

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman James Barnett at 1:30 P.M. on January 18, 2005 in Room 231-N of the Capitol.

Committee members absent:

Committee staff present: Emalene Correll, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Norm Furse, Office of Revisor of Statutes
Whitney Nordstrom, Committee Secretary

Conferees appearing before the committee: Julia Francisco, Program Director, Tobacco Use Prevention Program, Office of Health Promotion, KDHE
Anthony Wellever, Vice President and Director of Special Projects, Kansas Health Institute

Introduction of bills

Upon calling the meeting to order, Chairperson Barnett asked for the introduction of bills. Richard Morrissey, Interim Director of Health, KDHE, presented the introduction of three bills. The drafts of these bills were not available at the time of the meeting.

Senator Brungardt motioned to adopt the introduced bills. Senator V. Schmidt seconded the motion. Motion passed.

Chairperson Barnett then introduced Julia Francisco, Program Director, Tobacco Use Prevention Program, Office of Health Promotion, KDHE, who began by thanking the Committee then stated the title of her presentation: "Expected Impact of a Tobacco Use Prevention Program". A copy of her presentation is (Attachment 1) attached hereto and incorporated into the Minutes as referenced. Highlights of her presentation included:

- 1) Cost of Tobacco Use in Kansas
- 2) Prevention Works
- 3) Current Efforts in Kansas

Chairperson Barnett thanked Ms. Francisco for her presentation and asked the Committee for questions and/or comments.

A range of questions and comments came from Senators Barnett and V. Schmidt including why other states are more successful in their smoking prevention efforts and where the rest of the 90% of the settlement is allotted to.

Chairperson Barnett then introduced Anthony Wellever, Vice President and Director of Special Projects for the Kansas Health Institute, who began by thanking the Committee and stating the title of his presentation: "Cost-benefit of Tobacco Use Cessation". A copy of his presentation is (Attachment 2) attached hereto and incorporated into the Minutes as referenced. Highlights of his presentation included:

- 1) Tobacco use costs to the health care system
- 2) Probable return on investment of state expenditures on tobacco cessation programs
- 3) Tobacco Use Prevention Expenditures and Health Care Savings
- 4) Tobacco Use Prevention Expenditures and Health Care Savings (Time Lag)
- 5) Tobacco Use Prevention Expenditures and Health Care Savings (Sensitivity Analysis, Twenty Percent Reduction)

Chairperson Barnett thanked Mr. Wellever for his presentation and asked the Committee for questions and/or comments.

CONTINUATION SHEET

MINUTES OF THE Senate Public Health and Welfare Committee at 1:30 P.M. on January 18, 2005 in Room 231-N of the Capitol.

Adjournment

As there was no further business, the meeting was adjourned. The time was 2:15.

The next meeting is scheduled for January 24, 2005.



K A N S A S

RODERICK L. BREMBY, SECRETARY

KATHLEEN SEBELIUS, GOVERNOR

DEPARTMENT OF HEALTH AND ENVIRONMENT

Expected Impact of a Tobacco Use Prevention Program Testimony Presented

To

Senate Public Health and Welfare

By Julia M. Francisco
Program Director, Tobacco Use Prevention Program, Office of Health Promotion

Kansas Department of Health and Environment

January 18, 2005

Chairman Barnett and members of the Senate Public Health and Welfare Committee, my name is Julia Francisco and I am the program director of the Tobacco Use Prevention Program in the Office of Health Promotion in the Division of Health at the Kansas Department of Health and Environment. Thank you for the opportunity to appear before you today regarding the cost effectiveness of a tobacco use prevention program within the Department of Health and Environment.

Cost of Tobacco Use in Kansas

Tobacco use is the single most preventable cause of death and disease in Kansas. Most people who use tobacco begin using it in early adolescence, typically by age 16; almost all first use occurs before high school graduation. Currently 28% of Kansas adults report using at least one form of tobacco. This includes cigarettes, spit or smokeless tobacco, cigars, pipes, and other forms of novel smoked tobacco. Cigarette smoking is reported by 20% of Kansas adults. Currently 29% of high school students report using at least one form of tobacco. This includes cigarettes, spit or smokeless tobacco, cigars, pipes, and other forms of novel smoked tobacco. Cigarette smoking is reported by 21% of high school students.

History shows us that of teen smokers, one third will quit, one third will continue to use tobacco and suffer illness and reduced health, while one third will eventually die prematurely due to diseases caused by tobacco addiction. If current trends continue, nearly 57,000 Kansas youth who are alive today will die prematurely due to tobacco related diseases. Tobacco use is addictive; of the nearly 403,000 Kansas adults who currently smoke, more than 1/2 report that they have tried to quit in the past year. Less than 6% of smokers are able to quit in any given year.

*Senate Public Health and
Welfare 1-18-05
Attachment #1*

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K A N S A S

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DEPARTMENT OF HEALTH AND ENVIRONMENT

The health costs of tobacco are enormous. Tobacco currently costs Kansas \$724 million in direct medical costs, plus another \$741 million in indirect (lost productivity) costs per year. This includes \$153 million in Medicaid program expenditures. These costs will continue at this level or increase into the second quarter of this century if smoking rates are not reduced.

Prevention Works

A strong science base has been established over the past 2 decades that substantiate the effectiveness of state tobacco use prevention programs. The Centers for Disease Prevention and Control has prepared a guidance document, *Best Practices for Comprehensive Tobacco Control Programs* to assist state programs in implementing effective, comprehensive programs. Nine components have been identified in building an effective statewide Program. These include:

- 1) Community programs to reduce tobacco
- 2) Chronic disease programs to reduce the burden of tobacco-related diseases
- 3) School programs
- 4) Enforcement
- 5) Statewide programs
- 6) Counter-marketing
- 7) Cessation programs
- 8) Surveillance and evaluation
- 9) Administration

States who have invested in comprehensive tobacco use prevention programs have made tremendous gains in cutting tobacco use and in decreasing health care expenditures due to tobacco related diseases. For example: since 1990, California has cut its youth smoking by more than ½ and has experienced a faster decline in adult smoking than anywhere else in the country. The drop in lung cancer was significant within the first 10 years of their tobacco prevention program as a result of the declines in smoking. Similarly, Massachusetts accomplished a decline in adult smoking of 22% and decline in youth smoking by 27% in less than 10 years.

Mississippi has decreased middle school smoking prevalence by 42% and high school prevalence has decreased by 24% since implementing a youth targeted program in 1999. Oregon has seen an adult prevalence decrease of 13% since 1996 and a decrease in the prevalence of pregnant smokers of 28%, saving an approximate \$1.3 million in health care costs for low birth weight infants. In Texas, pilot communities reported a decline in smoking prevalence that was twice as high as the comparison communities during the same time period. More recently, Florida and Minnesota have implemented comprehensive programs and are experiencing similar impressive results. The studies to date indicate that a state will save \$3 for every \$1 invested into tobacco use prevention at a comprehensive level.



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Current efforts in Kansas

Kansas currently invests approximately 10% of the \$18.1 million minimum amount recommended for a comprehensive program. All but \$500,000.00 is from federal and private sources of funding. Even with the relatively small amount of funding that Kansas has invested, we can detect decreases in tobacco use through a variety of interventions throughout the state. Strong and productive partnerships across the state, supplemented by small, narrowly targeted grants have contributed to the decline in youth smoking, which has decreased by 19% in high school students and 8% in middle school students between 2000 and 2002. This represents approximately 4400 fewer teens smoking today than in 2000. Adult rates have been much slower in moving downward, decreasing from 22.4% in 1992 to 20.4% in 2003.

Thank you for your interest in tobacco use prevention. I would be happy to answer any questions you might have.



KANSAS HEALTH INSTITUTE

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Cost-benefit of Tobacco Use Cessation

January 18, 2005

Senate Committee on Public Health and Welfare

Anthony Wellever
Vice President and Director of Special Projects
Kansas Health Institute

Healthier Kansans Through Informed Decisions

The Kansas Health Institute is an independent, non-profit health policy and research organization based in Topeka, KS. Established in 1995 with a multi-year grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

*Senate Public Health and
Welfare
1-18-05
Attachment #2*

I am Anthony Wellever, Vice President and Director of Special Projects at the Kansas Health Institute, a non-partisan, nonprofit health policy research organization located in Topeka.

On October 12 of last year, we observed the 40th anniversary of the first appearance on cigarette packages of the Surgeon General's warning against smoking. The science linking cigarette smoking to lung cancer and other respiratory and cardiac diseases was sufficient by 1964 for the Surgeon General to place this unprecedented warning on the product itself.

And here we are 40 years later: 22 percent of adults and 21 percent of high school students in Kansas are tobacco users; approximately 460,000 Kansans still use tobacco products. Smoking is the leading cause of preventable death and disease in Kansas. Tobacco use costs the health care system in Kansas \$724 million per year in direct medical costs. Of this amount, \$153 million is paid by the Medicaid program. Estimates of the indirect costs of smoking in Kansas run as high as \$741 million in lost productivity due to absenteeism and damage to personal property. Direct and indirect costs of smoking in Kansas total \$1,465,000,000 *annually*, an amount equal to approximately \$543 for every man, woman, and child in Kansas regardless if they smoke or not.

This cost burden falls more heavily on users of tobacco products, as it should, but much of the burden is carried by non-smokers. I already mentioned the expense to the Medicaid program, but the cost of higher health insurance premiums for the state employees' health plan due to the avoidable cost of tobacco-related disease of state employees and their dependents who use tobacco products is also a cost born largely by the State of Kansas. Because insurance is based on the principle of pooled risk, one could argue that the cost of all health insurance would decrease if these costs were withdrawn from the system. In a sense, the 80 percent of us who do not use tobacco are being taxed without our knowledge and without our consent by the 20 percent who do.

I was invited here today by Senator Barnett to provide testimony on a specific aspect of the tobacco debate—the probable return on investment of state expenditures on tobacco cessation programs. The projected savings I am about to show you were calculated by the Campaign for Tobacco-Free Kids, a public health advocacy organization focused on reducing tobacco use. I have not seen the model employed, but I believe it is based on one prepared by the U.S. Centers for Disease Control and Prevention, which in turn is based on empirical findings from states, such as California, that have mounted large scale and sustained tobacco cessation efforts.

My presentation focuses on an explanation of the three charts at the back of this written testimony. The first chart is the most important, in part, because it is the easiest to understand. The other two charts are variations on a theme. The savings on all three charts represent only those coming from reductions in *medical* expenditures related to tobacco use.

I used the Campaign for Tobacco-Free Kids' projections to make some assumptions about savings over time and represent them graphically. I assumed a five-year expenditure of 90.3 million dollars (\$18.1m/yr.), the amount CDC suggests a state the size of Kansas should invest in tobacco cessation.

The Campaign for Tobacco-Free Kids projected lifetime adult health care savings of \$814.3 million and lifetime youth health care savings of \$427.2 million, for a total health care savings of \$1.24 billion. (Chart 1)

I made the following assumptions about the distribution of the savings over time. I assumed that approximately 70 percent of the adult lifetime savings would occur in the first 15 years after quitting smoking. Because of numerous factors—including the deaths of people who had previously smoked—I estimated that the cost savings per year would taper off over the next 20 years.

I assumed that the health costs of youths not taking up smoking would not become apparent until 15 years after the beginning of a smoking cessation program, allowing time for teenagers to become addicted to tobacco and for the long-term consequences of tobacco use on health to begin to show. Approximately 40 percent of the savings, I assumed, would be achieved between years 15 and 30. And in the next 15 years, as the youth cohort continues to age, cost savings per year will increase.

Finally, I added the youth curve to the adult curve to get total health care savings. In this estimate, there is no break-even point, because savings in every year exceed expenditures. However, this estimate is not how the world really works.

(Chart 2) In the real world, a smoking cessation program will not be up and running the moment it is funded. There will be an implementation time lag. The program has to be designed, tested, and implemented at the local level. And then it will take time for the message to be acted upon and for smokers to actually quit smoking.

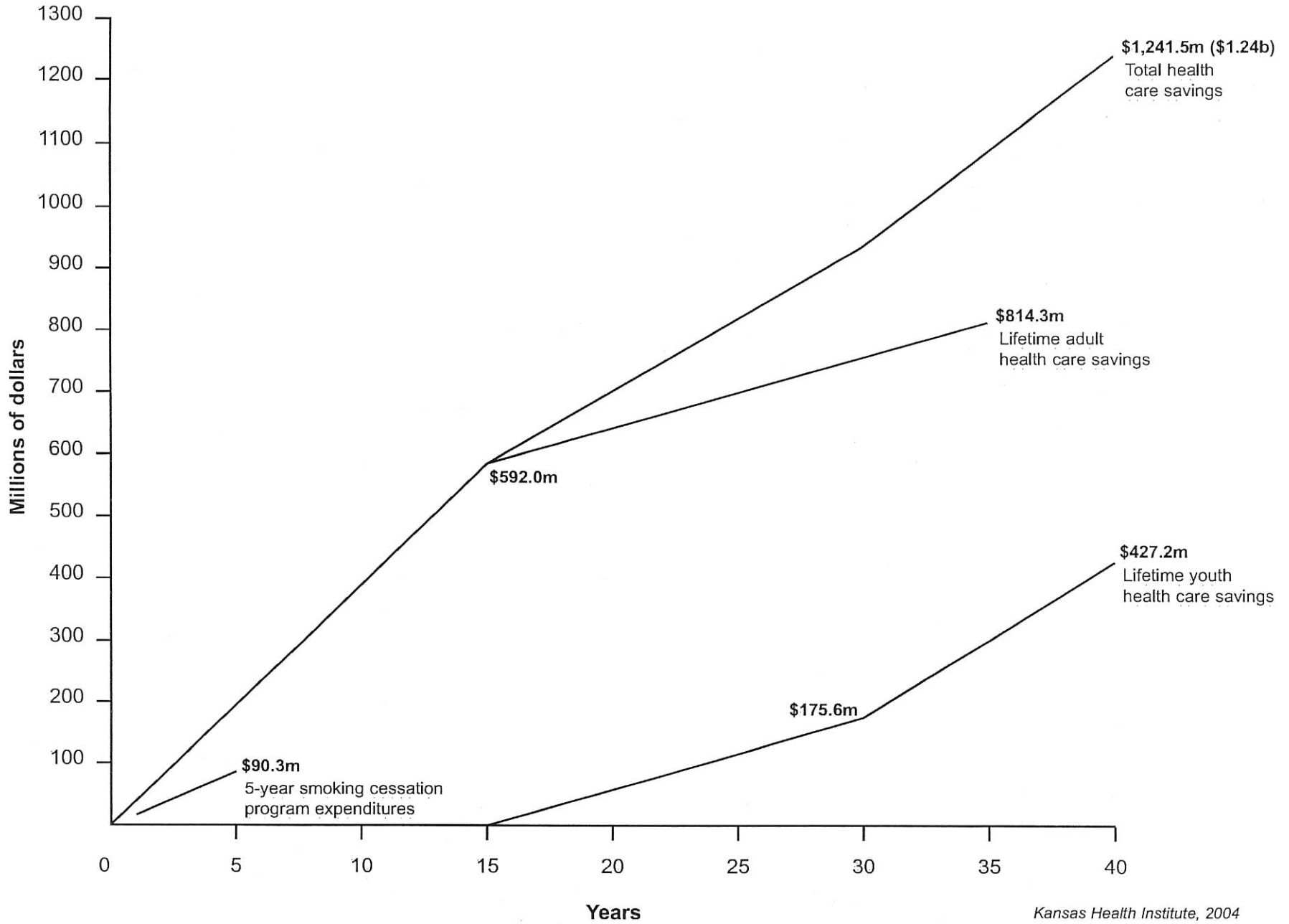
Therefore, I assumed that there would be a two and a half year lag between the beginning of the program and the first cost savings. When you make this assumption, program expenditures *do* exceed program benefits for the first five years and some months. After that, cost savings exceed program expenditures.

(Chart 3) The Campaign for Tobacco-Free Kids estimates a one percentage point per year decline in smoking for a five-year program. That would mean that after five years, approximately 98,700 Kansans would have quit smoking or would never have started to smoke. What if this projection is too rosy? What if some people resume smoking or youths begin to smoke as adults? I performed the following sensitivity analysis.

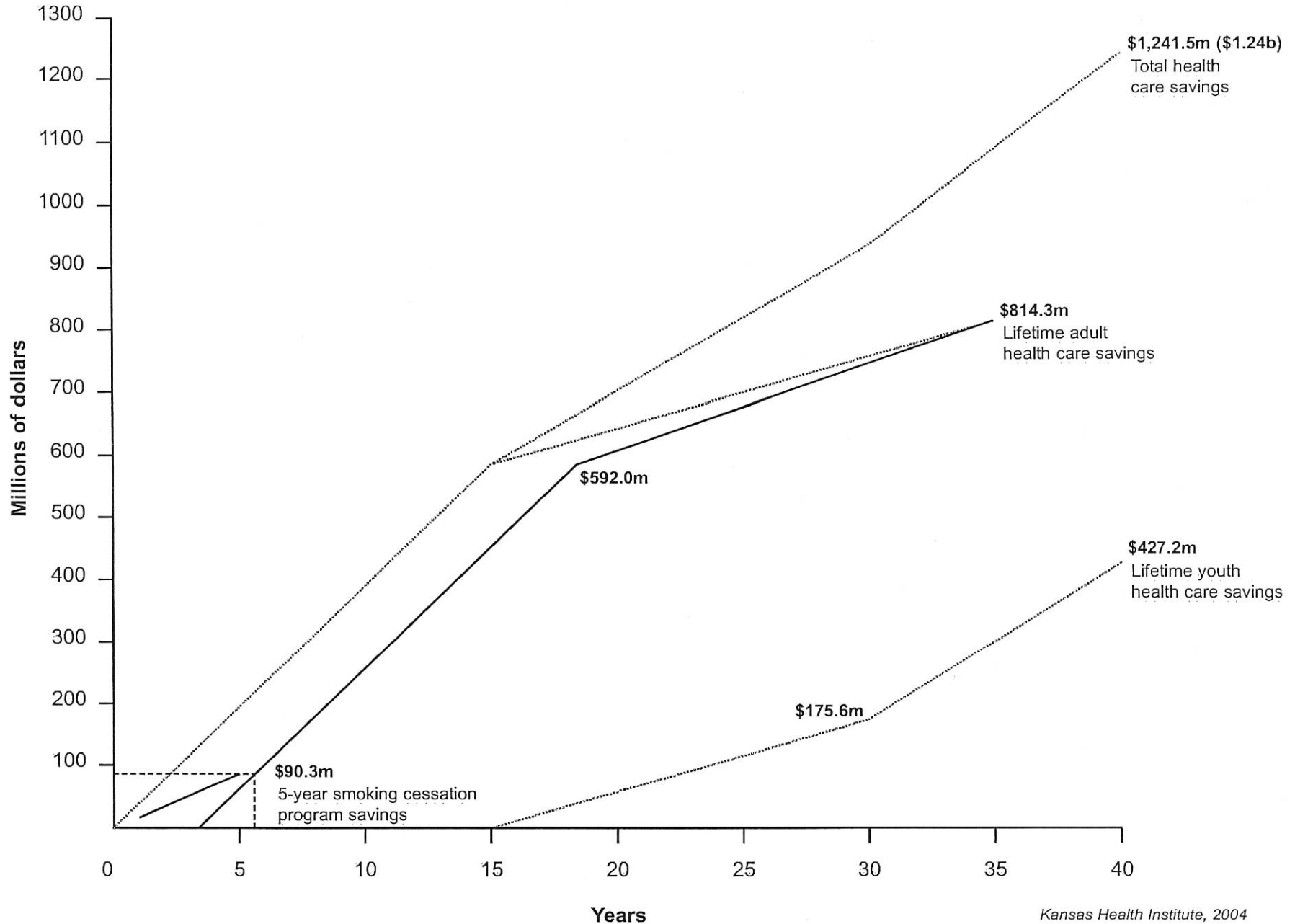
I assumed that adult and youth health care savings would be 20 percent less than those projected by the Campaign for Tobacco-Free Kids. Even so, benefits—reduced health care expenditures—exceed program expenditures almost immediately. Even if a time lag were factored in—which I did not do—the break even point would not be greater than seven years.

In short, Mr. Chairman, it is highly likely that an investment in tobacco use cessation of this magnitude will yield benefits to the state far in excess of expenditures. Careful listeners will note that I said “of this magnitude” by which I mean the \$18.1 million dollar per year expenditure for five years recommended by the CDC. I do not know whether CDC has found that the proportions of saving to investments I just showed you will hold at lower levels of investment.

Tobacco Use Prevention Expenditures and Health Care Savings



Tobacco Use Prevention Expenditures and Health Care Savings (Time Lag)



Tobacco Use Prevention Expenditures and Health Care Savings (Sensitivity Analysis, Twenty Percent Reduction)

