The Minnesota Plan for Nonsmoking and Health: The Legislative Experience

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INTRODUCTION

ON the tenth anniversary of the passage of the landmark Minnesota Clean Indoor Air Act, the Minnesota Legislature enacted the Omnibus Nonsmoking and Disease Prevention Act. This legislation funds statewide smoking intervention curricula for Minnesota youth; promotes nonsmoking through a public education and communications campaign; establishes a granting process for statewide and community-level multiple-strategy nonsmoking programs; expands enforcement for the Minnesota Clean Indoor Air Act; provides for evaluation of all programs; and raises the state excise tax on cigarettes. The legislation originated from the *Minnesota Plan for Nonsmoking and Health* (1,2,3), a prototypic, state-level smoking control plan. Minnesota's legislative experience may prove instructive for public health professionals contemplating large-scale interventions or public policy actions on cigarette smoking.

CHRONOLOGY OF EVENTS LEADING TO SMOKING CONTROL LEGISLATION

The chronology of events which antedated the 1985 legislative session provides the context for the legislative component of the Minnesota nonsmoking and health initiative.

Clean indoor air legislation. The Minnesota Clean Indoor Air Act (MCIAA) was passed in May, 1975 and has served as exemplary state-level legislation for regulating smoking in indoor public environments (4,5,6). The MCIAA bans smoking in public places except in designated

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Minnesota disease prevention initiatives. In 1981, the Minnesota Department of Health (MDH) embarked on a long-term project to control risk factors for chronic diseases (7). The major health problems of the state, as identified by an expert scientific committee, are being addressed through a systematic process. Cigarette smoking was selected as the first and most important target problem.

Center for Nonsmoking and Health. In the summer of 1983, the MDH established the Center for Nonsmoking and Health (CNSH) to coordinate the statewide nonsmoking initiative. Staffing consisted of two research scientists and a health educator/administrator under the direction of the State Epidemiologist. CNSH staff calculated Minnesota-specific epidemiologic and health economic estimates of the disease impact of smoking, reviewed the international literature on smoking behavior and smoking control methods, developed a database of research literature, and staffed meetings of an expert committee. The research scientists were responsible for drafting the full scientific report (1) with oversight by the State Epidemiologist. The health educator/administrator was responsible for providing expertise on educational and behavior-change methodologies and coordinating administrative aspects of the project.

The Technical Advisory Committee on Nonsmoking and Health. In the fall of 1983, the Commissioner of Health empaneled the Technical Advisory Committee on Nonsmoking and Health. This multidisciplinary expert committee was charged with the responsibility of proposing a comprehensive statewide plan for the active promotion of nonsmoking. Specialists were enlisted from the public health disciplines of epidemiology, health education, and health behavior research. Other members brought wide-ranging expertise from the fields of medicine, labor, wholesale/retail sales, hotel and restaurant management, business, education, insurance, nursing, economics, advertising, local and state government, and community action.

Mortality, morbidity, and economic cost calculations. In January, 1984, the philosophical and conceptual basis of the state nonsmoking and health plan—the benefits of nonsmoking throughout the lifespan—was presented in a short article in the state epidemiology newsletter (8). In February, 1984, estimates of statewide smoking-attributable mortality (4,600 deaths, 14 percent of total state mortality) and smoking-attributable morbidity (39,000 person-years of disability annually) were published and

received statewide news coverage (9). In May, 1984, preliminary health economic calculations were presented (10). Smoking-attributable disease was estimated to cost Minnesota $375 million in direct health care costs (seven percent of total direct costs, values in 1983 dollars), and for the 4,600 Minnesotans who die from smoking-linked disease each year, the indirect (lost income and productivity) costs were estimated at $303 million in present-valued 1983 dollars (1,11).

Release of the Minnesota Plan for Nonsmoking and Health. The full scientific report of the Technical Advisory Committee was released under the title, *The Minnesota Plan for Nonsmoking and Health* (1) and presented to the Commissioner of Health in September, 1984. Appended to the research chapters on the epidemiology, health behavior, and health economics of smoking, was a set of 39 recommendations presented in five topical areas: 1) school and youth education, 2) public education and communications, 3) public and private regulatory measures, 4) economic incentives and disincentives, and 5) information and evaluation needs (1,2). Each recommendation was accompanied by a background and rationale section.

Release of the report garnered substantial news coverage and mixed editorial comment which focused predominantly on the proposal to raise the state excise tax on cigarettes annually for five years. The recommendations for improved school-based smoking intervention programs were widely accepted.

To date, more than 2,000 copies of the full scientific report have been requested and distributed to researchers, legislators, and public health professionals. A succinct summary version of the recommendations and rationale sections has been published under the title, *The Path to Nonsmoking* (12), which is available for general public distribution (Note 1).

Minnesota Coalition for a Smoke-Free Society 2000. The Minnesota Coalition for a Smoke-Free Society 2000 was formed in November, 1984, with the purpose of operationalizing the challenge of Surgeon General C. Everett Koop to recreate a smoke-free nation by the year 2000 (13). The Coalition has made facilitating implementation of the *Minnesota Plan*, with particular emphasis on health care institutions and providers, one of its primary objectives. Coalition members include Minnesota chapters of the American Cancer Society, American Lung Association, and American Heart Association; the Minnesota Medical Association; the Minnesota Public Health Association; the Minnesota Department of Health; other health professional organizations; major health insurance

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carriers; and health maintenance organizations. The officers and members of the Coalition provided important testimony and support for the smoking control legislation.

Commissioner of Health's acceptance of the Minnesota Plan. In January, 1985, the Commissioner of Health held a press conference in which she formally accepted the recommendations comprising the *Minnesota Plan*, reviewed the salient epidemiologic and health economic findings on smoking, and announced the introduction of nonsmoking and health legislation. The proposed legislation was summarized in a memorandum which was circulated to the press highlighting seven key points: 1) worksite nonsmoking initiatives; 2) public education and communications campaigns; 3) tobacco-use prevention curricula for adolescents; 4) statewide and community grants for multifaceted nonsmoking programs; 5) technical assistance and program evaluation; 6) prohibition of the free distribution of cigarettes; and 7) increasing the state cigarette excise tax. The stated objective of the Minnesota nonsmoking initiatives was to reduce smoking rates in Minnesota by 30 percent by 1990 (from a 30 percent to a 21 percent smoking prevalence rate).

News coverage of the Commissioner's announcement provided additional publicity for state calculations on the disease impact of smoking, publicized state health policy, and introduced the provisions of the nonsmoking legislation.

THE OMNIBUS NONSMOKING AND DISEASE PREVENTION ACT

From its inception, the *Minnesota Plan* was intended for implementation. Completion of the *Minnesota Plan* document was envisioned as the launch point for a unified state nonsmoking and health program. Among the 39 recommendations, a subset, drawn from all five major areas, required legislative action. Drafted as the Omnibus Nonsmoking and Disease Prevention Act (14), the legislation was introduced in March, 1985. The bill contained the following provisions:

- Specification of the duties of the Commissioner of Health to increase worksite compliance with the Minnesota Clean Indoor Air Act and to assist worksites in the development of staged nonsmoking policies.
- Appropriation of money to school boards to implement targeted tobacco-use prevention curricula for adolescents, ages 12 to 14, and a continuum of nonsmoking education from kindergarten through grade 12. In order to receive funds, school districts must select

evaluated and effective smoking intervention curricula which provide in-service training.

- Appropriation of money to the Commissioner of Health to conduct a coordinated, multi-media public education and communications campaign to promote nonsmoking.
- Appropriation of money to the Commissioner of Health to award special project grants to community health service agencies and non-profit organizations for community-level and statewide smoking prevention and cessation programs.
- Appropriation of money for program evaluation and a biennial report to the Minnesota Legislature.
- A proposal to increase the state excise tax on cigarettes by seven cents per pack with proportional increases in the tax on other tobacco products. An additional provision would have further increased the state excise tax contingent upon and equal in amount to any decrease in the federal excise tax on cigarettes.
- Prohibition of the free distribution of cigarettes for promotional purposes in Minnesota.
- Provision of a complement of six positions in the MDH and one position in the Department of Education to staff the nonsmoking initiatives, including an epidemiologist, a research scientist, and two health educators, a health education specialist and a consultant for Minnesota Clean Indoor Air Act implementation in worksites.

HIGHLIGHTS OF THE LEGISLATIVE PROCESS

The Omnibus Nonsmoking and Disease Prevention Act was introduced in the Minnesota Legislature in March, 1985, and was passed on June 20, 1985, during a special session, as a section of a large, consolidated tax cut bill (15). That bill was signed into law by Governor Rudy Perpich on June 28, 1985 and the provisions of the Omnibus Nonsmoking and Disease Prevention Act took effect July 1, 1985 (See Note 1).

The final bill retained all of the provisions listed above except the ban on the free distribution of cigarettes and retained $4.0 million of the originally requested $5.0 million in appropriations. The final excise tax increase was 5 cents per pack rather than 7 cents. Several features of the legislative process that produced this bill are noteworthy.

Governor's support. The nonsmoking bill was introduced with strong support from the Governor of Minnesota. The nonsmoking and health initiative was the highest priority in preventive health services for the Commissioner of Health during the legislative session. Furthermore,

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the Governor had independently expressed interest in raising the excise tax on cigarettes in response to early press reports of the costs of smoking in Minnesota. Press reports based on the MDH calculations placed smoking-attributable health care costs at 80 to 90 cents per pack of cigarettes sold (11). Finally, the MDH is a part of the executive branch of state government and the MDH legislation is approved for introduction through the Governor's office. Therefore, nonsmoking and health legislation was drafted in tandem with the Governor's other legislative proposals.

Requested funding for nonsmoking programs was equivalent to revenues generated by about a one-half cent increase in excise taxes, leaving substantial revenues to fund other projects. In February, 1985, the Governor announced his intention to raise the excise tax on cigarettes and use the majority of the revenues to fund state sewer projects.

Surgeon General's endorsement. In early March, 1985, Surgeon General C. Everett Koop was invited to the state by the Minnesota Coalition for a Smoke-Free Society 2000 to commemorate the 10th anniversary of the passage of the Minnesota Clean Indoor Air Act. As part of his visit, he testified before the Minnesota House of Representatives on March 14, 1985, stating his strong advocacy for the *Minnesota Plan* and the pending legislation (16). His eloquent and persuasive talk cited both national and Minnesota statistics reinforcing his endorsement of the legislation. The Surgeon General also supported the legislation at other forums including the Minnesota Press Club and a large formal dinner reception sponsored by the coalition.

Additional support for the bill. Consistent support for the bill was provided by the health organizations represented among the members of the Minnesota Coalition for a Smoke-Free Society 2000. Active support was particularly evident from the American Cancer Society; the Association of Nonsmokers; the Minnesota, Ramsey County, and Hennepin County American Lung Association affiliates; the Minnesota Medical Society; and the Minnesota Medical Association Auxiliary. The principal spokesman for the bill during the committee hearings was the MDH's Director of Disease Prevention and Health Promotion, who summarized the provisions of the legislation and the epidemiologic and economic bases for the bill. Expert testimony was provided by smoking researchers from the University of Minnesota School of Public Health and a local pulmonary physician who is the president of the Minnesota Coalition for a Smoke-Free Society 2000.

Additional support was generated by informal alliances with other

state agencies and the business sector (reflecting an interest in reduction of workers' health care costs). Support for the bill came from such diverse quarters as proponents of state lead screening and surveillance, providers of maternal and child health programs, mosquito control advocates, and supporters of statewide sewer improvements, all of whom were slated to receive funding from the cigarette excise tax increase.

Opposition to the bill: the tobacco lobby. The tobacco industry was ably represented throughout the session by highly skilled lobbyists. By the end of the session, the number of lobbyists representing the tobacco interests had grown to at least nine persons representing the Tobacco Institute, Phillip Morris, Inc., R. J. Reynolds, Inc., Brown and Williamson, Inc., and the state candy and tobacco interests. Expert counter-testimony included economists flown in from the state of Virginia and from Duluth, Minnesota, the president of a cigarette sampling firm from New York City, an attorney on retainer with the Tobacco Institute, and local tobacco retailers. Tobacco support testimony initially was brought in from out-of-state; later testimony favoring tobacco came only from Minnesota-based "experts" or retailers. Paid counter-advertising appeared in outstate newspapers in opposition to the use of the tax for sewer projects.

Prior to the Senate Finance Committee hearing, postcard response forms in opposition to the bill were mailed by R. J. Reynolds, Inc. to smokers throughout the state, preaddressed for mailing to senators on that committee. Fortunately, even a few letters or calls favoring the bill had as much impact as hundreds of the tobacco lobby's postcards.

In the House, the bill faced a somewhat more difficult test. The bill was first referred to the House Tax Committee. The salient theme of the 1985 legislative session was tax reduction; a proposed tax increase on cigarettes was antithetical to that theme. Due to the House's strong support for reducing Minnesota taxes, the bill was not heard until the final weeks of the session. Ultimately, the House and Senate versions of the bill differed too much on several issues to be resolved in conference committee prior to close of the regular session. The Omnibus Nonsmoking and Disease Prevention Act was tabled along with major state tax and funding bills to await the special session convened in June, 1985.

A major portion of the revenue from the cigarette tax was earmarked to pay for sewer construction projects. Wisconsin is threatening to sue Minnesota if the state does not take more aggressive action with regard to sewage discharge into the Mississippi River. The need to act on this

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issue in 1985 was instrumental in the legislature's decision to include the cigarette tax on the special session agenda. At the close of the special session, the provisions of the Omnibus Nonsmoking and Disease Prevention Act were absorbed into the largest single piece of legislation passed in Minnesota to date, a consolidated bill which prominently featured a $1 billion cut in Minnesota's personal income taxes (15).

DISCUSSION AND CONCEPTUAL ISSUES

Guiding principles. Conceptual issues which evolved during the process of developing the *Minnesota Plan* have been described previously (3). Briefly, the issues are the following:

1. Broad epidemiologic and economic estimates of disease impact effectively portray the magnitude of a health issue to the public.
2. Multidisciplinary expertise, ranging beyond medicine and public health, is essential in designing measures for behavioral and societal change.
3. The focus on the desired behavior, the nonsmoking lifestyle, rather than the negative messages about risk of cigarette smoking, provides a positive "product" to be promoted and a goal to be achieved.
4. A multidimensional approach to the promotion of nonsmoking, including public education and communications campaigns, social changes, and school-based strategies, produces a synergistic effect which appears to be more effective than a single strategy alone.
5. Carefully chosen regulatory and economic measures have a place in nonsmoking and health programs.

These conceptual issues were relevant to the legislative process: smoking-attributable mortality and economic costs were repeatedly presented during testimony on the bill; expert testimony was provided from individuals with a wide range of expertise (including the Senate author of the bill who had previously served as a member of the Technical Advisory Committee); the bill, in title and intent, was designed to actively promote nonsmoking; and the provisions of the bill outlined multi-strategy statewide programming.

Cost-benefit analyses. Estimates of the absolute magnitude of smoking-attributable costs and development of cost-benefit arguments were strategic for presenting the case for nonsmoking and health programming to the legislature (Note 2). In addition to the calculations of smoking-attributable costs, the economic "benefits" of tobacco products

were computed for Minnesota. An estimate of the maximum economic contribution of tobacco products to the state was calculated on a per-pack-sold basis using a liberal accounting of wholesale and retail sales income, state excise and sales tax, a portion of the federal excise tax (returned to Minnesota in the form of state appropriations), and prorated advertising monies to the state, plus farm revenues for the tobacco acreage in the state. The outcome was that smoking-attributable costs not only overwhelmed this estimate of tobacco "income," but greatly exceeded the value of *total* tobacco product retail sales in Minnesota. This type of detailed economic argument provided a particularly compelling justification for smoking control legislation (17).

Furthermore, the cost-benefit comparison provided a counterclaim to the position presented by economists testifying on behalf of the tobacco interests that the state would experience a net loss of revenue as smoking rates, and therefore, excise taxes, decline. It reinforced the position that the tax should be raised in order to discourage smoking and, supplied with data from the cost-benefit analyses, legislators were apprised of the net savings to the state.

Tax policy. Raising the state excise tax on cigarettes, a single recommendation among 39 in the *Minnesota Plan*, was pivotal and strategic in the legislative process. From a strategy and public health policy perspective, the primary focus of the excise tax increase was deterrence of smoking rather than revenue generation.

The excise tax increase may be justified on several grounds. First, the excise tax increase is a method of smoking control based on increasing cigarette price. Economic data on the price elasticity of cigarettes indicate that raising the retail price on cigarettes by 10 percent is accompanied by a four to five percent reduction in per capita cigarette consumption (18,19,20). Furthermore, young males are particularly susceptible to price increases (21).

Second, in the context of the nonsmoking programs, the cigarette excise tax may be conceptualized as a user tax in the sense that it funds programs such as a public education and communications campaign, and statewide and community-level smoking cessation programs which directly facilitate quitting among smokers. Approximately 70 percent of smokers express a desire to quit and about 35 percent of smokers attempt to quit in a given year (22). Most individuals quit smoking without the assistance of formal programs, but they do not quit without help. The presence of statewide promotion of nonsmoking changes important

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aspects of every smoker's environment and legitimizes social pressure by family and friends while it reinforces individual attempts to quit by providing education and support (23).

Third, use of the excise tax as a smoking control measure may also be justified economically as a form of compensation for the excess medical care costs generated by smokers and borne by the whole society in the form of insurance and disability costs (11,24). Care should be exercised in the use of this argument because it begins to smack of "victim blaming" and may run counter to the positive thrust of promoting nonsmoking.

During the Minnesota legislative process, the cigarette excise tax was viewed as an attractive mechanism for funding desired programs while allowing a large cut in individual income taxes, the primary legislation of the session. However, it was also viewed as philosophically counter to the strong tax reduction spirit of the session. Maintaining the justification for the cigarette tax increase and guaranteeing that nonsmoking programs remained attached to the appropriations from that tax increase were important points of strategy.

The issue of adolescent smoking. Data on adolescent smoking behavior and on evaluated adolescent smoking prevention approaches were presented in testimony. The issue of deterring smoking initiation among minors was strongly supported by legislators; the marketing of tobacco products to minors through advertising, access to vending machines, and cigarette sampling was viewed negatively by most legislators.

Collaboration with other organizations. In Minnesota, state agencies are generally limited in their capacity to formally lobby individual legislators; agency staff may serve as resources in providing testimony and requested information to legislators. The formation of the Coalition for a Smoke-Free Society 2000 was an important asset to the legislative process; the Coalition aligned many of the state's important health interests on the issue of cigarette smoking and added credibility to the lobbying efforts. Additionally, key individuals from its affiliate organizations had a continual presence at the state capitol and spoke to legislators repeatedly to brief them on progress of the bill and to urge support. Several of the Coalition's member organizations produced letter and telephone campaigns by constituents of key legislators. In the final days before the special session, member organizations led a petition campaign and held a press conference to support inclusion of the nonsmoking bill on the special session agenda.

Cigarette excise tax increases generate substantial revenue; organizations and programs selected for funding from these revenues amplified support for the legislation. In the case of the Minnesota legislation, funding for sewer improvements was the major benefactor of tobacco tax revenues. The key for other states is to establish a linkage of excise tax revenues to essential legislation and maintain the visibility of the source and purpose of the tax increase to ensure that nonsmoking programs are funded with a portion of the revenues.

Keeping debate on the bill "open". The bill fared well in open debate and testimony before committees of both houses. Counter-testimony by the tobacco interests was frequently rebutted by legislators themselves.

Data on smoking. Testimony in support of the bill drew upon smoking-attributable mortality data, economic cost data, cost-benefit estimates, tax data, data on revenues lost due to bootlegging, smoking prevalence and trend data, quit statistics, behavioral intervention data, public opinion polls, and tobacco industry statistics. In the public legislative forums, a sampling of data was presented in summary factsheet form; however, the full array of data was used in the course of individual meetings with key legislators and staff. The MDH staff and allied advocates for the bill simply made it imperative to know more about the issue than anyone in the state or than anyone among the opposition. Testimony was soundly researched and data-based.

CONCLUSION

It is too early to say that Minnesota's Omnibus Nonsmoking and Disease Prevention Act will be the model for the nation, much as the Minnesota Clean Indoor Air Act has been. Only after full implementation of the new legislation and evaluation of its impact can that judgment be made. Nevertheless, the *Minnesota Plan for Nonsmoking and Health* has presented a template for state action to control smoking and to promote nonsmoking. The *Minnesota Plan* has been successfully translated into legislative action, and program implementation is currently in progress (25). This fact alone recommends it to others interested in similar action to control smoking and to promote nonsmoking.

NOTES

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form and final bill) can be obtained from the Center for Nonsmoking and Health, Minnesota Department of Health, 717 Delaware St. S.E., Minneapolis, MN 55440.

2. Economic calculations of the costs of smoking are summarized in the *Minnesota Plan for Nonsmoking and Health* (1). Shultz (11) has reviewed the literature on cost of smoking studies. *Smoking-Attributable Mortality, Morbidity, and Economic Costs: Methodololgy and Guide to Computer Software* (26) is available from the MDH for use by state health departments and public health professionals. The software computes estimates of smoking-attributable mortality, years of potential life lost (YPLL), direct health care costs, indirect morbidity (disability) costs, and indirect mortality costs. For additional information, contact James M. Shultz, Minnesota Department of Health, 717 Delaware St. S.E., Minneapolis, MN 55440.

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ABSTRACT

The Minnesota Department of Health has successfully introduced nonsmoking legislation which was enacted by the Minnesota Legislature in June, 1985. The legislation raises the excise tax on tobacco products and appropriates a percentage of the excise tax revenues to fund multiple programs comprising a coordinated nonsmoking initiative. Specific appropriations fund statewide tobacco-use prevention curricula targeted for adolescents; a continuum of nonsmoking education from kindergarten through grade 12; a multi-media public education and communications campaign; competitive special project grants to community health service agencies and nonprofit organizations for community-level and statewide smoking prevention programs; and peer-reviewed program evaluation.

The launch point for the legislation was a comprehensive statewide smoking control plan, developed by an expert committee with wide-ranging expertise. Support for the legislation was enhanced through coalition-building among organizations concerned with the health and economic effects of cigarette smoking. Detailed health and economic impact arguments, using Minnesota data, provided a clear problem statement, key points of testimony, and compelling justification for nonsmoking legislation.