services through Project Before have a home visitor. Based on needs, the home visitor and family will select the rest of the team. In the residential programs it is generally expected that the team would include at least the physician and counselor. For reintegration, a vocational counselor might be a team member. If the young children are showing social, developmental, or cognitive delays an early childhood specialist could be a team member. Families may also choose to have natural social supports as part of the team. If other family members (parents, brothers, sisters, or others) are an important support they might be team members. For single parents, friends might be included. The size of the teams should be reasonably small but should include the people that will work together and take responsibility to make the plan work.

Funding

Project Before was initially funded through SAMHSA (Substance Abuse and Mental Health Services Administration) grant of $275,000 per year and $92,000 of funding through four local non profit mental health centers. As the federal funding for this grant has ended, funding from family support, juvenile justice prevention, and community

health departments has sustained some of the grant operations. The philosophy and approach has been incorporated into other system of care early intervention services.

Evaluation

During the past three and a half years, Before services have been provided for more than 300 adults and 350 children in 205 families. The evaluation of this project has shown significant increases in the utilization and follow through with physical and behavioral health services for both care-givers and children. The evaluation has also shown a significant reduction in changeable risk factors and increases in protective factors for the children. The evaluation also found significant reductions in violence, substance use, child abuse, and arrests for these families. The rate of disengagement from the program was less than for similar populations of families from Healthy Family America and Parents as Teachers programs. At the time of intake less than 17% of the women were working or going to school. After six months of receiving support 67% were working and 19% were going to school. Currently an extensive process review is underway to isolate factors that created the success of this approach.

Strategic Responses to Welfare Changes

- The community assessment used for planning purposes for the overall system of care identified lack of affordable childcare as a primary barrier to work and school for families. This was especially true for nights and weekends and also care for infants. This lead to an increased priority on the development of childcare resources and funding of several new programs to build childcare resources.

- One goal of the system of care effort was to more fully engage the business and faith communities. The business community brought jobs and flexible resources. The faith community brought human support and basic care resources.

- The whole family wraparound process focuses on goals that are priorities for families. As welfare reform has focused on getting jobs, family goals have focused more in this area.

- The planning process focuses on important issues for the family. To meet these goals case managers shape, model and celebrate successes. This process helps families take the small steps that are necessary to break the intergenerational momentum within a complex set of rules and expectations with increasing confidence.

- The case managers have flexible schedules to meet with families where and when it works best for them. This is especially important as parents begin to work.

- Focus groups for teenage parents and other families included sessions on employment goals and strategies.

- Staff from early intervention providers received cross training to better understand roles and responsibilities. This included specific training in the new TANF program.

- This is very challenging work for staff and as stresses on families increase, the stress on staff also increases. For this reason, weekly (and more often as needed) sessions with mental health supervisors, weekly peer review sessions, and monthly cross project staff meetings provided support for staff.

Issues and Concerns

- The three primary concerns involve lack of community resources to support welfare to work. Although significant progress has been made to increase childcare there are still significant shortages. Without adequate, affordable childcare options, people often turn to their families. This is of special concern for these children because of the intergenerational nature of many of the risk factors.

- The seconded limited resource is transportation. In a rural area without any public transportation this is a barrier for many families. Finally, this area is economically depressed and there are few opportunities that pay much over the minimum wage. This often means working does not mean more disposable income.

- The demands to go to work within a short period of time is creating more stress for already overburdened families. For people with mental illness and substance dependency the stress and challenges are even greater.

- The move from AFDC to work is causing some families to lose Medicaid benefits without getting comparable health insurance. We are concerned that this will result in decreased utilization of preventative health care and behavioral health services.

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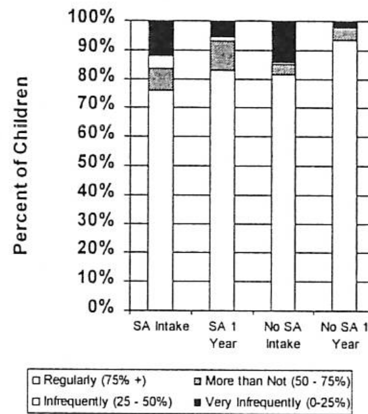
Is the Kan Focus Approach Successful for Children In Families with Substance Abuse Problems?

Analysis compares over
200+ children who live in homes with substance abuse problems
to
200+ children in which substance abuse was not reported
after one year in the project.

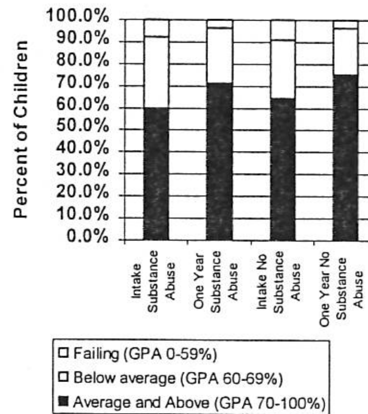
School Attendance

- All children attend school more frequently after one year in services.
- Children from homes with substance abuse did not attend as regularly at intake.
- Children from homes with substance abuse show significant progress in attendance but still lag behind children without substance abuse in their homes.



School Performance

- Both Groups show significant improvement in school performance.
- Children from homes with substance abuse have slightly lower grades at intake and one year.
- All Children show similar rates of progress.



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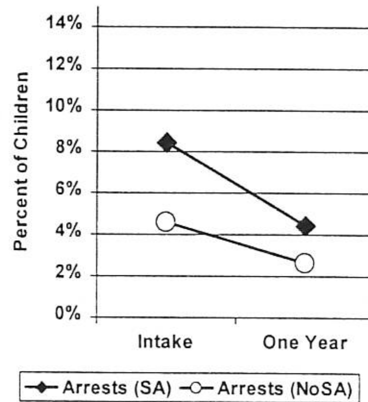
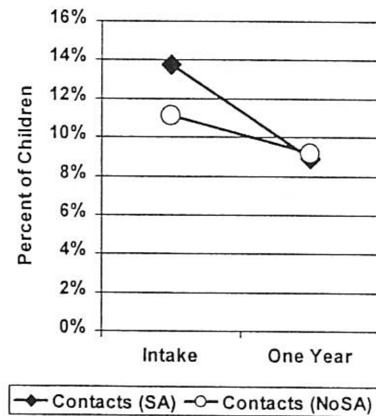
Arrests

- Both groups of children have fewer arrests.
- Children from homes with substance abuse have higher rates of arrest at intake and at one year but show the most improvement



Law Enforcement Contacts

- At intake children from homes with substance abuse were more likely to have have contacts with law enforcement.
- Both groups had less contact after one year.
- Children from homes with substance abuse were slightly less likely to have contacts after one year.



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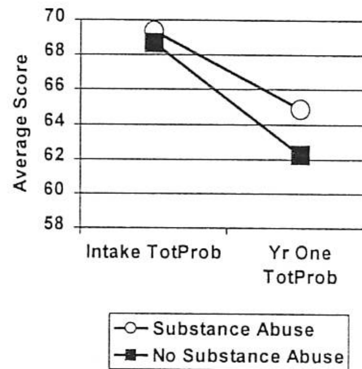
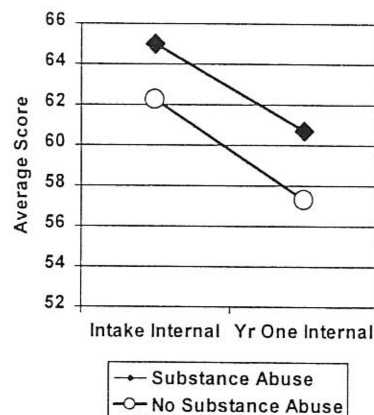
Behavior Problems

- Children from homes with substance abuse have more behavior problems at intake.
- Both groups Show significant reductions in behavior problems after one year.



Internalizing Symptoms

- Children from homes with substance abuse have more internal mental health symptoms at intake.
- Both groups show significant improvement in internal mental health symptoms after one year.



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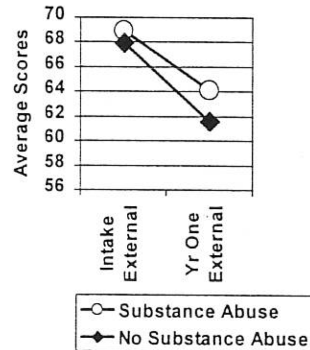
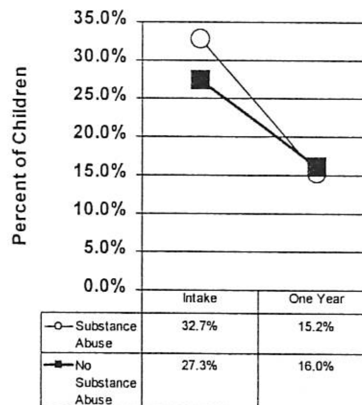
Externalizing Behavior

- Children from homes with substance abuse have more external behavior problems at intake.
- Both groups show significant improvement in external behaviors after one year.



Children with Severe Symptoms

- The percentage of children with severe emotional disorders reduced significantly after one year.
- Proportionally more children from homes with substance abuse improved.



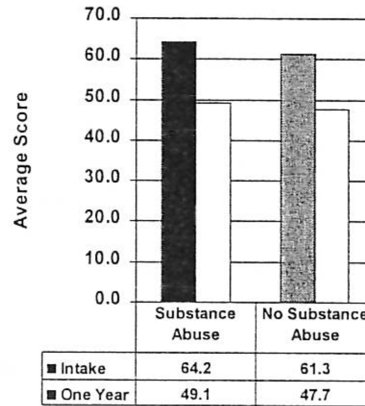
	Intake	One Year
Substance Abuse	32.7%	15.2%
No Substance Abuse	27.3%	16.0%

8-9

Mental Health Symptoms

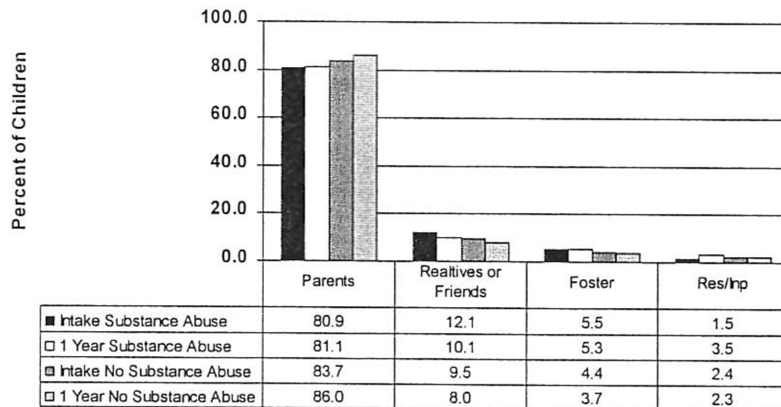
(Child and Adolescent Functioning Assessment Scale)

- Both groups show significant improvement in mental health symptoms after one year.
- While children from homes with substance abuse have more mental health symptoms they have better improvement rates.



	Substance Abuse	No Substance Abuse
Intake	64.2	61.3
One Year	49.1	47.7

Residential Placement of Children

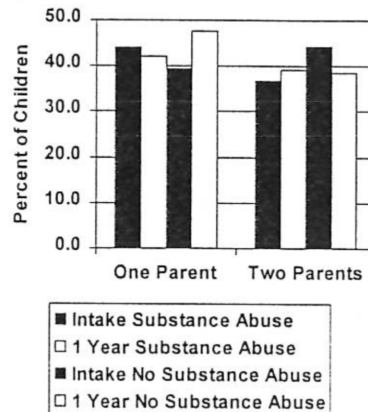


	Parents	Realtives or Friends	Foster	Res/Inp
Intake Substance Abuse	80.9	12.1	5.5	1.5
1 Year Substance Abuse	81.1	10.1	5.3	3.5
Intake No Substance Abuse	83.7	9.5	4.4	2.4
1 Year No Substance Abuse	86.0	8.0	3.7	2.3

8-10

Residential Placement

- Children from substance abuse homes are less likely to live with both parents at intake.
- Children from substance abuse homes are more likely to live with both parents at one year.



Overall Results

- ☞Children from homes with substance abuse had more problems at intake (reduced school performance, and increased behavior problems, mental health symptoms, and contacts with law enforcement).
- ☞Across all measures both groups showed significant improvement.
- ☞The whole-family strength-based approach resulted in more children from substance abuse homes living with both parents.
- ☞Clearly wraparound services provided through community mental health centers can very effectively support children from homes with substance abuse.

8-11

Tobacco *Free* Kansas Coalition, Inc.

March 17, 1999

Testimony before the House Appropriations Committee by
The Rev. Maxine M. Burch, M.S., R.D., L.D.
Health Educator, Marion County Health Department
Secretary-Treasurer, Tobacco Free Kansas Coalition

Thank you for the opportunity of coming before you this morning and speaking on a subject that is vital to our physical health and community well-being.

The persons living in rural and small town areas need our attention and care. Most mornings I drive from Newton to Marion along US Highway 50. Recently, I counted the cars and pick-ups (not the 18 wheelers), going to Newton and Wichita, over 60 vehicles alone in the 6 miles between Newton and Walton. These are the parents and grandparents of Marion County kids going to work. Later in the day, another group leaves for the night shifts between 3 PM and 11 PM in hospitals in Newton and Wichita.

Who is providing the adult monitoring and care-giving for school-aged children in Marion County? Local statistics show that there are 65 registered or licensed infant and child care units in Marion County which has a population of 13,000. Who is the child's adult role model and companion from dawn until midnight? Look at the increased incidence of smoking by sixth graders (little adults playing adult games across our state). We have created the base for billions of dollars in medical bills and years of suffering because tobacco companies spend billions for advertising as well as setting up plots with scenes of cigarette use on theTV programs these children watch when better ideas are not provided them.

The Marion County Health Department maintains school health care for our county's five school districts and is on call for this service Monday through Friday as needed. We could use more help. We could use more money which is always short. All health departments need and can use money which is received and allocated through the Kansas Department of Health and Environment's program budgeting. We need to extend our care to children, birth to 18 years, by expanding current programs and devising new programs to reduce juvenile problems in the community and the high cost of legal counsel and treatment facilities. The school districts have worked diligently to have all school sites smoke free. There is still difficulty in ensuring that guests do not smoke at school athletic events. We are still working in that area.

TOBACCO FREE KANSAS COALITION, INCORPORATED

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Maxine Burc
CHRONIC DISE
HEALTH PROMO
MARION COUNT

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I am paid for 40 hours a month, and volunteer for many other hours, to cover programs for cardiovascular care, tobacco-use prevention for all ages, health nutrition for all ages, increased physical activity to reduce obesity and to improve agility and flexibility, and breast cancer (I am a cancer survivor).

"The fields are ripe for harvest," and who will harvest the lives of our youth? Will it be the tobacco companies' nicotine addiction, a disease like emphysema, or surgery that removes a voice box? Or will it be legislators like you who will work for wellness and health promotion and care? Where do we, you and I put our money? You know the number of years and lives lost to tobacco use in Kansas.

I would say put sufficient tobacco settlement funds into tried and tested services with programs that are carefully monitored, publicly reported, and fiscally sound. An ounce of prevention is worth a pound of cure. Let's support tobacco-use prevention and cessation programs for people in our counties. Such programs are needed in the counties you represent.

EMBARGOED FOR RELEASE: 15 MARCH 1999 AT 12:00:00 ET US

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Cigarette Smoking Key To Future Risky Behaviors, Wake Forest Study Shows

WINSTON-SALEM, N.C. - It can be hard for educators, family members and even friends to know when a child begins to make choices that could end his life. Researchers at Wake Forest University Baptist Medical Center are making that distinction easier. A recent study shows that the age a child begins to smoke cigarettes is the key.

The study, published in the March issue of the Archives of Pediatrics and Adolescent Medicine, says middle school aged adolescents who begin to smoke cigarettes at age 11 or younger engage in twice the number of risky behaviors that could end their life.

"The age of onset of cigarette smoking has the highest correlation to other health risk behaviors," according to Robert H. DuRant, Ph.D., the Director of the Brenner Center for Child and Adolescent Health and Professor and Vice-chair of the Department of Pediatrics and the author of the study.

Those risky behaviors can include: riding in car with a drinking driver, carrying a knife or gun to school, fighting, inhalant use, having a suicide plan and using other substances such as marijuana and cocaine, according to DuRant.

"This study shows that adolescents who begin to smoke at earlier ages are much more likely to engage in behaviors that have the potential of ending their life in the near future, not down the road," DuRant said. " Other important factors associated with engaging in multiple risk behaviors are the use of alcohol and marijuana at an early age. Cigarette smoking and alcohol consumption are often considered gateway drugs to other substance abuse, because they are more easily accessible. Teens who smoke or drink, often find peer groups to reinforce their smoking and drinking and introduce them to other more dangerous drugs like cocaine as they mature."

The study also found that early use of cocaine, being male, being white, and not doing well in school, were also significantly associated with the number of health risk behaviors these middle school students reporting engaging in, DuRant said.

The study sampled over 2,000 students from 53 randomly selected North Carolina middle schools. Students were asked to rate on a Health Risk Behavior Scale the number of risk behaviors they had participated in from a list of 16 different behaviors.

"What this says to educators and the community is that we need comprehensive health education programs in our schools," DuRant said. "We need to explain to children the risks associated with these behaviors and teach them skills on how to avoid these risks to their health and well-being.

"We also need to provide after-school programs for our children, helping them with homework, teaching them to enjoy math, science, art, etc, and educating them about practical things like how to balance a checkbook."

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9-3

Tobacco Free Kansas Coalition, Inc.

March 17, 1999

TRUST FUND FOR TOBACCO SETTLEMENT DOLLARS-PRIORITIES

Good morning, my name is Terri Roberts and I am the Executive Director of the Kansas State Nurses Association and serve as the Chairperson of the Policy Task Force for the Tobacco Free Kansas Coalition.

The Coalition supports creation of a trust fund, if the priorities remain the same as in the current statute: Child Health Programs, Services for |Children and Tobacco Use and Prevention. We believe that a substantial portion of the money coming from the settlement should be used for the tobacco prevention aspect. The following is our rationale for this:

Tobacco Company Payments Should Go To Fight Tobacco Company Harms. The tobacco payments to Kansas are intended to compensate for past tobacco-related harms and related costs. Accordingly, the payments should be used to reduce the amount of damage tobacco use will cause and that means using settlement funds to sharply curtail smoking and other tobacco use in Kansas, especially among children.

The Public Supports Using Tobacco Settlement Money For Tobacco Control. In a recent nationwide poll, 84 percent of the respondents favored spending the money their state receives to reduce tobacco use among kids, including more that two-thirds (69%) who "strongly favor" spending the money for this purpose. Similarly, in pre-election polls of likely voters in 18 states, more than 85 percent, on average, said that about half or more of any settlement funds should be spent to reduce smoking among kids (with less that 1% saying that none of the funds should be so used.)

The Smoking Problem Is Big And Getting Worse. Almost one-quarter of all adults are current smokers, along with more than a third of all high school students. Adult smoking has generally been declining in recent years, but this downward trend may have slowed or stopped. Although a small drop in underage smoking from 1997 to 1998 has interrupted the otherwise steady increases in youth smoking since the early 1990s, smoking among kids is still at historically high levels. Over

Judy Keller, B.A., M.B.A. Renee Kelley Maxine Burch

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die from tobacco-related causes, with many more suffering serious health consequences.

Comprehensive Statewide Tobacco Control Strategies Dramatically Reduce Smoking And Other Tobacco Use. California and Massachusetts have already initiated tobacco control campaigns that have reduced overall smoking levels within their borders at a faster rate than elsewhere in the country.

New Tobacco Control Spending Will Save Lives. Tobacco use is responsible for more deaths than alcohol, auto accidents, AIDS, suicides, murders, and illegal drugs combined. Each year, more than 400,000 people die from smoking-related causes in the United States and Kansas. Countless others suffer from tobacco-related disease and distress, including many of those exposed to secondhand smoke. Directing tobacco settlement monies to tobacco control can reduce this unnecessary disease, misery, and death -- and there is no better investment a state can make to save lives and improve public health.

New Tobacco Control Spending Will Save Money. Public and private direct expenditures to treat health problems caused by smoking annually total more than $70 billion, with state governments paying more than $12.5 billion every year in cigarette-related Medicaid expenditures. Kansas is projected to spend $87,142,611. Expenditures for health care relating to smokeless tobacco use, cigar and pipe smoking, and exposure to secondhand smoke add even more to the health costs from tobacco use. Beyond these direct health expenditures are tobacco-related labor costs and lost productivity ($30 billion per year or more); damage and loss from cigarette-related fires ($500 million); and tobacco-related maintenance and cleaning expenses ($4 billion). Aggressive tobacco control initiatives would reduce all of these tobacco-related costs and save Kansas, its businesses, and its citizens, millions of dollars each and every year.

Nickel And Diming The Problem Won't Work. Significantly reducing tobacco use requires substantial investment in a sustained and comprehensive multi-year tobacco control strategy. Anything less will not effectively counter the addictive power of nicotine or the tobacco companies' advertising and marketing expenditures (more than $5 billion per year nationwide). Existing tobacco control efforts throughout the country demonstrate that the best way to reduce tobacco use, other than raising prices, is to take full advantage of a wide range of proven effective measures, including counter advertising, school and community-based prevention and cessation programs, the enhanced enforcement of laws prohibiting the sale of tobacco products to kids, and the firm maintenance of smoke-free workplaces and public areas. While any one of these tobacco control measures can reduce tobacco use by itself, they work much more powerfully and effectively when together.

Relying On The Settlement Agreement's Tobacco Control Provisions Won't Work. Although the MSA contains some useful restrictions on tobacco marketing, they will not, by themselves, significantly hinder the tobacco industry's ability to market to kids. Similarly, the new national public education campaign financed by the multi-state settlement can significantly reduce tobacco use only if it is accompanied by strong state tobacco control efforts, including new state public education strategies. Put simply, the tobacco settlements can dramatically cut tobacco use only if the states use their tobacco company payments to finance new tobacco control initiatives.

If The States Don't Do It, No One Else Will. Because of a special provision in the MSA agreement, until 2003 the tobacco companies' payments to Kansas will be reduced dollar for dollar by any new federal funding made available to the states for tobacco control efforts that comes from an increase in the federal tobacco tax or from any other new charges against the tobacco companies. Kansas received

Adequately Funding A Comprehensive Statewide Tobacco Control Strategy will Still Leave Plenty of Settlement Funding For Other Purposes. The Tobacco Free Kansas Coalition has estimates of what it would cost Kansas to adequately fund a comprehensive tobacco control effort. These estimates make it very clear that Kansas could establish a strong new tobacco control program with only a fraction of the settlement payments.

Directing Settlement Payments to Tobacco Control Will Not Waste Money. Thanks to the extensive research and evaluation of existing tobacco control efforts, Kansas could easily direct its settlement payments to support only those types of tobacco control initiatives that have successful track records and that follow available research findings on how best to maximize beneficial results. The Tobacco Free Kansas Coalition and health partners throughout the state that developed the comprehensive statewide tobacco control plan included an evaluation component that would further enhance cost effectiveness..

Dedicating the Tobacco Settlement dollars to a trust fund has the benefit of producing a sustaining source of funding until *infinity and beyond.* The Tobacco Free Kansas Coalition thanks the committee for committing the time to pursue testimony on using the Settlement dollars in the future.

CAMPAIGN for TOBACCO-FREE Kids

THE TOBACCO SETTLEMENT CAN PAY FOR TOBACCO CONTROL -- AND MORE

-- Fully Funding A New State Tobacco Control Program Leaves Plenty For Other Uses --

Under Kansas's settlement agreement with the tobacco companies, the companies will pay the state a total of $1.63 billion through the year 2025 (adjusted for inflation), or about $60 million per year, on average. But the actual payment schedule is somewhat irregular.

It makes sense to use this tobacco money to reduce future tobacco use and related costs in the state. But the U.S. Centers for Disease Control and Prevention (CDC) estimates that Kansas needs to spend only about $18 to $44 million per year to establish and run a comprehensive statewide tobacco control program that would sharply decrease tobacco use, save thousands of lives, dramatically improve public health, and garner enormous savings for the state, its businesses, and its citizens.*

Accordingly, Kansas could direct $31 million per year of the tobacco settlement monies to new tobacco control efforts (an amount roughly halfway between CDC's low and high recommendations), and still have, on average, roughly $20 million per year of remaining settlement payment funds to use for other purposes.

Kansas could further increase the amount of money available for tobacco control and other purposes by raising its tobacco taxes (which is another especially effective way to reduce smoking and other tobacco use). While some states already tax cigarettes at rates as high as $1.00 per pack, Kansas currently taxes cigarettes at a rate of 24 cents per pack.

Schedule of Tobacco Settlement Payments to Kansas
(Amounts in Millions of 1998 Dollars)

Year	Tobacco Co. Payments	For Tobacco Control (Median CDC Estimate)	Remaining Funds (In Each Year)	Cumulative Remainder (For Other Uses)
1999	$20	$16 (½ year)	$4.5	$4.5
2000	$53	$31	$22.5	$27.0
2001	$58	$31	$26.7	$53.7
2002	$69	$31	$38.3	$92.0
2003	$70	$31	$39.0	$130.9
2004	$58.4	$31	$27.4	$158.3
2005	$58.4	$31	$27.4	$185.7
2006	$58.4	$31	$27.4	$213.1
2007	$58.4	$31	$27.4	$240.5
2008	$59.5	$31	$28.5	$269.1
2009	$59.5	$31	$28.5	$297.6

Annual tobacco company payments stay at the 2008 level until increasing to $66.7 million/year starting in 2018. Table assumes that the new state tobacco control program will be enacted in 1999 and funded at a level midway between CDC's low and high estimates, with funds distributed halfway through 1999, at the earliest. 1999 payment actually scheduled for December 1998. Payment information from materials available through the National Association of Attorneys General (NAAG) website [http://www.naag.org/tob2.htm]. CDC estimates from its Office on Smoking and Health, "State Comprehensive Tobacco Prevention and Control Guidelines" (November 1998).

* A comprehensive tobacco control program would include counter advertising, community and school-based cessation and prevention programs, increased enforcement of existing laws that prohibit tobacco sales to kids and establish smoke-free workplaces or public areas, and rigorous oversight and evaluation to save money and promote effectiveness.

TABLE 1

The Economic Costs of Smoking in the United States

Source of Cost	Cost of Smoking in U.S. ($1998 billions)	Possible Long Run Benefits from Legislation ($1998 billions)
Adult Medical Spending	$45	$27
Smoking During Pregnancy	$4	$2.4
Lost Workdays	$0.5	$0.3
Lost Output from Shortened Work Lives	$80	$48
Smoking-Induced Fires	$0.5	$0.3
TOTAL SOCIAL COSTS OF SMOKING AND BENEFITS OF SMOKING REDUCTIONS	**$130**	**$78**
Additional Potential Costs		
Value of Reduced Mortality	$120	$72
Possible Productivity Reductions for Smokers	$50-$125	$20-$75

Office of Economic Policy, U.S. Treasury Department

It is important to recognize that all of these represent, in the language of economics, real resource costs. That it is to say, the $130 billion that smoking costs is much more burdensome to our economy than the same amount levied in taxes, which impose a cost on consumers, but provide offsetting revenues to our government. It is proverbial that there is no such thing as a free lunch. But in a sense, successfully preventing people from acquiring an addiction they do not want to have — by effectively combating youth smoking — is a free lunch with real benefits for

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CAMPAIGN for TOBACCO-FREE Kids

-- THE TOLL OF TOBACCO IN THE UNITED STATES OF AMERICA --

Tobacco Use in the USA

- **High school students who smoke: 36%**
- **High school males who use smokeless tobacco: 25%**
- **Number of kids (under 18) who become new regular smokers each day: 3,000+**
- **Kids exposed to secondhand smoke at home: 15.5 million**
- **Number of packs of cigarettes illegally sold to kids in the USA each year: 250+ million**
- **Adults in the USA who smoke: 23%**

While adult smoking has generally been decreasing throughout the country, these declines have slowed or stopped. Smoking among kids has sharply increased over the past decade, but a recent survey has finally showed a small decline. Nevertheless, youth smoking is still at historically high levels. Over the past ten years the number of kids under 18 who become daily smokers each year has increased by over half a million, a greater than 70% increase. Roughly 3,000 kids still become regular smokers each and every day and, given current smoking and disease patterns, almost a third of these underage smokers will ultimately die from tobacco-related causes.

Deaths in the USA From Smoking

- **Number of people who die each year from smoking: 400,000+**
- **Number of kids now under 18 who will die from smoking (if current trends continue): 5,000,000+**

Smoking kills more people than alcohol, AIDS, car accidents, illegal drugs, murders, and suicides combined -- and thousands more die from other tobacco-related causes, such as fires caused by smoking (over 1,000 deaths/year nationwide), smokeless tobacco use (no good estimates currently available), and exposure to secondhand smoke (over 40,000 deaths). Millions of other tobacco users suffer from serious tobacco-related diseases and other health problems each year without actually dying.

Tobacco-Related Monetary Costs

- **Total annual public and private health care expenditures in the USA directly related to smoking: $72 billion**
  - **Federal and state government Medicaid payments directly related to smoking: $12.8 billion**
  - **Federal government Medicare expenditures each year attributable to smoking: $14.1 billion**
- **Additional expenditures in the USA for health and developmental problems of infants caused by their mothers' smoking or being exposed to second-hand smoke during pregnancy: $1.4 to $4.0 billion**
- **Residential and commercial property losses from fires caused by cigarettes: $500 million**
- **Tobacco-related cleaning and maintenance (commercial only): $4 billion**

Additional tobacco costs include the healthcare costs from direct exposure to second hand smoke, smoking-caused fires, and smokeless tobacco use, which certainly total in the billions of dollars and increase the U.S. Government's Medicaid burden, but no good dollar-amount estimates are currently available. A major indirect cost from tobacco use comes from lost or reduced work productivity -- e.g., from work absences, on-the-job performance declines, and early termination of employment caused by tobacco-related health problems -- which totals at least $40 billion per year.

Tobacco Industry Advertising & Political Influence

- **Annual tobacco industry advertising and promotion expenditures nationwide: $5.1 billion**

Published research studies have found that kids are three times as 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 and promotion.

- **Annual tobacco industry contributions to federal candidates and political parties: Over $5 million**
- **Tobacco industry expenditures in 1998 to influence state ballot questions and for a media campaign against the McCain tobacco control bill: Over $70 million**
- **Tobacco Industry expenditures lobbying Congress during the first half of 1998: Over $40 million**

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BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

January 26, 1999

Ms. Terri Roberts
Executive Director
Kansas State Nurses Association
700 SW Jackson, Suite 601
Topeka, KS 66603-3731

Dear Terri:

I am responding to your request for information on Medicaid expenditures related to smoking which I received on Thursday, January 21, 1999. As we discussed on the phone January 21, the Kansas Foundation for Medical Care performed a study in 1997 for Medicaid on prenatal care. One finding in this study was that 24% of pregnant Medicaid beneficiaries smoked during their pregnancy. Additionally, the policy study conducted by the Adult and Medical Services Commission in 1998 consisted of a claims analysis to determine Medicaid expenditures related to smoking.

The claims analysis involved a review of Medicaid claims related to three pediatric disease states which may be affected by smoking. Based on the review of claims, it was estimated that a total of $858,000 was spent in FY 1996 on asthma and otitis media care attributable to smoking, and approximately $1.8 to $3 million was spent in FY 1997 on low birth weight infant care attributable to smoking.

Another Medicaid cost estimate conducted in 1998 utilized CDC data which estimated State Medicaid costs related to tobacco. A total annual Medicaid expenditure estimate was developed for 1983 - 1998 by applying an inflation factor to the CDC's estimate, and accounting for Medicaid person months each year. This information is attached. The data obtained from the CDC may also be retrieved from their website at www.cdc.gov.

If you have any questions related to the above information, please feel free to contact me at 296-6968.

Sincerely,

Karen S. Braman

Karen S. Braman, R.Ph., M.S.
Adult and Medical Services Commission

KSB:mks
Att.
cc: Ann E. Koci
Bob Heintzelman
Narinder Singh

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Kansas Medicaid Costs Related to Tobacco

State FY	Person Months	Average Persons Per Month	US Med CPI Dec.	Medicaid Costs (Base Dollars)	Medicaid Costs (Current Dollars)
1983	1,562,144	130,179	96.9	$25,347,088	$63,881,321
1984	1,545,734	128,811	103.1	$26,676,146	$63,210,261
1985	1,448,438	120,703	109.4	$26,519,231	$59,231,500
1986	1,445,878	120,490	116.8	$28,257,626	$59,126,813
1987	1,532,952	127,746	125.8	$32,278,378	$62,687,562
1988	1,508,240	125,687	133.1	$33,613,192	$61,677,005
1989	1,537,167	128,097	142.3	$36,614,686	$62,859,928
1990	1,653,085	137,757	154.4	$42,723,993	$67,600,204
1991	1,843,415	153,618	169.2	$52,209,897	$75,383,438
1992	2,048,554	170,713	182.6	$62,614,879	$83,772,262
1993	**2,218,414**	**184,868**	**194.7**	**$72,300,000**	**$90,718,490**
1994	2,371,514	197,626	205.2	$81,457,749	$96,979,182
1995	2,460,548	205,046	215.3	$88,675,823	$100,620,082
1996	2,341,665	195,139	223.8	$87,723,147	$95,758,556
1997	2,275,046	189,587	230.6	$87,817,050	$93,034,281
1998	2,130,972	177,581	237.1	$84,574,347	$87,142,611
1999 Est.	2,038,392	169,866	244.3	$83,356,703	$83,356,703
				Total 5-year	**$459,912,233**
				Total 10-year	**$874,365,809**

Notes:
Based on CDC data for 1993

Average Persons = Person Months / 12

Memorandum

TO: Representatives Phill Kline and Rocky Nichols

FROM: Jim Wilson, First Assistant Revisor

DATE: March 10, 1999

SUBJECT: Proposed Bill — Disposition of Tobacco Litigation Settlement Proceeds — 9rs1155

This bill would enact the following major policies:

1. All moneys received by the state of Kansas would be deposited to the credit of the Children's Trust Fund, which is created by the bill. The Children's Health Care Programs Fund is abolished and any moneys credited to the Children's Health Care Programs Fund are transferred to the Children's Trust Fund.

2. The Children's Initiatives Fund is created for the purposes of providing additional funding for programs, projects, improvements, services and other purposes directly or indirectly beneficial to the physical and mental health, welfare, safety and overall well-being of children in Kansas.

3. Moneys are to be annually transferred from the Children's Trust Fund to the Children's Initiatives Fund, commencing with $45,000,000 in FY 2000 and with amounts each ensuing fiscal year equal to 102.5% of the amount transferred during the preceding fiscal year.

4. A Children's Authority is established. The Children's Authority is to be composed of 11 persons who are children's advocates, members of organizations with experience in programs that benefit children or other individuals who have experience with children's programs and services [seven appointed by the Governor and one appointed by each of the Speaker, President and both Minority Leaders]. The Children's Authority is to advise and provide recommendations to the Governor and to the Legislature regarding the uses of the moneys transferred to the Children's Initiatives Fund.

5. A Children's Trust Fund Board of Trustees is established and is attached to the office of the State Treasurer. The Board of Trustees is composed of nine members who have backgrounds in finance or investments or experience working for a foundation or as a trust officer. The nine members are the State Treasurer and eight appointed members who are not legislators [four appointed by the Governor and one appointed by each of the Speaker, President and both Minority Leaders]. The appointed members serve for two-year terms and are subject to confirmation by the Senate. The State Treasurer is the chair.

6. The Children's Trust Fund Board of Trustees is responsible for the management and investment of the Children's Trust Fund. The Children's Trust Fund Board of Trustees will contract for the services of one or more professional investment managers and will utilize the services and assistance of the professional investment staff of the Board of Trustees of the Kansas Public Employees Retirement System.