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LOFT Oversight Committee

Co-Chairs


Members


Executive Summary

The 1998 Master Settlement Agreement (MSA) between states and tobacco companies provided states a continual funding stream from which to combat the health costs and consequences of tobacco use.

In 2000, Oklahoma voters approved constitutional protections for the millions in annual payments from tobacco companies, primarily dedicating the funds to preventing and combatting cancer and other tobacco-related diseases, improving the health of Oklahomans, and enhancing the provision of health care services to Oklahomans.

With the established economic and health toll of tobacco use, the State of Oklahoma has a vested interest in the success of TSET’s mission. Through this evaluation, the Legislative Office of Fiscal Transparency (LOFT) sought to determine if the programs and services provided by the Tobacco Settlement Endowment Trust (TSET) are providing outcomes aligned with its constitutional mandate, and whether 20 years of significant investment has led to measurable outcomes for the State.

LOFT’s evaluation resulted in four key findings:

Finding 1: Oklahoma’s ranking for tobacco use remains one of the worst despite high levels of spending and continued protection of the settlement fund.

Oklahoma currently ranks 8th highest in spending among states (based on percent of CDC recommended spending) but ranks 40th when it comes to adult smoking prevalence and 44th in youth smoking prevalence. Oklahoma has made progress to reduce smoking prevalence but continues to lag national trends, with an adult smoking prevalence rate of 18.9 percent compared to 15.9 percent nationally. Regionally, Oklahoma has the 4th highest smoking rate.

<table>
<thead>
<tr>
<th>OK Tobacco Policy Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status</td>
</tr>
<tr>
<td>8th in % CDC Recommended Spending</td>
</tr>
<tr>
<td>17th in Cigarette Excise Tax</td>
</tr>
<tr>
<td>Outcome</td>
</tr>
<tr>
<td>40th in Adult Smoking</td>
</tr>
<tr>
<td>44th in Youth Smoking</td>
</tr>
</tbody>
</table>
Approximately 40 percent of TSET’s spending is dedicated to tobacco cessation and prevention. However, LOFT observed a lack of evidence demonstrating correlation between state spending on tobacco cessation and prevention and smoking prevalence. Long-term, direct tobacco use outcomes are not tied to tobacco prevention and cessation programs and services provided by TSET.

Finding 2: Oklahoma ranks among worst states for critical health outcomes. TSET’s health strategy prioritizes three critical outcomes focused on improving the health of Oklahomans: obesity, cardiovascular disease deaths and cancer deaths. Oklahoma ranks 46th among states when examining measures of health. Compared to other states, Oklahoma has the highest cardiovascular disease death rate and ranks 4th highest for both cancer death rates and obesity rates.

In an effort to influence positive behavioral changes regarding tobacco use and healthy lifestyles, TSET invests approximately 35 percent of its annual budget in marketing and communication campaigns. With the vast external marketing efforts by the tobacco industry and others promoting unhealthy behavior, any funds spent by TSET on “mass reach” marketing must be extremely strategic and able to demonstrate direct impact on outcomes. TSET currently tracks short-term outcomes, such as awareness of media materials, but does not track the type of outcome data necessary to determine the effectiveness of media campaigns across the state.

Finding 3: TSET’s resources are not aligned to Oklahoma’s greatest needs. LOFT estimates that for every one percent reduction in smoking prevalence, Oklahoma would realize a cumulative savings of $135 million by 2030. In an analysis of smoking prevalence rates at a county level, compared to county-level programmatic spending by TSET, LOFT observed no apparent alignment of TSET resources with the areas of the state with the highest rates of smoking prevalence. Additionally, TSET does not conduct local level evaluation or analysis that would help determine the effectiveness (or replicability) of strategies within Oklahoma communities.

One of TSET’s signature programs, the Oklahoma Tobacco Helpline, spends approximately five times more per smoker for cessation services than the national average ($11.52 vs. national average of $2.21 and regional average of $2.55). While the Helpline reports positive outcomes, it reaches just three percent of Oklahoma’s smokers. Of those callers, approximately a third reportedly quit smoking. The percent of Helpline callers who register for services also declines year after year.
Finding 4: Oklahoma has opportunities to improve outcomes through policy changes, prioritization of spending, and a unified statewide strategy.

Over the past decade, the annual healthcare-related and economic costs of tobacco use in Oklahoma have increased from $3.1 billion to more than $4 billion.

LOFT’s comparative analysis and benchmarking study revealed variables that are most correlated with a state’s smoking prevalence: the cigarette tax rate, Medicaid expense per capita, and the state’s Stress Index calculation. Oklahoma ranks as the 6th highest state for Stress Index, 18th in cigarette taxation, and 40th in Medicaid expense per capita. These variables explain approximately 51 percent of the differences between state smoking rates.

Among the best-practice states evaluated, LOFT observed use of statewide comprehensive health action plans encompassing the categories contributing to the Stress Index ranking. These plans promote unified messaging and support related to state health objectives, including tobacco cessation and prevention. Oklahoma lacks a comprehensive state plan under one agency to spearhead tobacco prevention and cessation initiatives, provide strong support structure of partnerships within communities and other state agencies, and maximize state and federal resources.

LOFT also identified several best practices for Oklahoma to consider implementing, including regulating e-cigarettes and other alternative tobacco-derived products, or at the very least, collecting data on these emerging trends.
Summary of Policy Considerations and Agency Recommendations

The Oklahoma State Legislature and TSET may consider the following:

Policy Considerations

- Adopt a coordinated funding plan across all state agencies supporting tobacco cessation, prevention, and related health outcomes.
- Empower one of the State’s health agencies to determine state-specific spending priorities and identify measurable, observable outcome data for tracking and reporting progress for key health metrics, including tobacco use.
- Define within statutes specific areas of spending on health programs consistent with TSET’s mission and the original purpose of the Master Settlement Agreement, such as Medicaid.
- Amend statutes to provide clarity for the constitutional broadness of TSET’s mission.
- Amend O.S. Title 62, Section 2306 to provide clearer guidance to the Board of Directors for TSET regarding the type of allowable expenditures related to executing its duties.
- Reorganize TSET within an existing state agency focused on health outcomes aligned with TSET’s constitutional duties. Options include the Department of Health, the Health Care Authority, and the Department of Mental Health and Substance Abuse Services.
- Expand the definition of smoking in statutes to include e-cigarettes and emerging technologies for ingesting nicotine and tobacco-related products.
- Create or repurpose an existing governmental body with the authority to create and execute a statewide strategy for improving the health and wellness of Oklahomans, including reducing tobacco use to below the national average. One option could be to build on the existing Advancement of Wellness Advisory Council, which is led by the Commissioner of Health.
• Require the production of an annual report about tobacco products and trends in the region, including taxation, use, sales, illegal sales and emerging products, including e-cigarettes. The current State Plan produced by the State Department of Health could be adapted.

• Require licensure for the distribution and sale of e-cigarettes. Options for the enforcement agency could include the ABLE Commission or the Attorney General’s Office.

• Require an annual forecast for MSA payments be provided to the Legislature. For example, Colorado’s Department of Public Health and Environment currently provides this to the public.

Agency Recommendations

• TSET should reorient its logic models to measure for behavioral change. These models should be publicly available and include data-collection plans that measure statewide impact success metrics at every level; short-term, intermediate, and long-term.

• TSET should partner with the State Department of Health to conduct more rigorous statistical analysis to better understand relationships between variables that impact smoking prevalence.

• TSET should begin collecting data to understand e-cigarette use across the state, as well as other tobacco products and emerging trends.

• TSET should report data related to health outcomes directly attributable to TSET programs and spending.

• TSET should measure outcome data, both intermediate and long-term, to determine the statewide efficacy of media campaigns.

• TSET should prioritize tobacco prevention and control programs based on Oklahoma-specific outcomes and needs.

• TSET should examine the operational cost effectiveness of its Helpline, looking to other states for examples of cost-saving measures.
Introduction

Background of State’s Participation in the MSA

In the largest civil litigation settlement in U.S. history, forty-six U.S. states, the District of Columbia and five U.S. territories scored a legal victory that resulted in tobacco companies paying the states and territories billions of dollars in yearly installments. In exchange, the manufacturers were released from any past or future legal claims for smoking-related health costs to the states. Additionally, the agreement with the major tobacco companies, known as the 1998 Master Settlement Agreement (MSA), transformed tobacco control.

The MSA was predicated, in large part, on compensating states for the long-term health costs of smoking-related illnesses. The first four states to successfully settle with cigarette manufacturers did so by arguing that cigarette use contributed significantly to the state’s health care costs.1

A principal claim among the forty states that sued tobacco manufacturers between 1995 and 1997 was for recovery of state Medicaid expenditures for the treatment of tobacco-related illnesses. As the Center for Budget and Policy Priorities wrote in 1997:

“States have appropriately argued that the tobacco manufacturers are liable for the costs which state Medicaid programs have incurred – and will incur in the future – in paying for physician, hospital, nursing home, and other care and services on behalf of beneficiaries whose illnesses are caused by smoking.”2

In addition to requiring the tobacco industry to pay settling states billions of dollars annually in perpetuity, the MSA also imposed restrictions on the sale and marketing of cigarettes by participating cigarette manufacturers. This includes restrictions on direct or indirect targeting of its products to youth, advertising in public places, and use of cartoons in advertising. The MSA also dismantled tobacco industry specific advocacy groups, made internal industry documents available to the public, and created a research and education organization focused on preventing teen smoking and encouraging smokers to quit.3

Key Questions:

- What is the return-on-investment for key programs and services provided by TSET?
- What are the outcomes for the TSET program and how are results measured?
- How does Oklahoma’s tobacco cessation efforts and spending compare to other states and national averages and how does spending relate to smoking prevalence?
- Which TSET services or sets of services result in the best outcomes for Oklahomans?

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1 Mississippi, Minnesota, Florida, and Texas were the first four states to reach settlements, which pre-dated the Master Settlement Agreement. The Tobacco Settlements: Do all of the Medicaid Recoveries Belong to States? Center on Budget and Policy Priorities, December 1997.

2 Ibid.

Oklahoma’s Use of Settlement Funds

As part of the Master Settlement Agreement, participating states receive an annual payment from the tobacco industry for as long as cigarettes are sold anywhere in the nation. In 2000, Oklahoma voters approved a state question to amend the State Constitution (O.S. § Article 10 section 40), creating a trust fund (the Trust) to receive a percentage of the annual settlement payments. Since 2007, the Tobacco Settlement Endowment Trust (TSET) has received 75 percent of the annual MSA distribution. The remaining amount is distributed to the Legislature for appropriation, of which a portion is directed to the Office of the Attorney General for enforcing the terms of the agreement.4 The allocation of funds, since 2007, is as follows: 75 percent to TSET, 18.5 percent to the Legislature for appropriation and 6.25 percent to the Office of the Attorney General.5

Figure 01: FY20 Distribution of Master Settlement Agreement Payments across applicable entities6

The MSA funds distributed to the Legislature for appropriation have traditionally been allocated to the Oklahoma Health Care Authority (OHCA) or other health-oriented organizations. In FY21, the Legislature appropriated OHCA $11.7 million, 100 percent of the Board of Equalization February certified estimate.7 The MSA portion allocated to TSET is deposited into the Trust and, subsequently, used to fund programs aimed at tobacco cessation and prevention and improving the health of Oklahomans.

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4 See Appendix B for MSA FY00-20 apportionment trends
5 History | Tobacco Settlement Endowment Trust (ok.gov)
6 TSET FY20 AR.pdf (ok.gov)
7 See Appendix C Exhibit 1
The MSA funds received by the Office of the Attorney General are distributed to the agency’s Evidence Fund. Of the more than $4 million received, the Attorney General’s Office spends less than $1 million (an average of 18 percent) on tobacco enforcement, which translates to 1.12 percent of the overall tobacco payments distributed to Oklahoma from the Master Settlement Agreement. The Tobacco Enforcement Unit of the Office of the Oklahoma Attorney General was established to oversee the agreements reached as part of the Master Settlement Agreement and to ensure distributors and retailers are in compliance with state laws regarding the sale of cigarettes and roll-your-own tobacco.

The Tobacco Settlement Endowment Trust

TSET is overseen by a seven-member Board of Directors that determines how to use earnings from the Trust to fund programs aimed at improving the health and well-being of all Oklahomans.

Since FY10, the Board of Directors has supported a strategic plan to emphasize three primary areas of funding: prevention, research, and emerging opportunities.

- Prevention programs focus on reducing risk factors for cancer and cardiovascular disease - Oklahoma’s leading causes of death - through comprehensive programs that aim to prevent and reduce tobacco use, physical inactivity, poor nutrition, and obesity.
- Research programs focus on decreasing the burden of cancer, supporting cancer research, and reducing the toll of tobacco-related diseases.
- Emerging opportunities include grants to organizations proposing innovative and evidence-based approaches to transform and improve health.

A separate board oversees the investment of the Trust’s funds. The five-member TSET Board of Investors, chaired by the State Treasurer of Oklahoma, oversees TSET's investment of the annual MSA deposits and the protected fund balance. The Board of Investors is also responsible for determining the earnings available for use by the Board of Directors. See Appendix D for more information about the structure of the TSET Board of Directors and Board of Investors.

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8 See Appendix C Table 13 for more detail about how the Attorney General’s office uses its MSA allocation
9 Oklahoma State Constitution and Oklahoma Session Laws – 2001, Section 274 - Public finance; creating the Tobacco Settlement Endowment Trust Fund Act
Mission of TSET
The mission of the Tobacco Settlement Endowment Trust is to improve the health and quality of life of all Oklahomans through accountable programs and services that address the hazards of tobacco use and other preventable health conditions.10

Programs and Services
TSET funds programs and services using only the interest earned from annual MSA payments.11 In addition to administrative expenses, this trust fund is used by TSET for the following purposes:

- Research and treatment efforts for the purpose of preventing and combating cancer and tobacco-related disease,
- Tobacco prevention and cessation efforts,
- Programs designed to maintain and improve the health of Oklahomans or enhance the provision of health care services,
- Programs and services for the benefit of the children of Oklahoma, and
- Programs designed to enhance the health and well-being of seniors.12

Table 01: Overview of TSET Programs and Services.13 This table provides a high-level description of the categories across sixty-one programs, partnerships, and services offered by TSET. For more detailed information about each of these program areas, see Appendix E.

<table>
<thead>
<tr>
<th>TSET Program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wellness Grants</strong></td>
<td>Local community grants designed to prevent cancer and cardiovascular disease by preventing and reducing tobacco use and obesity</td>
</tr>
<tr>
<td><strong>The Tobacco Helpline</strong></td>
<td>Provides free cessation resources and support to tobacco users who are trying to quit.</td>
</tr>
<tr>
<td><strong>Healthy Incentive Grants</strong></td>
<td>Grants that promote wellness by providing funds to schools, school districts and local communities that adopt health-promoting policies and strategies</td>
</tr>
<tr>
<td><strong>Health System Grants</strong></td>
<td>Grants designed to address tobacco use and obesity by enhancing health systems across the state</td>
</tr>
<tr>
<td><strong>Research</strong></td>
<td>Includes promoting, coordinating, and supporting cancer research</td>
</tr>
<tr>
<td><strong>Campaigns and Communication Initiatives</strong></td>
<td>Communications projects designed to explain the dangers of second-hand smoke, poor nutrition, and tobacco use prevention.</td>
</tr>
</tbody>
</table>

Source: Tobacco Settlement Endowment Trust

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10 Strategic Planning & Results | Tobacco Settlement Endowment Trust (ok.gov)
12 Oklahoma Tobacco Settlement Endowment Trust Strategic Map: 2019-2022, TSET, April 2020 (tset.ok.gov)
13 TSET Programs | Tobacco Settlement Endowment Trust (ok.gov)
Note: All TSET programs, except Research, are evaluated by the OU College of Public Health and funded by TSET
TSET Partnerships

In addition to serving as a grant-making trust, TSET partners closely with several state agencies. LOFT observed good communication, cooperation, and coordination between TSET and other organizations with similar objectives. There does not appear to be duplication of effort or spending among state agencies involved in tobacco cessation, prevention, or related health initiatives. However, as demonstrated in this report, LOFT identified opportunities for better outcome measurement and data-driven prioritization through coordination of efforts.

The funding relationships for these partnerships vary from organization to organization. Some organizations are direct recipients of TSET grants under the Health Systems Initiatives, such as the Oklahoma Department of Mental Health and Substance Abuse Services, and the Oklahoma Hospital Association. Other state agencies have independent, separate sources of funding for major programs but are also recipients of TSET funding via contracts for services or as grantees. Additionally, the Office of the Oklahoma State Treasurer receives money directly budgeted by TSET annually to provide administrative services to the TSET Board of Investors and for trust fund management.

Figure 02: Oklahoma Tobacco Cessation and Control Agencies and Source of Funding. This figure displays the six state agencies (in purple framed boxes) that operate with some part of the annual MSA payments (shown through green flow arrows); red arrows illustrate the flow of state revenue; the blue arrow shows the flow of federal/CDC grant funding; and the orange flow arrows communicate recipients of TSET Grants. See Appendix G for Oklahoma tobacco excise tax apportionment.

14 This chart was created using information compiled during the course of LOFT’s evaluation.
Table 02. List of Agencies with Tobacco Control and Cessation Work. This table briefly explains the work of other organizations and agencies that have tobacco control and cessation work aligned with that of TSET, their funding structure, and summary of work.\textsuperscript{15}

<table>
<thead>
<tr>
<th>Agency or Organization</th>
<th>Funding Sources and Amounts</th>
<th>Tobacco Control and Cessation Efforts, Programs and Services</th>
</tr>
</thead>
</table>
| Oklahoma State Department of Health\textsuperscript{16} | • CDC grant, $1.3 million annually  
• Tobacco Excise Taxes, $1.2 million annually | • Contracts with TSET to provide technical assistance to grantees and evaluation and data collection services  
• Collects survey data about tobacco use in Oklahoma on behalf of the CDC  
• Provides free smokefree/tobacco free/Vape free signage throughout the state and oversees the Breathe Easy brand and website  
• Monitors clean indoor air regulations and focuses on reducing secondhand smoke exposure  
• Funds and promotes cessation services currently available through the Oklahoma Tobacco Helpline (1-800-QUIT-NOW or okhelpline.com)  
• Seeks to improve the health of Oklahoma’s Priority Populations through the identification, assessment, and implementation of high impact systems level strategies utilizing the M-POWER structure  
• Runs the Validate campaign, which is the youth access to tobacco campaign aimed at addressing youth access to tobacco at the point of sale  
• Creates the mandated, annual state tobacco control plan  
• Provides administrative support to the CDC-required state Tobacco Control Coalition |
| Oklahoma Health Care Authority\textsuperscript{17} | • Blend of federal (68%) and state funding (32%)  
• Medicaid funding to SoonerCare members  
• TSET Grant, $270,231 annually | • Provides grants to help improve the health of SoonerCare members by ensuring access to tobacco cessation services, targeting vulnerable populations such as pregnant women, and identifying health risks such as obesity and tobacco use  
• Removes copays and prior authorization requirements  
• Removes limits on length of treatment covered by Medicaid  
• Removes limits on quit attempts per year or lifetime  
• Eliminates requirements and barriers, such as, requirements to try one treatment before another is authorized and enrolling in counseling before receiving medication |
| Oklahoma Department of Mental Health and Substance Abuse Services\textsuperscript{18} | • TSET Grant, $584,788 annually  
• Wellness Services Matching funds, Medicaid, $450,000 annually | • Develops and implements programming and systems change to support tobacco-free environments, tobacco cessation, improved nutrition, and increased physical activity opportunities throughout their network of consumers, providers, and facilities  
• Develops worksite wellness policies, improving a culture of wellness and provision of wellness services  
• Increases helpline referrals  
• Provides NRT for those who do not receive it through other resources  
• Performs Oklahoma Prevention Needs Assessment |

Source: Legislative Office of Fiscal Transparency

\textsuperscript{15} See Appendix G for more information about TSET Partnerships  
\textsuperscript{16} OSDH Community Programs Funded by CDC and Tobacco Tax Funds  
\textsuperscript{17} OHCA Fiscal Year 2021 Cooperative Agreement with TSET  
\textsuperscript{18} ODMHSAS Fiscal Year 2021 Cooperative Agreement with TSET
Within OSDH, the Chronic Disease Prevention and Health Promotion division is responsible for tobacco cessation and prevention programs. The Oklahoma Health Care Authority (OHCA) provides smoking cessation services to Oklahomans via SoonerCare, the State’s Medicaid program. OHCA works with TSET to remove barriers to smoking cessation. In 2011, the smoking rate for Medicaid recipients was approximately twice that of the state in general. According to the Oklahoma Health Care Authority, the most recent data (2020) shows the Oklahoma adult smoking prevalence rate for Medicaid members has declined to 25.8 percent compared to 19.1 percent for Oklahoma currently.  

### TSET Funding and Budget Overview

TSET’s budget is based on the interest earned from management of the $1.66 billion trust fund. The management strategy of the Board of Investors involves retaining various investment managers to achieve the objective of earning a five percent return on investment for the fund. Every August, the Board of Investors receives a preliminary audit certificate. In November, the Board of Investors provides the Board of the Directors with the final figures to use for budgeting. The budget consists of two categories: operations for the agency, which includes the Board of Directors, and the operations for the Board of Investors, which includes management of the trust.

Chart 01 shows the agency’s total FY21 budget is $54.95 million, with $4.21 million set aside for the expenses related to the Board of Investors. As illustrated in Chart 01, the operating budget is $50.7 million. The chart portrays that, between FY17-FY20, the margin of unused budget was six percent (or $3.4 million yearly average), which is in proximity of the agency’s annual spending goal of 95 percent of budgeted funds actual to budget for a year.

*Chart 01: TSET Budget to Actual FY06-21. This bar chart depicts trends of actual expenditures vs. budget and consists of TSET’s operational budget and the Board of Investors’ budget. FY21* indicates that share of current year expenses has not yet materialized as of the date of this report.*

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19 Oklahoma Health Care Authority responses to LOFT questions, April 2021
20 Status as April 30, 2021, based on correspondence with the State Treasurer, April 30, 2021
Finding 1: Oklahoma’s Ranking for Tobacco Use Remains One of the Worst Despite High Levels of Spending and Continued Protection of the Settlement Fund

Oklahoma is the only state in the country that constitutionally protects funds received from the Master Settlement Agreement. However, other states, like Utah and Colorado, have similar statutory protections. Finding 3 of this report provides more detail regarding LOFT’s comparative analysis.

Having the strongest protection of settlement funds has resulted in Oklahoma ranking as the eighth-highest state for spending on tobacco cessation and prevention as of 2021. Currently, no state spends as much as the Center for Disease Control and Prevention (CDC) recommends but state rankings are determined according to the percent spent based on those recommendations.

The CDC does not suggest category-specific spending, instead identifying key areas for spending on tobacco prevention and control, including:

- state and community interventions
- mass-reach health communication interventions
- cessation interventions
- surveillance and evaluation
- infrastructure, administration, and management

Oklahoma budgeted $21.7 million for tobacco prevention and control in FY 2021, which represents 51.2 percent of CDC recommended spending. The national average for spending as a percentage of CDC recommendations is 19.8 percent. Only Alaska, Maine, Utah, California, Hawaii, North Dakota, and Delaware spend a higher percentage than Oklahoma.

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21 History | Tobacco Settlement Endowment Trust (ok.gov)
22 See Appendix H, Ranking of States’ Funding Spend
23 Since the CDC annually recommends spending based on a consistent formula for every state based on that state’s needs, examining percent spent of recommended CDC spending provides states a standard way to compare spending across the nation. Best Practices for Comprehensive Tobacco Control Programs, 2014 (cdc.gov)
24 Best Practices for Comprehensive Tobacco Control Programs—2014 | CDC
While funding levels are part of the equation for addressing public problems like tobacco use, over the course of this evaluation, LOFT observed a lack of evidence demonstrating correlation between state spending on tobacco cessation and prevention and smoking prevalence. LOFT’s regression analysis in Finding 4 supports this observation.

Table 03 compares Oklahoma to the ten states with the lowest rates of tobacco use along with their percentage of spending according to CDC recommendations.

Of states that spend more than 50 percent of what is recommended by the CDC, only Utah, California, and Hawaii rank among the top ten states in terms of lowest adult smoking prevalence. Connecticut, which does not dedicate any state funding to tobacco prevention, ranks third in adult smoking prevalence, further demonstrating a disconnect between spending and outcomes.

Table 03: Top Ten States, 2019 Adult Smoking Prevalence and 2021 Percent of CDC Recommended Spending. The lower the ranking, the lower the percent of population that smokes.

<table>
<thead>
<tr>
<th>State</th>
<th>Adult Smoking Prevalence (2019)</th>
<th>Percent of CDC 2021 Recommended Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rate</td>
<td>Rank</td>
</tr>
<tr>
<td>Utah</td>
<td>7.9%</td>
<td>1st</td>
</tr>
<tr>
<td>California</td>
<td>10.0%</td>
<td>2nd</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>12.0%</td>
<td>3rd</td>
</tr>
<tr>
<td>Connecticut</td>
<td>12.1%</td>
<td>4th</td>
</tr>
<tr>
<td>Hawaii</td>
<td>12.3%</td>
<td>5th</td>
</tr>
<tr>
<td>Washington</td>
<td>12.6%</td>
<td>6th</td>
</tr>
<tr>
<td>Maryland</td>
<td>12.7%</td>
<td>7th</td>
</tr>
<tr>
<td>New York</td>
<td>12.7%</td>
<td>8th</td>
</tr>
<tr>
<td>New Jersey</td>
<td>13.1%</td>
<td>9th</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>13.3%</td>
<td>10th</td>
</tr>
<tr>
<td>Oklahoma</td>
<td><strong>18.9%</strong></td>
<td><strong>40th</strong></td>
</tr>
<tr>
<td>U.S. Average</td>
<td>15.9%</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: Smoking Rates by State, World Population Review and Tobacco Free Kids

As illustrated in Table 03 above and Figure 03 below, Oklahoma is one of eight states spending more than fifty percent of what the CDC recommends for annual spending on tobacco prevention and cessation.

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25 One size fits all? Disentangling the effects of tobacco taxes, laws, and control spending on adult subgroups in the United States - PubMed (nih.gov)
26 1_FY2021_Rankings_Funding_for_State_Tobacco_Prevention_Programs.pdf (tobaccofreekids.org)
Figure 03: FY21 State Tobacco Prevention Spending as a Percent of CDC Recommendations by State.  
This map reflects Oklahoma as among the top eight states for spending. Connecticut and Tennessee do not budget any state funding for tobacco control and cessation.

Tobacco Use and Smoking Prevalence in Oklahoma

Oklahoma’s smoking rates remain among the highest in the nation. While there has been progress over the past 20 years, the state’s improvements lag behind the progress achieved in other states. Oklahoma’s adult smoking prevalence today is approximately 19 percent, which was the national average in 2011. As of 2019, Oklahoma had the eleventh-highest adult smoking prevalence in the nation. From 2011 to 2019, Oklahoma reduced the number of adult smokers from 23.3 percent to 18.9 percent, as illustrated in Chart 02.

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27 FY2021 State Rankings (tobaccofreekids.org)
28 ahr_2019annualreport.pdf (americashealthrankings.org)
29 oklahoma-medicaid-tobacco-cessation.pdf.pdf (lung.org)
30 BRFSS Prevalence & Trends Data: Home | DPH | CDC
31 State Tobacco Activities Tracking and Evaluation (STATE) System (nccd.cdc.gov)
A 2016 study determined that TSET funding had a favorable impact on the adult smoking prevalence in Oklahoma between 2006 and 2014. The “Assessing the Impact of Tobacco Settlement Endowment Trust” report compared Oklahoma to states with similar laws at that time, related to comprehensive clean air and tobacco taxation, and found that the adult smoking prevalence had fallen faster in Oklahoma than this set of six peer states (Alabama, Arkansas, Colorado, Idaho, Louisiana, and Tennessee). However, data does not measure correlation or strengths of relationships to directly attribute declines in smoking to any specific programs or services. This study is also outdated in both taxation and policy information and when data was reexamined in 2019, Oklahoma’s progress over this peer group had declined.34

It is important to note there are many variables that impact the adult smoking rate over which tobacco prevention and cessation programs have little control, including education, age, and the presence of certain pre-existing medical conditions.37

Oklahoma has made progress in reducing smoking rates in the last seven years. Regionally, Oklahoma has moved from the second-most smoking prevalent state to the fourth-most, as displayed in Chart 02.

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32 Tobacco use in Oklahoma 2020 (truthinitiative.org)
33 State Tobacco Activities Tracking and Evaluation (STATE) System (cdc.gov) and Key State-Specific Tobacco-Related Data & Rankings (tobaccofreekids.org)
34 Fiore, Bebee and Christiansen, 2016, Assessing the Impact of the Tobacco Settlement Endowment Trust on Oklahoma’s Adult Smoking Prevalence.
37 Fishbain et al. “Variables Associated with Current Smoking Status in Chronic Pain Patients”. University of Miami School of Medicine, 2007
Chart 02: Trends in Smoking Rates between 2011-2019 - Regional Analysis. This chart depicts adult tobacco prevalence in Oklahoma and regional states.

[Diagram of smoking rates over 9 years showing regional comparison with labels for Arkansas, Colorado, Kansas, Louisiana, Missouri, New Mexico, Oklahoma, and Texas.]

In addition to regional comparisons, LOFT also compared Oklahoma to other states with above average rates of adult smoking prevalence. Between 2011 to 2019, Oklahoma has reduced the proportion of adult smokers by 27.6 percent while the national average changed by 25 percent. Despite this progress, as Chart 03 (below) indicates, Oklahoma ranked as the eleventh-most prevalent state for adult smokers in the United States.39

Chart 03: Top States by Smoking Rate. Oklahoma ranks 11th highest in adult smoking rates as of 2019.

[Diagram showing OK vs. Bottom-Ten States and US Average in Adult Smoking Prevalence in 2019 with Oklahoma at 18.9% and other states listed with their respective percentages.]

Source: Legislative Office of Fiscal Transparency analysis, based on CDC

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38 Current Cigarette Smoking Among Adults in the United States | CDC
39 State Tobacco Activities Tracking and Evaluation (STATE) System (cdc.gov)
40 Current Cigarette Smoking Among Adults in the United States | CDC
As shown in Chart 04 below, Oklahoma also had the fourth-highest adult smoking rate in the region and is bordered by two states whose rates are better than the national average of 15.9%.

*Chart 04: Oklahoma Regional Adult Smoking Rates 2019*

Finding 4 of this report examines how other states are achieving outcomes in smoking prevention and cessation. As a component of this evaluation, LOFT sought to examine tobacco-related outcomes directly attributable to programs designed to impact such outcomes. LOFT determined most TSET programs cannot be tied directly to measurable, observable outcomes. While data for outputs (e.g., the number of Helpline callers, the dollar amount of research grants brought to the state, or the number of community grantees) is abundant, data establishing a direct link between specific programs and reduced smoking across the state is not available. An exception is the Helpline, which captures outcomes associated with reported quit rates.

As illustrated in Chart 05, cigarette smoking among high-school students is nine percent as of 2019 but e-cigarette use is 28 percent (not unduplicated count).

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41 [Tobacco Use by Geographic Region | Smoking & Tobacco Use | CDC](https://www.cdc.gov/tobacco/data_statistics/fact_sheets/other_data/mandates/)

Source: Legislative Office of Fiscal Transparency, Center for Disease Control and Prevention, Tobacco Use by Geographic Region
E-Cigarette Usage

E-cigarettes entered the market in 2013, introducing smokers to a new method of consuming nicotine in an inhalable form in a wide variety of flavors. While combustible cigarettes are the most harmful to consumers of nicotine, e-cigarettes are often a gateway to cigarette addiction, especially among high school students. A 2020 study by the Truth Initiative found that young people using e-cigarettes were seven times more likely to try a combustible cigarette within one year than those who have never tried an e-cigarette. Nearly nine out of ten adults who smoke begin smoking before the age of eighteen. To fully understand smoking trends in Oklahoma, LOFT examined e-cigarette use among youth and adults in addition to data on traditional cigarette use.

While adult smoking is relatively high in Oklahoma, combustible cigarette smoking is on a downward trend. However, Oklahoma may be experiencing product displacement with e-cigarette usage.

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42 OK State Plan for Tobacco Use Prevention & Cessation 2020(1).pdf
43 “Vaping products” were introduced in 2006 and the term is sometimes used interchangeably with “e-cigarettes”. For the purposes of this report, the use of the term e-cigarettes references the electronic cigarettes that were widely introduced in 2013.
44 Will Vaping Lead Teens to Smoking Cigarettes? | Johns Hopkins Medicine
45 Young people who vape are much more likely to become smokers, new research confirms (truthinitiative.org).
46 Youth and Tobacco Use | CDC
Chart 06: Oklahoma’s Adult Smoking Prevalence 2000-2019. 47 This chart includes both traditional (combustible) cigarettes and e-cigarette use. E-cigarette use is any use in the last 30 days. Cigarette smoking includes both every day and “some” smoking. As the tobacco excise tax increases, the smoking rate decreases; however, lack of a specific tax for e-cigarettes enables the demand for tobacco to shift to e-cigarettes.

There is some research indicating that the option of e-cigarettes may reduce overall quitting frequency for combustible cigarettes.48 But when both these types of smoking are taken into consideration, Oklahoma has not achieved much progress toward the goal of reducing overall use over time. As Chart 06 demonstrates, when use data is combined, Oklahoma had an adult smoking prevalence of 26.1 percent (cigarettes alone) in 2011 and a combined adult smoking prevalence of 25.1 percent in 2019 (both cigarettes and e-cigarettes).49

The unknown health impact of e-cigarettes, the ease of youth access, and youth interest in flavored products have become a growing concern of health policy leaders across the nation.50 Evidence shows most individuals begin using tobacco products by age eighteen.51 Because e-cigarettes have become popular among high school age youth, with nearly 28 percent of Oklahoma’s youth using in 2019,52 the continued focus on combustible cigarettes and exclusion of e-cigarettes from reporting data may leave Oklahoma unprepared to address the next generation of tobacco users.53

47 CDC - BRFSS (Behavioral Risk Factor Surveillance System), a telephone health survey system operated by the CDC
48 E-cigarettes: Facts, stats and regulations (truthinitiative.org)
49 This data is not unduplicated
50 Know the Risks: E-cigarettes & Young People | U.S. Surgeon General’s Report
51 OK State Plan for Tobacco Use Prevention & Cessation 2020(1).pdf
52 Ibid.
53 E-Cigarettes, Vapor Products, & Emerging Products (oklahoma.gov)
Policy Considerations and Agency Recommendations

Policy Considerations

• The Legislature may consider requiring adoption of a coordinated funding plan across all state agencies supporting tobacco cessation, prevention, and related health outcomes.

This would include TSET, the Department of Health, the Health Care Authority and the Department of Mental Health and Substance Abuse Services. For example, Colorado, Utah, and Connecticut utilize a statewide, comprehensive health plan to set the health initiatives for their respective states. These plans are then used to form action plans which include state agencies and partnerships, and include resources needed to achieve desired objectives, including tobacco cessation and prevention.

• To achieve desired outcomes for the State, the Legislature may consider empowering one of the State’s health agencies to determine state-specific spending priorities and identify measurable, observable outcome data for tracking and reporting progress for key health metrics, including tobacco use.

The changing and differing needs across the state should be taken into consideration when designing or adapting programs. Spending should be aligned to specific agency objectives and in areas where meaningful, long-term outcome data can be measured to determine progress.

Agency Recommendations

• TSET should reorient its logic models to measure for behavioral change. These models should be publicly available and include data-collection plans that measure statewide impact success metrics at every level; short-term, intermediate, and long-term.

This approach would allow the agency to determine what impacts tobacco use, for both smoking and other methods of consumption, and design programs to influence key long-term, statewide outcomes. Logic Models are recommended by the CDC for evaluation purposes. A logic model is a graphic depiction that communicates shared relationships among the resources, activities, outputs, outcomes, and impact for a program.

54 See Appendix I for logic model examples
It depicts the relationship between a program’s activities and its intended effects. A key purpose is measuring effect and identifying exactly what contributes to the desired result for each program.

The CDC provides, as an example to other states, California’s logic model, which maps out short-term, intermediate, and long-term outcomes matched to activities and outputs. This provides a data collection plan to determine the success of specific initiatives. See Appendix I for examples.

- **TSET should partner with the State Department of Health to conduct more rigorous statistical analysis to better understand relationships between variables that impact smoking prevalence.**

TSET has evaluation expertise available through contracts with research universities and the State Department of Health but does not currently collect the type of data needed to determine program impact. Conducting regression analysis, for example, would differentiate which variables truly have an impact and which do not. The value of regression analysis is in measuring the strength of correlations between variables. Epidemiologists, through either the State Department of Health or research universities, would be equipped to provide this type of statistical analysis.

- **TSET should begin collecting data to understand e-cigarette use across the state, as well as other tobacco products and emerging trends.**

To make decisions about Oklahoma’s program priorities, e-cigarette use among both adults and youth should be more effectively measured and understood. There is no conclusive evidence regarding e-cigarettes aiding smoking cessation. This relationship among products should be better understood, which requires additional data collection and analysis. Evaluation questions to be answered could include:

  o To what extent is e-cigarette use displacing the use of combustible cigarettes?
  o What percent of smokers are using e-cigarettes as a cessation tool and how successful is that approach for Oklahoma smokers?
  o What are the emerging trends related to e-cigarette use and other non-combustible tobacco products?

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56 [Logic Models - Program Evaluation - CDC](https://www.cdc.gov/evaluation/programevaluation/logicmodels.html)
58 [Planning for Policy Evaluation | Smoking & Tobacco Use | CDC](https://www.cdc.gov/tobacco/globalonga/policyevaluation/index.htm)
59 [A Refresher on Regression Analysis (hbr.org)](https://hbr.org/2016/01/a-refresher-on-regression-analysis)
Finding 2: Oklahoma Ranks Among Worst States for Critical Health Outcomes

TSET is a dual-mission organization. In addition to smoking cessation and prevention, the agency is constitutionally directed to “maintain or improve the health of Oklahomans or to enhance the provision of health care services to Oklahomans.”

TSET’s health strategy prioritizes three measures of health among Oklahomans: obesity, cancer deaths, and cardiovascular disease deaths. Because of the alignment between these health measures and TSET programs, LOFT examined respective health outcomes across the State in addition to smoking trends.

While TSET is not the primary state agency working to improve the health of Oklahomans, the agency dedicates more than half its annual spending toward health improvement initiatives. TSET-funded Healthy Lifestyle Grants, Incentive Grants, Health Systems Initiatives, and Health Communication Interventions all include important, statewide health improvement initiatives.

Programmatic Outcomes - Health

As a component of this evaluation, LOFT sought to identify and examine health-related outcomes directly attributable to TSET programs and activities designed to impact such outcomes. However, TSET does not collect the type of data needed to tie health programs directly to long-term, statewide health outcomes.

In addition to data collected by OSDH on behalf of the CDC (through the Behavioral Risk Factor Surveillance System, or BRFSS), TSET also utilizes national data about Oklahoma’s health outcomes to understand the health of Oklahomans.

Oklahoma is ranked 46th among states when it comes to measures of health. According to America’s Health Rankings, the longest running annual assessment of the nation’s health on a state-by-state basis, health outcomes are a function of four main overarching categories, social and economic factors, clinical care, behaviors, and physical environment. Thirty-five metrics across the four categories are measured and used to rank states.

61 TSET Responses to LOFT questions, November 2020
62 Findings State Rankings | 2018 Annual Report | AHR (americashealthrankings.org)
63 annual20-rev-complete.pdf (americashealthrankings.org)
In FY2021, TSET spent approximately $45 million in grants to accomplish its mission. TSET’s grant agreements include information about the county in which the grantee resides, whether the grant is for a statewide program, and cites the constitutional authority for making the expenditure.\(^{64}\) Chart 07 depicts the grant expenditures by category and percent.

**Chart 07: TSET Grants Total by Purpose\(^{65}\)**

Cancer Deaths

Cancer is estimated to cost the U.S. healthcare system $174 billion dollars every year.\(^{66}\) Oklahoma has the fourth-highest cancer death rate in the nation with 8,309 deaths in 2019, and cancer is the second leading cause of death in the state.\(^{67}\) Cigarette smoking is responsible for about one-third of all cancer deaths in Oklahoma.\(^{68}\)

As demonstrated in Chart 08, the annual rates of cancer deaths in Oklahoma have decreased by 14.5 percent over eighteen years, while the national decrease was 24 percent. These health outcomes do not show TSET budgetary expenditures have had a measurable impact on reducing cancer rates.

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64 TSET FY21 Agreements Listing (tset.ok.gov)
65 Ibid
66 Health and Economic Costs of Chronic Diseases (cdc.gov)
67 Stats of the State of Oklahoma (cdc.gov) and Stats of the States - Cancer Mortality (cdc.gov)
68 State-Level Cancer Mortality Attributable to Cigarette Smoking in the United States | Health Disparities | JAMA Internal Medicine | JAMA Network
Oklahoma has the highest heart disease mortality rate in the nation ...

Cigarette smoking is responsible for approximately twenty percent of these deaths.

Cardiovascular Disease Deaths

Cardiovascular disease is estimated to cost the United States $214 billion dollars. Between 1999 to 2007, heart disease death rates across the country decreased. However, this was not true for Oklahoma. As of 2019, Oklahoma has the highest heart disease mortality rate in the nation at 231.4 deaths per 100,000 total population (up from 3rd in 2018). Cigarette smoking is responsible for approximately twenty percent of these deaths.

Comparatively, Utah, the state with the lowest adult smoking prevalence, had 3,882 deaths due to heart disease in 2019. Utah’s mortality rate was 146.5 persons per 100,000. The Center for Disease Control and Prevention also indicates that New Mexico had 4,245 deaths due to heart disease in 2019, a rate of 158.2 deaths per 100,000 total population. In Minnesota, there were 116.7 deaths per 100,000, the lowest in the nation. For Oklahoma, the number of deaths due to heart disease in 2019 was 10,960, according to the CDC.

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69 Stats of the States - Cancer Mortality (cdc.gov)
70 Health and Economic Costs of Chronic Diseases (cdc.gov)
71 Stats of the States - Heart Disease Mortality (cdc.gov)
72 Tobacco-Related Mortality | CDC
73 Stats of the States - Heart Disease Mortality (cdc.gov)
Obesity

Obesity is estimated to cost the United States healthcare system $147 billion dollars.\(^{74}\) In 2019, Oklahoma ranked fourth highest in the nation for adult obesity prevalence.

Almost 37 percent of adults in Oklahoma reported they were obese, which is higher than the national average of approximately 31 percent.\(^{75}\) Additionally, obesity is linked to thirteen different types of cancer.\(^{76}\)

Figure 06: Prevalence of Self-Reported Obesity Among U.S. Adults by State and Territory. This map illustrates how Oklahoma’s obesity rates compare to other states.\(^{77}\)

TSET Spending Agreements

To determine how TSET’s spending aligns with improving the State’s poor health outcomes, LOFT reviewed TSET’s agreements for programs and services. LOFT observed that more than a quarter of TSET’s FY21 contract expenses were spent on communications with a single firm. It was also observed that TSET references the State Constitution to validate these contracts. Article 10, Section 40 of the Oklahoma State Constitution lists six appropriate programmatic uses of the earnings of the trust fund:

1. Clinical and basic research and treatment efforts in Oklahoma for the purpose of enhancing efforts to prevent and combat cancer and other tobacco-related diseases;

\(^{74}\) Health and Economic Costs of Chronic Diseases (cdc.gov)
\(^{75}\) BRFSS Prevalence & Trends Data: Home | DPH | CDC
\(^{77}\) Adult Obesity Prevalence Maps | Overweight & Obesity | CDC
2. Cost-effective tobacco prevention and cessation programs;
3. Programs other than those specified in paragraph 1 of this subsection designed to maintain or improve the health of Oklahomans or to enhance the provision of health care services to Oklahomans, with particular emphasis on such programs for children;
4. Programs and services for the benefit of the children of Oklahoma, with particular emphasis on common and higher education, before- and after-school and pre-school programs, substance abuse prevention and treatment programs and other programs and services designed to improve the health and quality of life of children;
5. Programs designed to enhance the health and well-being of senior adults; and
6. Authorized administrative expenses of the Office of the State Treasurer and the Board of Directors.

The average number of constitutional citations for each of the sixty-one agreements is 3.2, as illustrated in Table 04 below. The use of so many constitutional references per agreement indicate that language may be too broad to drive specific health outcomes.

Table 04: Number of Constitutional References in the TSET’s Agreements

<table>
<thead>
<tr>
<th>Constitutional Authority</th>
<th>Number of times cited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programs designed to maintain or improve the health of Oklahomans</td>
<td>51</td>
</tr>
<tr>
<td>Programs and services for the benefit of the children of Oklahoma</td>
<td>46</td>
</tr>
<tr>
<td>Cost-effective tobacco prevention and cessation programs.</td>
<td>45</td>
</tr>
<tr>
<td>Programs designed to enhance the health and well-being of senior adults</td>
<td>45</td>
</tr>
<tr>
<td>Clinical and basic research and treatment efforts in Oklahoma for the purpose of enhancing efforts to prevent and combat cancer and other tobacco-related diseases</td>
<td>3</td>
</tr>
<tr>
<td>Authorized administrative expenses of the Office of the State Treasurer and the Board of Directors</td>
<td>3</td>
</tr>
</tbody>
</table>

Source: Legislative Office of Fiscal Transparency based on TSET documents

State Spending vs. Tobacco Industry Spending

The CDC recommends as a best practice that states spend cessation and prevention funds on “mass-reach health communication interventions.” It is left up to each state to prioritize this spending. The CDC provides guidance that such strategies should be based on strong evidence and effectiveness in decreasing use of tobacco. TSET maintains that its public campaigns are necessary to provide a counter voice to the tobacco industry.

Tobacco industry spending in Oklahoma is estimated as a percentage of the tobacco industry’s total spending across the nation. Based on these estimations, for every dollar spent by Oklahoma on mass communication, the tobacco industry spends seventeen, which does not address marketing by other industries related to poor health outcomes. With the vast external marketing efforts impacting public health, any funds spent by TSET on “mass-reach”

78 Contracts and Agreements | Tobacco Settlement Endowment Trust (ok.gov)
79 Best Practices for Comprehensive Tobacco Control Programs—2014 | CDC
80 Oklahoma 2020 State Tobacco Plan
marketing must be extremely strategic and be able to demonstrate direct impact on outcomes.81

Chart 09 compares the amount of state spending on tobacco prevention and cessation programs to the amount the tobacco industry spends on marketing and advertising.

Chart 09. Tobacco Marketing Spending vs. Prevention Spending in Oklahoma, 2008-2019.82

Marketing Campaigns

In an effort to help change behavior, TSET invests in marketing and prevention campaigns. In FY21, TSET budgeted $16.26 million for various marketing purposes.83 Services across media program contracts include media costs, traditional and digital media, planning and placement, account service, social media development and management, public relations, subcontracting for research, maintaining a fulfillment center for health promotion items, website development, management and updating, invoicing, creative planning and production, sponsorships, content strategy and evaluation.

81 Mass-Reach Health Communication Interventions (cdc.gov)
82 CDC state spending data and OK State Plan for Tobacco Use Prevention & Cessation 2020(1).pdf
83 PeopleSoft, Operating Budget Comparison Summary by Account/Division as of 04/20/2021
TSET also funds health communication interventions. There are currently three large initiatives within this category of programs:

- The Tobacco Stops with Me (TSWM) campaign was designed to increase knowledge of the dangers of tobacco use and secondhand smoke with a target population.\textsuperscript{84}
- The Shape Your Future (SYF) campaign aims to enhance Oklahoman’s health by addressing poor nutrition, obesity, physical inactivity, and tobacco use. This program provides educational and engaging content, positioning SYF as a resource for improving community health in Oklahoma and creating simple messaging that is easy for the audience to act upon.\textsuperscript{85}
- The TSET Healthy Youth Initiative is a statewide program focused on preventing and reducing tobacco use and obesity for Oklahoma youth.\textsuperscript{86}

Of the $16.26 million budgeted for marketing in 2021, TSET accounts for approximately $13.6 million attributed to specific health communication initiatives.

\textit{Table 05. Examples of TSET Marketing Budget Attributed to Specific Media Campaigns.}\textsuperscript{87, 88}

<table>
<thead>
<tr>
<th>Campaign</th>
<th>Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Stops with Me</td>
<td>$3,815,000</td>
</tr>
<tr>
<td>Shape Your Future</td>
<td>$3,300,000</td>
</tr>
<tr>
<td>Promoting Helpline Statewide</td>
<td>$4,000,000</td>
</tr>
<tr>
<td>Healthy Youth Initiative</td>
<td>$2,500,000</td>
</tr>
<tr>
<td>Total</td>
<td>$13,615,000</td>
</tr>
</tbody>
</table>

\textit{Source: Legislative Office of Fiscal Transparency based on TSET data}

\textsuperscript{84} Tobacco Stops with Me Cross-Sectional Survey 2019, PowerPoint Presentation provided by TSET
\textsuperscript{85} Shape Your Future Web-based Survey June-September 2019, PowerPoint Presentation provided by TSET
\textsuperscript{86} \textit{TSET Healthy Youth Initiative | Tobacco Settlement Endowment Trust (ok.gov)}
\textsuperscript{87} TSET responses to LOFT questions, April 2021
\textsuperscript{88} Promoting Helpline Statewide - OHCA reimburses TSET for a portion of advertising the Helpline to SoonerCare Members
Policy Considerations and Agency Recommendations

Policy Considerations

• The Legislature may consider defining within statutes specific areas of spending on health programs consistent with TSET’s mission and the original purpose of the Master Settlement Agreement, such as Medicaid.

• The Legislature may consider addressing the constitutional broadness of TSET’s mission by placing clarifying language in statute.89

There is precedence for this, as statutes have previously been amended to provide clearer direction to TSET in executing its constitutional duties. For example, O.S. Title 62, Section 2306 more clearly defines the duties of the Board of Investors, how funds are to be managed, and even establishes a limit for administrative support.

• The Legislature may consider amending O.S. Title 62, Section 2306 to provide clearer guidance to the Board of Directors for TSET regarding the type of allowable expenditures related to executing its duties.

Agency Recommendations

• TSET should report data related to health outcomes directly attributable to TSET programs and spending.

The Oklahoma State Department of Health, which currently reports county-level smoking prevalence and other key health indicators, has the capability to collect and analyze health data for the purposes of outcome measurement associated with health improvement initiatives. Logic models to determine short-term outcomes and subsequent measurement of those outcomes would aid the agency in determining where money should be spent on health improvement initiatives. This type of evaluation data would allow the agency a data-driven approach to health improvement initiatives by county.

• TSET should measure outcome data, both intermediate and long-term, to determine the statewide efficacy of media campaigns.

TSET currently tracks some output and short-term outcome measures, such as awareness of media materials and number of persons having seen a particular campaign, but does not track the type of outcome data necessary to determine effectiveness across the state. A good starting point is the CDC guidance to states for improving the efficacy and reducing costs of media campaigns.90

89 See Appendix J for constitutional language
90 Evaluating Communication Campaigns (blogs.cdc.gov)
Finding 3. TSET’s Resources Are Not Aligned to Oklahoma’s Greatest Needs

LOFT estimates that for every one percent reduction in smoking prevalence, there would be a cumulative savings of $135 million by 2030 realized by Oklahoma’s citizens, as illustrated in Chart 10.

*Chart 10: Annualized Possible Savings for Every 1% Reduction in Smoker Prevalence; saving projections have been adjusted for inflation.*

LOFT compared TSET program spending to the agency’s stated, publicized priorities and found approximately 86 percent of TSET’s operating budget aligns with these priorities. TSET’s FY21 budget allocations are aligned with four out of six of the agency’s major program areas: Healthy Lifestyle Grants, Incentive Grants, Health Systems Initiative Grants, Research, Healthy Youth Initiative and Healthy Communication Interventions.92

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92 TSET Programs [tset.ok.gov]
Table 06: TSET’s Budget Class Funding Items vs. Stated Programs. This table depicts budget items according to TSET’s publicly identified programs; for details see Appendix E. 85.6 percent ($43.4M vs. $50.7M) of TSET’s operating budget (excluding the Board of Investors) align to TSET’s stated programs.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Communication Interventions</td>
<td>$15,336,442</td>
<td>30%</td>
</tr>
<tr>
<td>Healthy Lifestyle Grants</td>
<td>$14,275,468</td>
<td>28%</td>
</tr>
<tr>
<td>Research</td>
<td>$11,931,000</td>
<td>24%</td>
</tr>
<tr>
<td>Health Systems Initiative</td>
<td>$1,864,376</td>
<td>4%</td>
</tr>
<tr>
<td>Incentive Grants</td>
<td>$-</td>
<td>0%</td>
</tr>
<tr>
<td>Healthy Youth Initiative</td>
<td>$-</td>
<td>0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$43,407,286</td>
<td>85.6%</td>
</tr>
</tbody>
</table>

Source: Legislative Office of Fiscal Transparency based on TSET and data from PeopleSoft.

CDC Best Practices Categories

Using the categories from the CDC’s best practices for tobacco cessation, published in 2014, TSET’s FY21 budget allocations are aligned with four out of five categories, amounting to 73.4 percent ($37.2M vs. $50.7M) of TSET’s budget, excluding the operating cost of the Board of Investors.

Table 07: TSET Budget Funding vs. CDC’s Best Practices Categories and Category. This chart depicts trends of actual expenditures according to TSET defined budget departments/programs. (For details see Appendix E and I)

<table>
<thead>
<tr>
<th>CDC Categories</th>
<th>Matching Budget Items</th>
<th>Share of Op. Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>State and Community Interventions</td>
<td>$23,084,777</td>
<td>46%</td>
</tr>
<tr>
<td>Cessation interventions</td>
<td>$9,351,827</td>
<td>18%</td>
</tr>
<tr>
<td>Infrastructure, administration and management</td>
<td>$3,225,441</td>
<td>6%</td>
</tr>
<tr>
<td>Health communication interventions</td>
<td>$1,562,692</td>
<td>3%</td>
</tr>
<tr>
<td>Surveillance and evaluation</td>
<td>$-</td>
<td>0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$37,224,737</td>
<td>73.4%</td>
</tr>
</tbody>
</table>

Source: Legislative Office of Fiscal Transparency based on CDC, TSET and data from PeopleSoft.

However, when evaluating figures provided by TSET to the CDC (see Chart 11), the agency budgeted closer to 40 percent on tobacco programs. The Chart depicts the State’s total budget of $21.7 million for tobacco cessation for FY21. TSET accounts for $20.7 million of the state’s budgeted spending, representing a 94.4 percent share, with OSDH accounting for the remaining $1.2 million, representing a 5.6 percent share. OSDH’s contribution is from the Tobacco Tax.

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93 For detailed breakdown by funding class see Appendix K, Table 14
94 Best Practices for Comprehensive Tobacco Control Programs—2014 | CDC
Data demonstrating the effectiveness of individual programs across various communities is not available from TSET. While TSET program spending is aligned with CDC recommended best practices, this approach appears to have had limited effectiveness in Oklahoma.

**TSET Spending per County vs. Smoking Prevalence**

In response to LOFT’s inquiry regarding the factors that are positively impacting counties achieving smoking prevalence rates below sixteen percent, TSET responded that “essentially it is the behaviors of individuals, community and its environment, including policy environment and clinical care/access to care that interacts with each other in a complex web of cause and effect to create the desirable healthy outcomes, achieve health equity, and improve the overall health profile of a community. When it comes to tobacco use, similar types of determinants occur.”

TSET does not conduct local level evaluation or analysis that would help determine what is working within Oklahoma communities. The following map displays the smoking prevalence by county.

TSET displays the partnerships it utilizes and the counties in which those partners operate. For FY2021, approximately $7.6 million was spent in counties, while $37.3 million was spent on statewide programs.

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95 PeopleSoft data, OSDH data and Tobacco Free Kids
96 Official responses provided by TSET to LOFT March 26, 2020
Reviewing county-centric data, programmatic spending does not appear to be connected to the counties and regions that have high rates of adult smoking.

TSET reports that in 2020, the Tobacco Helpline reached out to approximately 28,000 smokers across the state. Figure 09 shows the number of Helpline callers per 1,000 residents in each county.

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97 2020 Wellness County Profiles and Census Tract Appendices | OK In the Know
98 TSET’s website reports spending by county. Data has been summed by county. Where more than one county was the recipient of funds, LOFT evenly divided the funds among counties. Contracts and Agreements (tset.ok.gov)
Statewide expenditures can be grouped into the following categories, as shown in Chart 12 below.

Chart 12: Examination of FY2021 Statewide Expenditures by TSET.\textsuperscript{100}

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\textsuperscript{99} Data provided by TSET.
\textsuperscript{100} Ibid.
TSET’s Helpline

In 2004, a national quit line was established along with CDC funding for state quit lines. Quitlines (sometimes called helplines) exist to provide tobacco users services and support for quitting tobacco products. Services vary by state, but often provide counseling, referrals to local cessation programs, self-help materials or medications.\(^{101}\)

In addition to information and a variety of support services, the Oklahoma Tobacco Helpline (Helpline) provides eighty percent of tobacco users who express a desire to quit with nicotine replacement therapy (NRT). Approximately fifty percent of the Helpline’s annual budget is spent on NRT. NRT is also provided through a grant to the Oklahoma Department of Mental Health and Substance Abuse Services and NRT represents approximately nineteen percent of that grant’s budget. Currently, TSET spends approximately four percent of their overall budget on Nicotine Replacement Therapy, spending $1.8 million in FY20.\(^{102}\)

The number of referrals to the Helpline in 2020 was greater than the prior two years but the percent and number of tobacco users registering for services was lower during the same time (11.5% in FY 20 compared to 12.6% in FY19 and 20.1% in FY18).

Approximately eighty percent of those registering for services will receive some nicotine replacement therapy (NRT) products from TSET. In 2020, 34.4 percent of registrants were successful at quitting when measured seven months after the onset of services. When e-cigarettes are taken into consideration, the overall quit rate is around thirty percent. The single call program and multiple call program with eight weeks of NRT have the highest quit rates of all the service options, with 39.8 percent and 38.5 percent quit rates, respectively.\(^{103}\)

These results indicate that increased investment in direct tobacco cessation products to smokers would likely reduce smoking prevalence.

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\(^{101}\) Centers for Disease Control and Prevention. Celebrating the 15th Anniversary of the National Network of Tobacco Cessation Quitlines. Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2019.

\(^{102}\) TSET Reponses to LOFT questions. April 2021

\(^{103}\) Evaluation of the Oklahoma Tobacco Helpline, University of Oklahoma, Department of Biostatistics and Epidemiology, 2020
Oklahoma spends $11.52 per smoker utilizing its Helpline.

The median state investment into quitlines is $2.21 per smoker.

Chart 13: Proportion of Adult Smokers with a Quit Attempt in the Last Year, 2011-2019. This chart compares Oklahoma to the rest of the nation as a whole. Data is collected via surveys by the Oklahoma State Department of Health on behalf of the Center for Disease Control and Prevention for their annual Behavioral Risk Fact Surveillance System.

Oklahoma spends approximately five times more per smoker than the national average on its tobacco quit line (1-800-QUIT-NOW). This is more than four times the regional average, as illustrated in Figure 10. The 2019 CDC Report reflects the median state investment into quitlines was $2.21 per smoker.

Figure 10: Regional Spend per Helpline Caller, as of October 2020.

104 Behavioral Risk Factor Surveillance System | DPH | CDC
105 Cost-Effectiveness of Community-Based Tobacco Dependence Treatment Interventions: Initial Findings of a Systematic Review (cdc.gov)
106 The Truth Initiative
Agency Recommendations

- **TSET should prioritize tobacco prevention and control programs based on Oklahoma-specific outcomes and needs.**

  The Center for Disease Control and Prevention, Best Practices for Comprehensive Tobacco Control Programs (2014) should be used as a guide to inform tobacco control. However, based on the absence of outcome data directly attributable to programs and the current ranking of the State in terms of adult and youth smoking, vaping and e-cigarette use, TSET should consider revising its current priorities. These revisions should be data-driven and tied directly to the needs of individual Oklahoma counties. This approach would allow for the identification of best practices from one county to the next.

- **TSET should examine the operational cost effectiveness of its Helpline, looking to other states for examples of cost-saving measures.**
Finding 4: Oklahoma Has Opportunities to Improve Outcomes Through Policy Changes, Prioritization of Spending, and a Unified Statewide Strategy

Economic Toll of Tobacco in Oklahoma

Tobacco use rates impact various areas of public policy and increase public costs. These long-term costs to states, particularly for health impacts, compelled states to act against the tobacco companies. States engage in public wellness policy initiatives to improve the general quality of life for residents, but also to contain costs. As detailed below, smoking is a leading component of Medicaid expenses and the overall tax burden, and those costs are continuing to grow.

Table 08: Smoking-Caused Monetary Costs in Oklahoma, from Tobacco Free Kids. \(^\text{107}\) This table does not include health costs caused by exposure to secondhand smoke, fires caused by smoking, and smokeless tobacco use of cigar and pipe smoking. This data also does not include additional costs such as workplace productivity losses and damage to property.

<table>
<thead>
<tr>
<th>Smoking-Caused Monetary Costs in Oklahoma</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual health care costs in Oklahoma directly caused by smoking</td>
<td>$1.62 billion</td>
</tr>
<tr>
<td>Medicaid costs caused by smoking in Oklahoma</td>
<td>$264 million</td>
</tr>
<tr>
<td>Residents’ state &amp; federal tax burden from smoking-caused</td>
<td>$849 per</td>
</tr>
<tr>
<td>government expenditures</td>
<td>household</td>
</tr>
<tr>
<td>Smoking caused productivity losses in Oklahoma</td>
<td>$2.1 billion</td>
</tr>
</tbody>
</table>

Source: The Toll of Tobacco in Oklahoma, Tobacco Free Kids, October 2020

Chart 14 shows how the annual healthcare and economic costs of tobacco use in Oklahoma have increased from approximately $3.1 billion to more than $4 billion in just ten years.

\(^{107}\) Oklahoma - Campaign for Tobacco-Free Kids [en]
Comparative Analysis

Through this report’s comparative analysis and benchmarking study, LOFT observed several common characteristics of states that have improved their adult smoking prevalence. Using data from all fifty states, plus Washington, D.C., comparative analysis showed the largest drivers (51.10 percent) in explaining the variance between a state’s adult smoking prevalence are:

- Cigarette tax rate (33.54 percent)
- Medicaid expense per capita (10.95 percent)
- Stress Index (6.61 percent)

Oklahoma ranks the 6th highest for Stress Index, 18th in cigarette taxation, and 40th in Medicaid expense per capita.\(^\text{109}\)

The Stress Index calculation encompasses four major categories: Economics, Financial, Health, and Family. These categories are prevalent within the Connecticut, Utah, New Mexico, and Colorado statewide comprehensive health action plans. These plans promote unified messaging and support related to state health objectives, including tobacco cessation and prevention. Oklahoma produces an annual Tobacco Use Prevention and Cessation Plan, compiled by the Advancement of Wellness Advisory Council (established under 63 OS §1-229.5).

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\(^{108}\) Tobacco Free Kids, Economic Costs of Tobacco in Oklahoma, adjusted for inflation

\(^{109}\) Most & Least Stressed States (wallethub.com) Criteria for Stress Index
The Tobacco Use Prevention and Cessation Plan is developed by and for the Oklahoma State Department of Health (OSDH) and its stakeholders. However, Oklahoma lacks a comprehensive state plan which has led to multiple agencies within the State attempting to achieve similar goals while utilizing the same resource pool.

Table 09: Oklahoma vs. Top Ten and Neighboring States.\footnote{110} This table captures comparative figures among top states and Oklahoma in prevalence, taxations, state spending, stress index, and Medicaid.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Utah</td>
<td>1</td>
<td>$1.70</td>
<td>80.2%</td>
<td>79.4%</td>
<td>Yes</td>
<td>30.2</td>
<td>$702</td>
</tr>
<tr>
<td>California</td>
<td>2</td>
<td>10.0%</td>
<td>2.87</td>
<td>76.7%</td>
<td>67.0%</td>
<td>Yes</td>
<td>51.0</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>3</td>
<td>12.0%</td>
<td>$3.51</td>
<td>85.8%</td>
<td>7.7%</td>
<td>Yes</td>
<td>44.0</td>
</tr>
<tr>
<td>Connecticut</td>
<td>4</td>
<td>12.1%</td>
<td>$4.35</td>
<td>81.3%</td>
<td>0.0%</td>
<td>Yes</td>
<td>43.6</td>
</tr>
<tr>
<td>Hawaii</td>
<td>5</td>
<td>12.3%</td>
<td>$3.20</td>
<td>75.2%</td>
<td>57.8%</td>
<td>Yes</td>
<td>44.2</td>
</tr>
<tr>
<td>Washington</td>
<td>6</td>
<td>12.6%</td>
<td>$3.03</td>
<td>86.4%</td>
<td>3.4%</td>
<td>Yes</td>
<td>44.0</td>
</tr>
<tr>
<td>New York</td>
<td>7</td>
<td>12.7%</td>
<td>$4.35</td>
<td>80.8%</td>
<td>19.6%</td>
<td>Yes</td>
<td>47.0</td>
</tr>
<tr>
<td>Maryland</td>
<td>8</td>
<td>12.7%</td>
<td>$3.75</td>
<td>83.0%</td>
<td>22.6%</td>
<td>Yes</td>
<td>39.5</td>
</tr>
<tr>
<td>New Jersey</td>
<td>9</td>
<td>13.1%</td>
<td>$2.70</td>
<td>81.0%</td>
<td>7.6%</td>
<td>No</td>
<td>42.5</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>10</td>
<td>13.3%</td>
<td>$4.25</td>
<td>82.2%</td>
<td>3.1%</td>
<td>Yes</td>
<td>46.6</td>
</tr>
<tr>
<td>Colorado</td>
<td>11</td>
<td>13.5%</td>
<td>$1.94</td>
<td>81.5%</td>
<td>37.8%</td>
<td>Yes</td>
<td>43.2</td>
</tr>
<tr>
<td>New Mexico</td>
<td>26</td>
<td>16.0%</td>
<td>$2.00</td>
<td>71.5%</td>
<td>24.2%</td>
<td>Yes</td>
<td>58.3</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>40</td>
<td>18.9%</td>
<td>$2.03</td>
<td>75.9%</td>
<td>51.2%</td>
<td>No</td>
<td>51.4</td>
</tr>
<tr>
<td>National Average</td>
<td>N/A</td>
<td>15.9%</td>
<td>$1.91</td>
<td>80.1%</td>
<td>19.8%</td>
<td>Over Half</td>
<td>44.8</td>
</tr>
</tbody>
</table>

Source: Legislative Office of Fiscal Transparency

In evaluating the body of research on tobacco cessation, most often mentioned – including by TSET - as effective strategies are:

- cigarette tax rate increases
- clean air laws, and
- funding levels towards cessation and prevention programs.

LOFT’s independent statistical analysis showed the tax rate, clean air laws, and CDC suggested spending levels account for approximately 34.15 percent of the variance in smoking cessation. Of that, the tax rate represents 33.54 percent.\footnote{111}

As shown in Chart 15, there is a strong correlation between the tax rate on cigarettes and adult smoking prevalence. According to a 2012 report by the U.S. Surgeon General, a ten percent increase in the cost of cigarettes decreases consumption by three to five percent.\footnote{112} However, the emergence of e-cigarettes complicates the presumption of offsetting health cost avoidance metrics used by TSET. As of this report, twenty-six states currently tax e-cigarettes, seventeen

\footnote{110} Compilation of CDC data including \url{State Tobacco Activities Tracking and Evaluation (STATE) System: Custom Reports | OSH | CDC} and \url{STATE CIGARETTE EXCISE TAX RATES (tobaccofreekids.org)} and \url{Most & Least Stressed States (wallethub.com)} and \url{U.S. E-Cigarette Regulations - 50 State Review (2020) | Public Health Law Center} 

\footnote{111} See Appendix M for Statistical Summary Outputs

\footnote{112} \url{Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General (nih.gov)}.
states regulate the indoor smoking of e-cigarettes the same as traditional cigarettes, and thirty states require retail licensure.\textsuperscript{113}

\textit{Chart 15: 2021 Cigarette Tax Rate vs 2019 Adult Smoking Prevalence. Tax Rate vs Adult Smoking Prevalence displays that Oklahoma is less sensitive to tax rate increases as a method to lower smoking prevalence than other states.}\textsuperscript{114} Utah is more sensitive to tax rate increases as a method to lower smoking prevalence than other states.\textsuperscript{115}

\textit{Figure 11: A 2020 National Bureau of Economic Research Study Shows E-Cigarettes and Traditional Cigarettes are Economic Substitutes.}\textsuperscript{116} Cross-price elasticity of traditional cigarettes with e-cigarettes indicates price increase of one product may decrease usage but increase demand of the other product.

\textsuperscript{113} CDC Smoking and Tobacco Use Data, 2019
\textsuperscript{114} See Appendix L for excise taxes per 20-pack of cigarettes by state
\textsuperscript{115}\texttt{STATE\_CIGARETTE\_EXCISE\_TAX\_RATES\_\{}\texttt{tobacofreekids.org}\texttt{\} and Open Data | Centers for Disease Control and Prevention | Chronic Disease and Health Promotion Data & Indicators | cdc.gov
\textsuperscript{116} Study based on national data with limitation of analysis tied to packaging and selling of vaping/E-cigarettes \texttt{w26724.pdf | nber.org}
### Benchmarking Study and Regional Trends

*Table 10: Benchmarking Key Stats and Best Practices.*\(^{117}\) The table reflects key elements of states’ best practices, policies, and funding sources.\(^{118}\)

<table>
<thead>
<tr>
<th>State</th>
<th>MSA Distribution to State</th>
<th>Direct MSA Allocation to Tobacco Prevention &amp; Cessation</th>
<th>State Appropriated Funds Towards Prevention &amp; Cessation</th>
<th>Federal Funds for Prevention &amp; Cessation</th>
<th>Tobacco Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utah</td>
<td>$25.7M</td>
<td>$3.874M</td>
<td>$3.159M</td>
<td>$7.547M</td>
<td>$84.843M</td>
</tr>
<tr>
<td></td>
<td><strong>Requires Licensure for E-Cigarette Products</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Strong emphasis on clean indoor air/secondhand smoke laws. Provides legal and financial impact studies to multi-housing unit owners to convert to smoke free housing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Comprehensive state plan under one agency which spearheads tobacco prevention and cessation directives</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Connecticut</strong> $118.8M</td>
<td>No</td>
<td>$4.873M</td>
<td>$6.823M</td>
<td>$325.4M</td>
</tr>
<tr>
<td></td>
<td><strong>Requires Licensure for E-Cigarette Products</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Maximizes federal funding to operate “Quit Line”</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Consolidated multiple agencies and divisions with similar outcome focuses into Department of Mental Health and Addiction Services (DMHAS). Provides a 5-step Strategic Preventive Framework spearheaded by the State Epidemiologist Outcome Workgroup (SEOW) which coordinates statewide efforts across 12 state agencies and University of Connecticut Health Center</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Colorado</strong> $82.4M</td>
<td>No</td>
<td>Yes - TBD</td>
<td>TBD</td>
<td>$187.05M</td>
</tr>
<tr>
<td></td>
<td><strong>Requires Licensure for E-Cigarettes Products</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Utilizes an “Evidence-Based Public Health Framework” approach to the State’s health initiatives spread headed by the Department of Public Health &amp; Environment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Statewide, comprehensive health plan which is updated based on outcomes on 4-year basis</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Conducts annual forecast on MSA payments to maximize budget</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>New Mexico</strong> $33.9M</td>
<td>$5.4M</td>
<td>$5.264M</td>
<td>$1.142M</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td><strong>Requires Licensure for E-Cigarettes Products</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Developed plan to &quot;change to culture of smoking&quot; within New Mexico</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Unified stakeholders’ efforts through New Mexico Allied Council on Tobacco</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Oklahoma</strong> $66.3M</td>
<td>No</td>
<td>Yes - TBD</td>
<td>TBD</td>
<td>$241.074M</td>
</tr>
<tr>
<td></td>
<td><strong>Does not require Licensure of E-Cigarette Products</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Advancement of Wellness Advisory Council (OSDH) provides the “State Plan,” but the State Plan appears to conflict with some of TSET’s stated goals. Example: TSET’s goal is to have adult smoking prevalence (SP) below 10% while OSDH's goal is to have SP below national average by 2022. Agencies have shared goals, but process does not appear to be a comprehensive, unified approach to achieving goals of the State’s Plan.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source: Legislative Office Fiscal Transparency*

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\(^{117}\) See Appendix N for complete benchmarking study analysis.

\(^{118}\) See Appendix F for Oklahoma tobacco excise tax apportionment.
Chart 16: Comparison of Benchmarked States’ Adult Smoking Prevalence and the Impact of Policies Implemented by Respective States as Compared with the National Trend. Improvements in Oklahoma’s smoking rate do not appear to be independent of nation-wide factors.

The criteria for state selection varied for this analysis: New Mexico and Colorado were selected because they are regional states which have “below average” adult smoking prevalence; Connecticut was selected based on the fact it is ranked fourth in adult smoking prevalence (currently appropriates no state funds, either from their general funds or the Tobacco Master Settlement Agreement (MSA) specifically toward tobacco cessation); and, Utah was selected due to being the only state which is currently at or below TSET’s stated goal of having adult smoking prevalence below 10 percent. Refer to Appendix M for details about the individual states assessed.

LOFT observed numerous best practices through its benchmarking study and comparative analysis. The most common best practice among Utah, Connecticut, Colorado, and New Mexico was each’s “evidence-based public health framework” for building their state’s respective health plans, including tobacco cessation and prevention.

119 CDC, Behavioral Risk Factor Surveillance System, 2019
Figure 12: Example of an Evidence-Based Public Health Framework, from Colorado. The evidence-based approach allows for a more complete picture and understanding of the problems, which processes work and can be replicated, and where an agency should formulate new plans and processes to resolve key issues.

Table 11: Best Practices. Compilation from benchmarking study and comparative analysis.

<table>
<thead>
<tr>
<th>Best Practices Compiled from Benchmarking Study and Comparative Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensure of E-Cigarette Policies</td>
</tr>
<tr>
<td>Comprehensive state plan under one agency which spearheads tobacco prevention and cessation directives</td>
</tr>
<tr>
<td>Create repository of information and efforts of statewide efforts for tobacco cessation, prevention, and health promotion into clearly identified lead agency with strong support structure of partnerships within communities and other state agencies</td>
</tr>
<tr>
<td>Strong emphasis on clean indoor air/secondhand smoke laws. Provides legal and financial impact studies to multi-housing unit owners convert to smoke free housing</td>
</tr>
<tr>
<td>Maximize Federal Funding to run and operate a more efficient &quot;Quit Line&quot;</td>
</tr>
<tr>
<td>Comprehensive, evidence-based public health framework which uses data and metrics to determine funding requirements and drive desired outcomes</td>
</tr>
<tr>
<td>Conduct annual analysis on MSA payments to the state for more informed budgeting process</td>
</tr>
</tbody>
</table>

Source: CDPHE Chronic Disease State Plan 2018-2020

Source: Legislative Office of Fiscal Transparency
Regional Legislative Activity

LOFT evaluated recent policy trends among Oklahoma’s neighboring states and found regional peers to be more active in data collection and regulation of emerging trends regarding tobacco and e-cigarettes.

Arkansas

The Arkansas Tobacco Settlement Commission is housed within the Arkansas Department of Health. The Commission provides general oversight and evaluation of all programs funded by Master Settlement Agreement dollars in Arkansas. The Tobacco Prevention and Cessation Program is a branch of the Arkansas Department of Health and provides the State with prevention programming and cessation services. Within the Tobacco Prevention and Cessation Program is the Be Well Arkansas program, which is the only cessation call center in the nation operated by a state health department.121

The Arkansas Tobacco Control office, under the umbrella agency of the Department of Finance & Administration, is charged with reviewing permits and ensuring retailers, wholesalers and manufacturers of tobacco, vapor and alternative nicotine products comply with the state’s tobacco laws.122 The Arkansas Department of Health funds the enforcement of tobacco laws. Permitting and administrative operations of the office are supported with a different source of state funding.

The State’s Legislature has recently considered but not enacted taxing e-cigarettes to match current tobacco products taxation (68 percent of the manufacturer price).123 Although the sale of e-cigarettes is not yet taxed, it is licensed at an annual fee of $50.124

Colorado

Up until this January, retailers were not required to obtain a license to sell tobacco products but were required to be licensed for the sale of e-cigarette products.

Colorado’s law defines a nicotine product as any product that contains “nicotine derived from tobacco or created synthetically” including those inhaled.

Effective January 1, 2021, any distribution of nicotine products requires a license. ($10 annually, remitted to the State’s General Fund).

121 Correspondence with the Arkansas Tobacco Prevention and Cessation Program, April 29, 2021
122 Sources: Arkansas Tobacco Settlement Commission, Arkansas Department of Health, Arkansas Attorney General
123 SB2 Bill Information - Arkansas State Legislature
124 Interview with the Arkansas Tobacco Control, April 28, 2021
New Mexico

In 2019, New Mexico raised its state excise tax rate for cigarettes, taxed e-cigarette and vaping products at 12.5 percent and added a 50-cent tax to closed system cartridges.\(^{125}\) Also, House Bill 256 added e-cigarettes to the clean air act.\(^{126}\) Senate Bill 131, enacted during the 2020 NM Legislative Session, took effect January 1, 2021.\(^{127}\) SB131 raised NM’s legal age for the purchase of tobacco products from 18 to 21 years and requires all distributors, manufacturers, and sellers of tobacco products to be licensed with the NM Regulation and Licensing Department. SB131 provided enforcement authority to the Department of Public Safety, with licensing fees supporting administrative and enforcement costs.

In 2021, New Mexico considered but did not enact House Bill 167, which proposed an increase in the tobacco products tax for goods distributed for consumption from 25 percent to 83 percent, for e-liquids from 12.5 percent to 83 percent, and for closed system cartridges from 50 cents to $3.32 per closed system cartridge.\(^{128}\)

Texas

In 2015, Texas updated its statutes pertaining to the distribution of cigarettes and tobacco products to include the sale, delivery, registration, and reporting of e-cigarettes. Provisions of the requirements capture the same data for e-cigarettes as what the state collects for combustible cigarettes; notably, the quantity sold.

The legislation also requires the Texas Department of State Health Services to present a biennial report on the status of e-cigarette to be provided to the Governor and legislative leadership.

This past session, Texas’ Legislature considered more than 20 legislative proposals pending to increase regulation or taxation on e-cigarettes while also expanding the definition of e-cigarettes to include all vaporized or aerosolized products, “regardless of whether the liquid or other material contains nicotine.” Senate Bill 248, which as of June 7, 2021 was awaiting the Governor’s action, would require retailers of e-cigarettes to obtain a permit.\(^{129}\) Revenues derived from the sale of permits would be deposited into the State’s general revenue fund. Enforcement of permit compliance is to be provided by the State Comptroller’s Office.

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\(^{125}\) [2019-HB6 - New Mexico Legislature (nmlegis.gov)]
\(^{126}\) [2019-HB256 - New Mexico Legislature (nmlegis.gov)]
\(^{127}\) [2020-SB131 - New Mexico Legislature (nmlegis.gov)]
\(^{128}\) [2021-HB167 - New Mexico Legislature (nmlegis.gov)]
\(^{129}\) SB 248 passed the Legislature on June 1, 2021 and awaits action by the Governor. Sources: Office of the Texas State Comptroller, the Texas Legislature.
Policy Considerations

- The Legislature may consider reorganizing TSET within an existing state agency focused on health outcomes aligned with TSET’s constitutional duties. Options include the Department of Health, the Health Care Authority, and the Department of Mental Health and Substance Abuse Services.

- The Legislature may consider expanding the definition of smoking in statutes to include e-cigarettes and emerging technologies for ingesting nicotine and tobacco-related products. (note: currently, some product definitions are provided within Executive Orders, leading to poor enforcement.)

- The Legislature may consider creating or repurposing an existing governmental body with the authority to create and execute a statewide strategy for improving the health and wellness of Oklahomans, including reducing tobacco use to below the national average. One option could be to build on the existing Advancement of Wellness Advisory Council, which is led by the Commissioner of Health.

- The Legislature may consider requiring the production of an annual report about tobacco products and trends in the region, including taxation, use, sales, illegal sales and emerging products, including e-cigarettes. The current State Plan produced by the State Department of Health could be adapted.

- The Legislature may consider requiring licensure for the distribution and sale of e-cigarettes. Options for the enforcement agency could include the ABLE Commission or the Attorney General’s Office.

- The Legislature may consider utilizing a percentage of the share of MSA funds currently allocated to the Attorney General’s for the enforcing agency, if enforcement of other cigarette products is enacted.

- The Legislature may consider requiring an annual forecast for MSA payments be provided. For example, Colorado’s Department of Public Health and Environment currently provides this to the public.

- According to the MSA, a key component to the funding formula is a state’s cigarette sales. MSA Payments to a state decrease as cessation and prevention programs achieve success. A forecast of MSA payments will ensure adequate funding for programs and agencies.
About the Legislative Office of Fiscal Transparency

Mission
To assist the Oklahoma Legislature in making informed, data-driven decisions that will serve the citizens of Oklahoma by ensuring accountability in state government, efficient use of resources, and effective programs and services.

Vision
LOFT will provide timely, objective, factual, non-partisan, and easily understood information to facilitate informed decision-making and to ensure government spending is efficient and transparent, adds value, and delivers intended outcomes. LOFT will analyze performance outcomes, identify programmatic and operational improvements, identify duplications of services across state entities, and examine the efficacy of expenditures to an entity’s mission. LOFT strives to become a foundational resource to assist the State Legislature’s work, serving as a partner to both state governmental entities and lawmakers, with a shared goal of improving state government.

Authority
With the passage of SB1 during the 2019 legislative session, LOFT has statutory authority to examine and evaluate the finances and operations of all departments, agencies, and institutions of Oklahoma and all its political subdivisions.

Created to assist the Legislature in performing its duties, LOFT’s operations are overseen by a legislative committee. The 14-member Legislative Oversight Committee (LOC) is appointed by the Speaker of the House and Senate Pro Tempore and receives LOFT’s reports of findings.

The LOC may identify specific agency programs, activities, or functions for LOFT to evaluate. LOFT may further submit recommendations for statutory changes identified as having the ability to improve government effectiveness and efficiency.
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Appendices

Appendix A. Methodology

States with relative geographical proximity were used for regional comparison. Some national and regional data was procured from Tobacco Free Kids and the Bureau of Labor statistics. For the purposes of TSET’s funding across Oklahoma, where more than one county was listed as a recipient, it was assumed that funds were equally divided and utilized within those counties. Annualized cost savings projections FY2030 were developed by calculating the trend of population, smoker prevalence, and the consumer price index for medical care.

All data used for the comparative analysis were open source, quantitative data compiled through the Centers for Disease Control and Prevention, Tobacco Free Kids, Wallet Hub, and Public Health Law Center. Sources for this analysis were chosen based on national recognition, consistency of information, and are sources cited by TSET in their own research and analysis. Additionally, comparative analysis and benchmarking states were selected based on current success rates with outlying characteristics such as being the only state to be at or above TSET’s stated goal for adult smoking prevalence of 10 percent, showed significant lack of funding as shown by the CDC while additionally exhibit low adult smoking prevalence, or regional states which were at or above the national average for adult smoking prevalence. Comparative analysis and benchmarking were conducted to obtain insight into best practices and determine which processes each state employs have the potential to be replicated within Oklahoma.

Other than independent research, data used within this report was obtained from the Tobacco Settlement Endowment Trust and the Oklahoma State Department of Health. Information and data were obtained directly from The Office of the Oklahoma Attorney General and Office of the Oklahoma State Treasurer. Sections of this report were reviewed with the relevant state agency or organization for the purpose of confirming accuracy. It is the purpose of LOFT to provide both accurate and objective information: this report has been reviewed by LOFT staff outside of the project team to ensure accuracy, neutrality, and significance.

Interviews were conducted with:

- Tobacco Settlement Endowment Trust
- Office of the Oklahoma Attorney General
- Office of the Oklahoma State Treasurer
- Oklahoma State Department of Health
- Oklahoma Health Care Authority
- Oklahoma Department of Mental Health and Substance Abuse Services
- Oklahoma Hospital Association
- OU Health Sciences Center, Department of Biostatistics and Epidemiology
- Health Promotion Research Center
- Utah Tobacco Prevention and Control Program
- New Mexico Tobacco Use Prevention and Control Program
Appendix B. MSA Payments to Oklahoma

Chart 17: MSA Payments to the State of Oklahoma (Bar chart depicting MSA’s yearly deposits and their apportionment between TSET, General Fund, and Attorney General, and also other funds used in FY00)

Source: Legislative Office of Fiscal Transparency based on data from OMES
## Table 12: MSA Payments Distribution

<table>
<thead>
<tr>
<th>FY MSA Deposit</th>
<th>Total MSA Payment</th>
<th>General Revenue Fund</th>
<th>200 AG's Revolving Fund</th>
<th>700 AG's Evidence Fund</th>
<th>Tobacco Settlement Fund (000-300)</th>
<th>Tobacco Settlement Endowment Trust Fund (C92-305)</th>
<th>Total Payment Allocation</th>
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<td>49,710,559.54</td>
<td>66,280,746.05</td>
</tr>
</tbody>
</table>

Source: Legislative Office of Fiscal Transparency based on data from OMES
Appendix C. FY21 Legislature’s and AG’s MSA Spend

Exhibit 01: The Share of MSA for Appropriation by the Legislature.\textsuperscript{130} The Board of Equalization certifies the estimate for Legislature’s appropriation in February, which is before MSA yearly settlement amount is deposited with the State in April. The reverse sequence of that resulted with certified limit to be 94.3 percent of the actual, $12.4 million, MSA apportionment for the Legislature.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>TOBACCO SETTLEMENT FUND</td>
<td>$13,383,490</td>
<td>$11,718,750</td>
<td>$(1,664,740)</td>
<td>-12.4%</td>
</tr>
</tbody>
</table>

Source: Board of Equalization February 2021

Table 13: Office of the Attorney General Tobacco Settlement Payment Amounts and Spending Distribution between FY17-20\textsuperscript{131}

| OAG Tobacco Settlement Distribution Share FY17-FY20 |
|---|---|---|---|---|
| Budget Item | FY17 | FY18 | FY19 | FY20 |
| Tobacco Enforcement Uni | $880,596 | $871,972 | $841,106 | $704,720 |
| Administration: Salaries and Benefits | $749,220 | $412,433 | $411,052 | $147,568 |
| Bond Payments | $1,016,822 | $1,016,311 | $1,017,163 | $1,017,568 |
| Information Technology | $1,673,782 | $1,626,598 | $1,539,461 | $1,718,260 |
| Building Rent | $551,645 | $551,645 | $551,645 | $554,431 |
| OAG MSA Share | $4,872,055 | $4,478,958 | $4,360,426 | $4,142,547 |

Source: Office of the Oklahoma Attorney General

\textsuperscript{130} Proposed FY-2021 Revenue Certification (oklahoma.gov)

\textsuperscript{131} Attorney General Responses to LOFT, December 2020
Appendix D. TSET Organizational Structure and Leadership

TSET is led by a Board of Directors consisting of seven members (see Table 14) who supervise the earnings from the Trust to fund programs that improve the health and well-being of all Oklahomans. Initial appointed members serve staggered terms of office, and subsequent appointed members serve seven-year terms. Each congressional district must have representation by one appointee apiece, and no more than two appointees may be appointed from any single congressional district. Further, no more than four appointees may be from any one political party. All appointees must demonstrate expertise in public or private healthcare or programs that benefit children or senior adults.132

Since FY10, the Board of Directors has supported a strategic plan emphasizing three primary areas of funding: prevention, research, and emerging opportunities. Preference has been given to proposals that impact large populations, organizations, or systems, those with multiple funding partners, short-term grants, and those that address the Board of Directors’ strategic goals.

Table 14: TSET Board of Directors133

<table>
<thead>
<tr>
<th>TSET Board of Directors Appointed By</th>
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</thead>
<tbody>
<tr>
<td>The Speaker of the House of Representatives</td>
</tr>
<tr>
<td>The Governor</td>
</tr>
<tr>
<td>The State Superintendent of Public Instruction</td>
</tr>
<tr>
<td>The President Pro Tempore of the Senate</td>
</tr>
<tr>
<td>The Attorney General</td>
</tr>
<tr>
<td>The State Auditor and Inspector</td>
</tr>
<tr>
<td>The State Treasurer</td>
</tr>
</tbody>
</table>

Source: TSET Organizational Structure and Leadership, Board Overview

The five-member TSET Board of Investors is responsible for investing Oklahoma’s annual payments from the tobacco companies. The board is chaired by the State Treasurer of Oklahoma, who oversees TSET’s investments along with designees of the Governor of Oklahoma, the President Pro Tempore of the Oklahoma Senate, the Speaker of the Oklahoma House of Representatives and the Oklahoma State Auditor and Inspector.134 No more than two appointees may be from any single congressional district. All appointees must have demonstrated expertise in public or private investment funds management. They are appointed for four-year terms. No funds are invested in tobacco stocks, per policy.135

132 Board of Directors (tset.ok.gov)
133 Board Overview-061219 (test.ok.gov)
134 Board of Investors (tset.ok.gov)
135 Board Overview-061219 (ok.gov)
Appendix E. TSET Programs

Research and Treatment Efforts
According to TSET, research and treatment efforts include promoting new scientific discoveries and giving Oklahomans access to cutting-edge cancer treatments by funding three major research programs: the Stephenson Cancer Center, the Health Promotion Research Center (HPRC), and the Oklahoma Center for Adult Stem Cell Research (OCASCR).

The mission of the Stephenson Cancer Center is to decrease the burden of cancer by promoting, coordinating and supporting innovative cancer research.

The mission of the Health Promotion Research Center (formerly the Oklahoma Tobacco Research Center) is to reduce the burden of disease in Oklahoma by addressing modifiable health risk factors such as tobacco use, sedentary lifestyle, poor diet, and risky alcohol and other substance use.

Established in 2010 with TSET funding, the Oklahoma Center for Adult Stem Cell Research promotes research in the emerging field of adult stem cell research by awarding research grants to scientists in Oklahoma, recruiting researchers to the state and conducting public education.136

Prevention and Cessation Efforts
Tobacco prevention and cessation efforts include maintaining the Oklahoma Tobacco Helpline (1-800-QUIT-NOW), providing direct support to Oklahomans trying to quit smoking, managing large educational campaigns to help reduce smoking across the state, providing grants to local communities to assist with tobacco-free lifestyles, education and policies, providing grants to health systems across the state to supplement and improve services to Oklahomans.137

The Oklahoma Tobacco Helpline offers free, customizable services and products to Oklahomans to assist those interested in quitting smoking. In 2020, over 28,000 users registered for some type of services with the Oklahoma Tobacco Helpline. The Helpline reaches approximately three percent of all tobacco users in the state.

Health System Initiatives
TSET’s health system initiatives provide three-year grants to enhance state efforts to reduce smoking and obesity throughout the state. These grants include the Oklahoma Physician Loan Repayment Program, which helps recruit primary care physicians to medically underserved areas of the state by offering medical school loan repayment assistance. This grant is currently funding twenty-six physicians in rural and underserved areas of the state.138 Another grant supports physician training in rural and medically underserved areas to increase access to preventative care and screenings and address the critical shortage of primary care doctors in Oklahoma.

A grant to the Oklahoma Hospital Association promotes best practice strategies to engage patients in quitting tobacco use and focuses on improving health among staff and patients by promoting physical activity, offering healthy food options, and creating tobacco-free

136 Research | Tobacco Settlement Endowment Trust (ok.gov)
137 TSET Programs | Tobacco Settlement Endowment Trust (ok.gov)
138 TSET Responses to LOFT questions, November 2020
environments. A partnership with the Oklahoma Health Care Authority focuses on improving the health of SoonerCare members by ensuring access to tobacco cessation services, targeting vulnerable populations such as pregnant women, and identifying health risks such as obesity and tobacco use. Finally, the Oklahoma Department of Mental Health and Substance Abuse Services received a health system grant to work with contract providers of behavioral health services to make facilities tobacco free and promote positive health behaviors.139

The TSET Healthy Living Program grants are five-year grants designed to prevent cancer and cardiovascular disease by preventing and reducing tobacco use and obesity on a local level. TSET issues grants to thirty-five organizations across thirty-seven Oklahoma counties. “Using a data-driven approach, grantees work with businesses, city governments, community organizations and schools to encourage healthy eating, physical activity and tobacco-free lifestyles.”140

TSET Healthy Incentive Grants “promote wellness by offering grants to schools, school districts and local communities that adopt health-promoting policies and strategies. These grants are designed to encourage healthy eating, physical activity and tobacco-free lifestyles.”141

Health Communication Interventions
TSET also funds health communication interventions. There are currently three large initiatives within this category of programs. The Tobacco Stops with Me (TSWM) campaign was designed to increase knowledge of the dangers of tobacco use and secondhand smoke with a target population that includes Oklahomans 18-54 years old and “influencers,” and smokers and young adults ages 18-30 years old. The objectives of the TSWM campaign include creating an environment where Oklahomans are more accepting of smoke-free and tobacco-free policies where they live, learn, work and play and increasing the proportion of Oklahomans that agree that secondhand smoke is very harmful to health.142

The Shape Your Future (SYF) campaign aims to enhance Oklahoman’s health by addressing poor nutrition, obesity, physical inactivity and tobacco use. The SYF’s target population includes Oklahomans 18-49 years of age, women, home food preparers, and those who influence the lives of children.144

The TSET Healthy Youth Initiative is a statewide program focused on preventing and reducing tobacco use and obesity for Oklahomans ages 13-18. The initiative “promotes healthy lifestyle choices for teens and gives parents resources to support their children in maintaining or developing healthy habits for a lifetime.”145

139 Health Systems Initiative | Tobacco Settlement Endowment Trust (ok.gov)
140 Healthy Lifestyle Grants | Tobacco Settlement Endowment Trust (ok.gov)
141 Incentive Grants | Tobacco Settlement Endowment Trust (ok.gov)
142 Tobacco Stops with Me Cross-Sectional Survey 2019, PowerPoint Presentation provided by TSET
143 See Appendix I for more detailed information about partnerships and roles of other state agencies.
144 Shape Your Future Web-based Survey June-September 2019, PowerPoint Presentation provided by TSET
145 TSET Healthy Youth Initiative | Tobacco Settlement Endowment Trust (ok.gov)
## Appendix F. Tobacco Excise Tax Apportionment

**Table 15: Tobacco Excise Tax Apportionment**[^footnote146]

<table>
<thead>
<tr>
<th>Oklahoma Tobacco Revenue Benefiting Funds</th>
<th>FY19</th>
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<th>FY17</th>
<th>FY16</th>
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<td>Oklahoma Building Bonds Sinking Fund</td>
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<td>Oklahoma Health Care Authority</td>
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<td>Teachers Retirement Revolving Fund</td>
<td>$950,486</td>
<td>0.35%</td>
<td>$1,355,166</td>
<td>0.78%</td>
</tr>
<tr>
<td>Tobacco Prevention and Cessation Revolving Fund</td>
<td>$627,321</td>
<td>0.26%</td>
<td>$894,410</td>
<td>0.51%</td>
</tr>
<tr>
<td>Belle Maxine Hillard Breast and Cervical Cancer Fund</td>
<td>$418,214</td>
<td>0.17%</td>
<td>$596,273</td>
<td>0.34%</td>
</tr>
<tr>
<td>Reserves Fund</td>
<td>$90,900</td>
<td>0.04%</td>
<td>$1,108</td>
<td>0.00%</td>
</tr>
<tr>
<td>Oklahoma Emergency Response System Stabilization &amp; Improvement Fund</td>
<td>$    -</td>
<td>0.00%</td>
<td>$467,210</td>
<td>0.27%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$241,074,103</strong></td>
<td><strong>100%</strong></td>
<td><strong>$174,479,777</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: Legislative Office of Fiscal Transparency based on Oklahoma Tax Commission Annual Reports

[^footnote146]: [https://www.ok.gov/tax/Forms_&_Publications/Publications/Annual_Reports/](https://www.ok.gov/tax/Forms_&_Publications/Publications/Annual_Reports/)
Appendix G. TSET Partnerships

In addition to serving as a grant making trust, TSET partners closely with several state agencies.

Oklahoma Health Care Authority

In 2011, the smoking rate for Medicaid recipients was approximately twice that of the state in general. OHCA has worked with TSET to remove barriers to smoking cessation. Efforts include removing copays and prior authorization requirements and limits on length of treatment covered by Medicaid and quit attempts per year/lifetime, and eliminating requirements such as, having to try one treatment before another or enroll in counseling before medication.

The Oklahoma Health Care Authority (OHCA) is charged with controlling costs of state-purchased health care for Oklahomans without private insurance. One of its primary goals is to foster collaboration among public and private entities to build a responsive healthcare system for Oklahoma. TSET provides a grant to OHCA to help improve the health of SoonerCare members by ensuring access to tobacco cessation services, targeting vulnerable populations such as pregnant women, and identifying health risks such as obesity and tobacco use.

In FY21, the Legislature appropriated to OHCA $11.7M, or 94.3 percent, of its $12.4M (18.75 percent) share in MSA apportionment.

Oklahoma State Department of Health

OSDH’s tobacco activities include monitoring clean indoor air regulations, pursuing policy implementation to reduce secondhand smoke exposure, promote cessation services that are currently available to every Oklahoman through the Oklahoma Tobacco Helpline (okhelpline.com), supporting the OSDH MPOWER Program, and supporting local community grantees working on tobacco control such as the TSET Healthy Living Program.

Oklahoma State Department of Health (OSDH) is the State’s agency responsible for aggregating health outcome data, including tobacco. The agency reports to CDC State’s summarized tobacco cessation budget that comprises of the own and TSET’s budget items. The agency conducts surveys about secondhand smoke, tobacco related newborn deaths, and smoking prevalence among youth. OSDH leads the State’s Tobacco Coalition.

Oklahoma Attorney General

The Office of the Attorney General of Oklahoma receives funding from Tobacco Settlements directly. Annually, approximately 6.25 percent of the tobacco settlement payments are distributed to the Attorney General’s Evidence Fund upon receipt by Oklahoma. Of this 6.25 percent received by the Attorney General’s office, 17.96 percent is spent on tobacco enforcement, which translates to 1.12 percent of the overall tobacco payments distributed to Oklahoma from the Master Settlement Agreement.

147 oklahoma-medicaid-tobacco-cessation.pdf.pdf (lung.org)
148 FY'21 APPROPRIATIONS (oksenate.gov)
149 See Appendix C
The Attorney General’s Tobacco Enforcement Unit was established to oversee agreements reached as a part of the MSA. This unit enforces the Oklahoma Prevention of Youth Access to Tobacco Act, which requires cigarette manufacturers selling to Oklahomans, either directly or indirectly through an intermediary, to become a Participating Manufacturer, or make annual payments into an escrow account as a Non-Participating manufacturer. The unit also publishes a directory of cigarette and roll-your-own tobacco products approved to be stamped, sold, offered for sale, possessed for sale, or imported for personal consumption within the State of Oklahoma. Any brand family not listed in this Directory, except those bearing a tax-free stamp pursuant to 68 O.S. §349.1.C, are considered contraband and subject to seizure and forfeiture.\textsuperscript{150} The goal of the involvement of the Attorney General’s office is primarily to ensure that the payments made to Oklahoma are accurate based on the settlement agreement.

**Treasurer’s Office**

The Office of the State Treasurer serves the people of Oklahoma by providing sound banking and investment services, reuniting individuals and businesses with their unclaimed property, and promoting economic opportunities in a fiscally responsible and efficient manner. The Office of the State Treasurer partners with TSET under an annual interagency agreement, paid for from TSET earnings and budgeted each year. The State Treasurer serves as the Chair of the TSET Board of Investors. The Treasurer’s office provides staff support services to the Board of Investors of TSET in accordance with the Oklahoma Statutes Title 62 Section 2306, Paragraph G. Up to two full-time equivalent personnel provide TSET with the following services:

- Records management,
- Development and review of requests for proposals,
- Maintenance of investment and fund management guidelines,
- Preparation of preliminary estimates and final calculations of investment earnings,
- Establish investment accounts with master custodian,
- Summarize and record monthly investment activity by manager and account,
- Annually prepare a budget of operating expenses,
- Prepare the annual financial statements of the Fund, and
- Other duties as required.

\textit{Table 16: Annual Costs of Services provided by The Office of the State Treasurer to TSET.}\textsuperscript{151}

<table>
<thead>
<tr>
<th>Year</th>
<th>FTE</th>
<th>Administrative Support</th>
<th>Legal</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY21</td>
<td>1.29</td>
<td>$154,490.00</td>
<td>$23,488.24</td>
</tr>
<tr>
<td>FY20</td>
<td>1.29</td>
<td>$153,464.00</td>
<td>$22,605.00</td>
</tr>
<tr>
<td>FY19</td>
<td>1.29</td>
<td>$152,964.00</td>
<td>$12,605.00</td>
</tr>
<tr>
<td>FY18</td>
<td>1.32</td>
<td>$150,521.00</td>
<td>$22,588.00</td>
</tr>
<tr>
<td>FY17</td>
<td>1.21</td>
<td>$139,044.00</td>
<td>$12,588.00</td>
</tr>
</tbody>
</table>

\textit{Source: Office of the Oklahoma State Treasurer}

\textsuperscript{150} Tobacco Enforcement Unit | Oklahoma Attorney General
\textsuperscript{151} Office of the State Treasurer responses to LOFT, December 2020
Appendix H. Ranking of States’ Spending

Table 17: FY21 Ranking of States’ spending on tobacco cessation (Table compares how much states budgeted in FY21 against what recommended by the CDC; both figures are divided by states’ population).

<table>
<thead>
<tr>
<th>Current Rank</th>
<th>State</th>
<th>FY2021 Current Annual Funding</th>
<th>CDC Annual Rec.</th>
<th>Per Capita FY21 Annual Spend</th>
<th>Per Capita FY21 Rec. Spend</th>
<th>FY2021 Percent of CDC's Rec.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Alaska</td>
<td>$9,100,000</td>
<td>$10,200,000</td>
<td>$12.34</td>
<td>$13.83</td>
<td>89.7%</td>
</tr>
<tr>
<td>2</td>
<td>Maine</td>
<td>$13,900,000</td>
<td>$15,900,000</td>
<td>$10.39</td>
<td>$11.88</td>
<td>87.4%</td>
</tr>
<tr>
<td>3</td>
<td>Utah</td>
<td>$15,300,000</td>
<td>$19,300,000</td>
<td>$4.84</td>
<td>$6.11</td>
<td>79.4%</td>
</tr>
<tr>
<td>4</td>
<td>California</td>
<td>$233,100,000</td>
<td>$347,900,000</td>
<td>$5.89</td>
<td>$8.79</td>
<td>67.0%</td>
</tr>
<tr>
<td>5</td>
<td>Hawaii</td>
<td>$7,900,000</td>
<td>$13,700,000</td>
<td>$5.56</td>
<td>$9.64</td>
<td>57.8%</td>
</tr>
<tr>
<td>6</td>
<td>North Dakota</td>
<td>$5,400,000</td>
<td>$9,800,000</td>
<td>$7.10</td>
<td>$12.89</td>
<td>55.5%</td>
</tr>
<tr>
<td>7</td>
<td>Delaware</td>
<td>$7,100,000</td>
<td>$13,000,000</td>
<td>$7.34</td>
<td>$13.44</td>
<td>54.5%</td>
</tr>
<tr>
<td>8</td>
<td>Oklahoma</td>
<td>$21,700,000</td>
<td>$42,300,000</td>
<td>$5.50</td>
<td>$10.73</td>
<td>51.2%</td>
</tr>
<tr>
<td>9</td>
<td>South Dakota</td>
<td>$4,500,000</td>
<td>$11,700,000</td>
<td>$5.10</td>
<td>$13.26</td>
<td>38.5%</td>
</tr>
<tr>
<td>10</td>
<td>Colorado</td>
<td>$20,000,000</td>
<td>$52,900,000</td>
<td>$3.51</td>
<td>$9.29</td>
<td>37.8%</td>
</tr>
<tr>
<td>10</td>
<td>Florida</td>
<td>$73,400,000</td>
<td>$194,200,000</td>
<td>$3.45</td>
<td>$9.12</td>
<td>37.8%</td>
</tr>
<tr>
<td>12</td>
<td>Montana</td>
<td>$4,900,000</td>
<td>$14,600,000</td>
<td>$4.61</td>
<td>$13.74</td>
<td>33.2%</td>
</tr>
<tr>
<td>13</td>
<td>Vermont</td>
<td>$2,700,000</td>
<td>$8,400,000</td>
<td>$4.31</td>
<td>$13.41</td>
<td>32.0%</td>
</tr>
<tr>
<td>14</td>
<td>Arkansas</td>
<td>$10,800,000</td>
<td>$36,700,000</td>
<td>$3.58</td>
<td>$12.18</td>
<td>29.5%</td>
</tr>
<tr>
<td>15</td>
<td>Arizona</td>
<td>$18,500,000</td>
<td>$64,400,000</td>
<td>$2.58</td>
<td>$8.98</td>
<td>28.7%</td>
</tr>
<tr>
<td>16</td>
<td>Wyoming</td>
<td>$2,400,000</td>
<td>$8,500,000</td>
<td>$4.15</td>
<td>$14.71</td>
<td>27.7%</td>
</tr>
<tr>
<td>17</td>
<td>New Mexico</td>
<td>$5,500,000</td>
<td>$22,800,000</td>
<td>$2.62</td>
<td>$10.88</td>
<td>24.2%</td>
</tr>
<tr>
<td>18</td>
<td>Oregon</td>
<td>$9,400,000</td>
<td>$39,300,000</td>
<td>$2.24</td>
<td>$9.38</td>
<td>23.9%</td>
</tr>
<tr>
<td>19</td>
<td>Mississippi</td>
<td>$8,700,000</td>
<td>$36,500,000</td>
<td>$2.91</td>
<td>$12.22</td>
<td>23.8%</td>
</tr>
<tr>
<td>20</td>
<td>Minnesota</td>
<td>$12,400,000</td>
<td>$52,900,000</td>
<td>$2.21</td>
<td>$9.43</td>
<td>23.5%</td>
</tr>
<tr>
<td>21</td>
<td>Idaho</td>
<td>$3,600,000</td>
<td>$15,600,000</td>
<td>$2.05</td>
<td>$8.89</td>
<td>23.3%</td>
</tr>
<tr>
<td>22</td>
<td>Maryland</td>
<td>$10,800,000</td>
<td>$48,000,000</td>
<td>$1.79</td>
<td>$7.94</td>
<td>22.6%</td>
</tr>
<tr>
<td>23</td>
<td>New York</td>
<td>$39,800,000</td>
<td>$203,000,000</td>
<td>$2.04</td>
<td>$10.39</td>
<td>19.6%</td>
</tr>
<tr>
<td>24</td>
<td>District of Columbia</td>
<td>$1,900,000</td>
<td>$10,700,000</td>
<td>$2.70</td>
<td>$15.23</td>
<td>17.8%</td>
</tr>
<tr>
<td>25</td>
<td>Iowa</td>
<td>$4,000,000</td>
<td>$30,100,000</td>
<td>$1.27</td>
<td>$9.54</td>
<td>13.4%</td>
</tr>
<tr>
<td>26</td>
<td>Nebraska</td>
<td>$2,600,000</td>
<td>$20,800,000</td>
<td>$1.35</td>
<td>$10.78</td>
<td>12.4%</td>
</tr>
<tr>
<td>27</td>
<td>Nevada</td>
<td>$3,500,000</td>
<td>$30,000,000</td>
<td>$1.15</td>
<td>$9.89</td>
<td>11.5%</td>
</tr>
<tr>
<td>28</td>
<td>Illinois</td>
<td>$15,100,000</td>
<td>$136,700,000</td>
<td>$1.19</td>
<td>$10.73</td>
<td>11.0%</td>
</tr>
<tr>
<td>29</td>
<td>Pennsylvania</td>
<td>$14,700,000</td>
<td>$140,000,000</td>
<td>$1.15</td>
<td>$10.93</td>
<td>10.5%</td>
</tr>
<tr>
<td>30</td>
<td>Indiana</td>
<td>$7,500,000</td>
<td>$73,500,000</td>
<td>$1.12</td>
<td>$10.98</td>
<td>10.2%</td>
</tr>
<tr>
<td>31</td>
<td>South Carolina</td>
<td>$5,000,000</td>
<td>$51,000,000</td>
<td>$0.98</td>
<td>$10.03</td>
<td>9.8%</td>
</tr>
<tr>
<td>32</td>
<td>Ohio</td>
<td>$12,300,000</td>
<td>$132,000,000</td>
<td>$1.05</td>
<td>$11.29</td>
<td>9.3%</td>
</tr>
</tbody>
</table>

152 FY2021 State Rankings (tobaccofreekids.org)
153 NST01 (census.gov)
<table>
<thead>
<tr>
<th></th>
<th>State</th>
<th>FY2021 Budget</th>
<th>FY21 Budget</th>
<th>FY21 Expo</th>
<th>FY21 CCA</th>
<th>FY21 CCR</th>
</tr>
</thead>
<tbody>
<tr>
<td>33</td>
<td>Wisconsin</td>
<td>$5,300,000</td>
<td>$57,500,000</td>
<td>$0.91</td>
<td>$9.89</td>
<td>9.2%</td>
</tr>
<tr>
<td>34</td>
<td>Virginia</td>
<td>$8,300,000</td>
<td>$91,600,000</td>
<td>$0.97</td>
<td>$10.75</td>
<td>9.1%</td>
</tr>
<tr>
<td>35</td>
<td>Louisiana</td>
<td>$5,200,000</td>
<td>$59,600,000</td>
<td>$1.12</td>
<td>$12.79</td>
<td>8.8%</td>
</tr>
<tr>
<td>36</td>
<td>Massachusetts</td>
<td>$5,100,000</td>
<td>$66,900,000</td>
<td>$0.74</td>
<td>$9.69</td>
<td>7.7%</td>
</tr>
<tr>
<td>37</td>
<td>New Jersey</td>
<td>$7,800,000</td>
<td>$103,300,000</td>
<td>$0.88</td>
<td>$11.60</td>
<td>7.6%</td>
</tr>
<tr>
<td>38</td>
<td>Kansas</td>
<td>$1,000,000</td>
<td>$27,900,000</td>
<td>$0.34</td>
<td>$9.58</td>
<td>3.6%</td>
</tr>
<tr>
<td>39</td>
<td>Kentucky</td>
<td>$2,000,000</td>
<td>$56,400,000</td>
<td>$0.45</td>
<td>$12.62</td>
<td>3.5%</td>
</tr>
<tr>
<td>40</td>
<td>Washington</td>
<td>$2,100,000</td>
<td>$63,600,000</td>
<td>$0.28</td>
<td>$8.44</td>
<td>3.4%</td>
</tr>
<tr>
<td>41</td>
<td>Rhode Island</td>
<td>$395,337</td>
<td>$12,800,000</td>
<td>$0.37</td>
<td>$12.11</td>
<td>3.1%</td>
</tr>
<tr>
<td>42</td>
<td>Alabama</td>
<td>$1,500,000</td>
<td>$55,900,000</td>
<td>$0.31</td>
<td>$11.44</td>
<td>2.7%</td>
</tr>
<tr>
<td>43</td>
<td>New Hampshire</td>
<td>$360,000</td>
<td>$16,500,000</td>
<td>$0.27</td>
<td>$12.16</td>
<td>2.2%</td>
</tr>
<tr>
<td>44</td>
<td>North Carolina</td>
<td>$1,900,000</td>
<td>$99,300,000</td>
<td>$0.18</td>
<td>$9.56</td>
<td>1.9%</td>
</tr>
<tr>
<td>45</td>
<td>Michigan</td>
<td>$1,800,000</td>
<td>$110,600,000</td>
<td>$0.18</td>
<td>$11.06</td>
<td>1.7%</td>
</tr>
<tr>
<td>46</td>
<td>Texas</td>
<td>$4,200,000</td>
<td>$264,100,000</td>
<td>$0.15</td>
<td>$9.20</td>
<td>1.6%</td>
</tr>
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<td>47</td>
<td>West Virginia</td>
<td>$445,000</td>
<td>$27,400,000</td>
<td>$0.25</td>
<td>$15.17</td>
<td>1.6%</td>
</tr>
<tr>
<td>48</td>
<td>Georgia</td>
<td>$750,000</td>
<td>$106,000,000</td>
<td>$0.07</td>
<td>$10.08</td>
<td>0.7%</td>
</tr>
<tr>
<td>49</td>
<td>Missouri</td>
<td>$171,885</td>
<td>$72,900,000</td>
<td>$0.03</td>
<td>$11.90</td>
<td>0.2%</td>
</tr>
<tr>
<td>50</td>
<td>Connecticut</td>
<td>$0</td>
<td>$75,600,000</td>
<td>$ -</td>
<td>$8.96</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Source: Legislative Office of Fiscal Transparency based on FY21 Campaign for Tobacco-Free Kids and 2018 US Census data

Chart 18: Oklahoma Spending for Tobacco Prevention between FY08-21 (Bar and line chart of TSET’s and OSDH’s yearly budgets for immediate tobacco cessation efforts; for FY21 CDC recommends Oklahoma invest a minimum of $42.3 million for tobacco prevention)
Appendix I. Logic Models from TSET, the CDC and Other States

Exhibit 02: TSET Logic Model for Teen Obesity

Teen Obesity Prevention Logic Model

Exhibit 03: TSET Logic Model for Teen Vape Prevention

Teen Vape Prevention Logic Model

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154 TSET Responses to LOFT Questions. Rescue Logic Models.pdf, 04/22/2021
155 Ibid.
**Exhibit 04: CDC Logic Model**

The logic model for this FOA briefly describes the interventions, strategies, activities and outcomes of State Public Health Approaches for Ensuring Quitline Capacity. (Italicized are those outcomes that are expected during the project period.)

<table>
<thead>
<tr>
<th>National Tobacco Quitline Logic Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inputs:</strong> Tobacco Quitline promotion and outreach, funding, infrastructure, capacity, and partnerships</td>
</tr>
<tr>
<td><strong>Evidence-Based Interventions, Strategies and Activities</strong></td>
</tr>
<tr>
<td>Ensure infrastructure for state-quitline—sufficient to support increased demand</td>
</tr>
<tr>
<td>Improve quitline capacity</td>
</tr>
<tr>
<td>Participate in surveillance and evaluation efforts and use findings</td>
</tr>
<tr>
<td>Identify and target disparate populations</td>
</tr>
<tr>
<td>Increase media efforts</td>
</tr>
<tr>
<td>Enhance quitline protocol and operations</td>
</tr>
<tr>
<td>Improve sustainability</td>
</tr>
<tr>
<td>Improve understanding of comprehensive cessation coverage for Medicaid recipients</td>
</tr>
<tr>
<td>Promote health systems changes</td>
</tr>
</tbody>
</table>

**Environmental Context**
State Medicaid cessation coverage, private coverage for cessation, state excise tax rates, rates of smoking, smoke-free policies, media campaigns, integration of quitlines with health systems, state tobacco control funding (as a proxy for state tobacco control expenditures)

**Exhibit 05: Wisconsin Logic Model**

Overarching model: Reducing and Preventing Youth Tobacco Use

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Reach</th>
<th>Outcomes - Impact</th>
<th>Long</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coalition Members</td>
<td>Promote community involvement in mediating tobacco access to youth</td>
<td>Public community partners, Caregivers, Law enforcement Retailer Health Depart.</td>
<td>Increased awareness of need to eliminate youth access to tobacco products, including tobacco industry tactics, laws, noncompliance</td>
<td>Decreased access to tobacco for minors</td>
</tr>
<tr>
<td>Partners</td>
<td>Facilitate youth involvement in policy change</td>
<td>Community org, Policy makers, Adults, Youth serving org Youth</td>
<td>Increased commitment to eliminate access barriers</td>
<td></td>
</tr>
<tr>
<td>Funding</td>
<td></td>
<td></td>
<td>Increased knowledge and skills in participating in policy change</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Increased # of youth activity engaged in policy change</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Increased adoption of policy change that motivate youth in the change process</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Decreased average age at first use, reduced initiation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Increased effectiveness at reducing tobacco use</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

156 The Logic model for National Tobacco Quitline (cdc.gov)
157 Youth Documenting Outcomes in Tobacco (wisc.edu)
**Exhibit 06: California Logic Model**

### California State T21 Logic Model

<table>
<thead>
<tr>
<th>INPUTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide Tobacco 21 Implementation Plan, Surveillance of Tobacco-Related Attitudes and Behaviors, Surveillance of Tobacco Sales to Minors, Statewide Tobacco Cessation Quiltline</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>OUTPUTS</th>
<th>SHORT-TERM OUTCOMES</th>
<th>INTERMEDIATE OUTCOMES</th>
<th>LONG-TERM OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distribute new age-of-sale warning signs to all CA tobacco retailers</td>
<td>Warning signs posted at 100% of tobacco retailers</td>
<td>Increased awareness and support for new age-of-sale law among the general public and 18-20-year-olds</td>
<td>Decreased illegal sales of tobacco to youth under 18 and young adults ages 18-20</td>
<td>Increased age of tobacco use initiation</td>
</tr>
<tr>
<td>Develop and disseminate materials to educate retailers about increased age of sale and effective employee training</td>
<td>Educational materials and training tools distributed to retailers</td>
<td>Increased awareness of new age of sale among retailers</td>
<td>Decreased ability for minors under age 21 to obtain tobacco products</td>
<td>Decreased tobacco use prevalence among young adults ages 18-20</td>
</tr>
<tr>
<td>Administer and promote a statewide tobacco use quitline to general public and 18-20-year-old tobacco users</td>
<td>Operational quitline promoted to diverse populations and 18-20-year-old tobacco users</td>
<td>Increased competence of retailers to comply with the new age of sale law</td>
<td>Decreased sales of tobacco products</td>
<td>Decreased youth and adult tobacco use prevalence</td>
</tr>
<tr>
<td>Display ads at point of sale to educate public about increased age of sale and quitline</td>
<td>Advertisements notifying public about new law and quitline displayed at tobacco retailers</td>
<td>Increased compliance with new age-of-sale law</td>
<td>Decreased susceptibility to experimentation with tobacco products</td>
<td>Decreased tobacco consumption</td>
</tr>
<tr>
<td>Conduct enforcement-related compliance checks of tobacco sales to minors under 21</td>
<td>Demand letters issued to violating retailers through compliance checks of tobacco sales to minors under 21</td>
<td>Increased awareness of dangers of young adult smoking</td>
<td>Increased quit attempts among tobacco users age 18-20</td>
<td>Decreased exposure to secondhand smoke/ toxic aerosol</td>
</tr>
<tr>
<td>Educate American Indian communities about tobacco age of sale disparity</td>
<td>Educational materials for American Indian communities</td>
<td>Increased call volume to quitline from diverse callers and 18-20-year-old tobacco users</td>
<td>Increased quit attempts among all tobacco users</td>
<td>Decreased tobacco-related morbidity and mortality</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increased awareness among American Indian leaders about disparity in age of sale and health consequences</td>
<td>Increased number of tribal compacts or tribal policies with age of sale as 21</td>
<td>Minimized tobacco-related disparities among American Indian population</td>
</tr>
</tbody>
</table>

**Environmental Context**
State excise tax rates, rates of tobacco use, national media campaigns, state tobacco control funding, utilization of statewide quitline, tobacco cessation insurance coverage, tobacco and e-cigarette industry spending

**Note:** "Tobacco products" include electronic smoking devices; "smoking" includes smoking tobacco and vaping electronic smoking devices; "smoke-free" and "secondhand smoke" include tobacco smoke and toxic aerosol emitted from electronic smoking devices; and "thirdhand smoke" includes residue from tobacco.

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158 Planning for Policy Evaluation | Smoking & Tobacco Use | CDC
Appendix J. Applicable State Policies

Constitution: Article X, Section 40 - Tobacco Settlement Endowment Trust Fund.¹⁵⁹

A. There is hereby created a trust fund to be known as the “Tobacco Settlement Endowment Trust Fund”. The trust fund principal shall consist of the portion of monies which are received by the State of Oklahoma on or after July 1, 2001, pursuant to any settlement with or judgment against any tobacco company or companies as provided by subsection B of this section, and any other monies that may be appropriated or otherwise directed to the trust fund by the Legislature.

B. 1. Deposits into the trust fund from monies which are received by the State of Oklahoma pursuant to any settlement with or judgment against any tobacco company or companies shall be based on the following schedule:

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Minimum Percentage of Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ending June 30, 2002</td>
<td>50%</td>
</tr>
<tr>
<td>Ending June 30, 2003</td>
<td>55%</td>
</tr>
<tr>
<td>Ending June 30, 2004</td>
<td>60%</td>
</tr>
<tr>
<td>Ending June 30, 2005</td>
<td>65%</td>
</tr>
<tr>
<td>Ending June 30, 2006</td>
<td>70%</td>
</tr>
<tr>
<td>Ending June 30, 2007</td>
<td>75%</td>
</tr>
</tbody>
</table>

2. Deposits into the trust fund in subsequent fiscal years shall never be less than seventy-five percent (75%) of the payments.

3. The monies received by the State of Oklahoma pursuant to any settlement with or judgment against any tobacco company or companies after June 30, 2001, not deposited into the trust fund as provided in this section, shall be deposited into a special fund established by the Legislature solely for the purpose of receiving the payments; provided, the Legislature may, by law, direct a certain portion of such monies to the Office of the Attorney General. The special fund shall be subject to legislative appropriations.

C. There is hereby created the Board of Investors of the Tobacco Settlement Endowment Trust Fund. The Board of Investors shall have the duty of investing monies in the trust fund, subject to restrictions and limitations provided by law for and in accordance with laws applicable to the investment of monies in state retirement funds.

The Board of Investors shall consist of five (5) members as follows:

1. The State Treasurer who shall be the chair;
2. An appointee of the Governor;
3. An appointee of the Speaker of the House of Representatives;
4. An appointee of the President Pro Tempore of the Senate; and
5. An appointee of the State Auditor and Inspector.

¹⁵⁹ Tobacco Settlement Endowment Trust Fund (oscn.net)
The initial appointees shall serve staggered terms of office as provided for by law. Thereafter, appointees shall serve four-year terms of office. No more than two appointees shall be appointed from any single congressional district. All appointed members shall have demonstrated expertise in public or private investment funds management.

D. There is hereby created the Board of Directors of the Tobacco Settlement Endowment Trust Fund. The Board of Directors shall consist of seven (7) members, one appointed by each of the following appointing authorities:

1. The Governor;
2. The President Pro Tempore of the Senate;
3. The Speaker of the House of Representatives;
4. The Attorney General;
5. The State Treasurer;
6. The State Auditor and Inspector; and
7. The State Superintendent of Public instruction.

The initial appointed members shall serve staggered terms of office as provided for by law. Thereafter, the appointed members of the Board of Directors shall serve seven-year terms of office. At least one appointee shall be appointed from each congressional district, and not more than two appointees shall be appointed from any single congressional district. Not more than four appointees shall be members of the same political party. An appointee shall have been a member of the political party to which the appointee belongs for at least one (1) year prior to the date of appointment. Appointees shall have demonstrated expertise in public or private health care or programs related to or for the benefit of children or senior adults.

The Board of Directors shall meet at least one time each calendar quarter.

E. Earnings from the trust fund, including but not limited to interest, dividends, and realized capital gains from investments of the trust fund shall be expended as provided in subsection F of this section for the following purposes:

1. Clinical and basic research and treatment efforts in Oklahoma for the purpose of enhancing efforts to prevent and combat cancer and other tobacco-related diseases;
2. Cost-effective tobacco prevention and cessation programs;
3. Programs other than those specified in paragraph 1 of this subsection designed to maintain or improve the health of Oklahomans or to enhance the provision of health care services to Oklahomans, with particular emphasis on such programs for children;
4. Programs and services for the benefit of the children of Oklahoma, with particular emphasis on common and higher education, before- and after-school and pre-school programs, substance abuse prevention and treatment programs and other programs and services designed to improve the health and quality of life of children;
5. Programs designed to enhance the health and well-being of senior adults; and
6. Authorized administrative expenses of the Office of the State Treasurer and the Board of Directors.

F. Each fiscal year, the Board of Directors may expend the amount of earnings which actually accrued to the trust fund during the preceding fiscal year. Any amount not so expended shall remain in
the trust fund. The Board shall direct specific expenditures to be made for the purposes specified in subsection E of this section.

G. The Legislature may enact laws to further implement the provisions of this section.

Added by State Question No. 692, Legislative Referendum No. 320, adopted at general election held on Nov. 7, 2000.

Statute: Relevant Sections of the Tobacco Settlement Endowment Trust Fund Act

§62-2302. Purpose. The purpose of the Tobacco Settlement Endowment Trust Fund Act is to further implement the provisions of Section 40 of Article X of the Oklahoma Constitution that:
1. Created the Tobacco Settlement Endowment Trust Fund, the Board of Investors of the Tobacco Settlement Endowment Trust Fund, and the Board of Directors of the Tobacco Settlement Endowment Trust Fund;
2. Directs the apportionment of revenues from settlements with or judgments against tobacco companies between the Tobacco Settlement Endowment Trust Fund and a special fund established for the purpose of receiving tobacco settlement payments not deposited to the trust fund; and

§62-2309. Duties of board

Executive director.

A. The Board of Directors of the Tobacco Settlement Endowment Trust Fund shall be empowered to:
1. Appoint an executive director and other staff necessary to perform the duties of the Board of Directors;
2. Make and execute contracts and other instruments necessary or convenient to the exercise of its powers on such terms and for such period of time as the Board of Directors shall determine; and
3. Promulgate rules in accordance with the Administrative Procedures Act and not inconsistent with the Tobacco Settlement Endowment Trust Fund Act to implement its duties and responsibilities as provided by law.

B. Funding for capital expenditures and operating expenses incurred by the University of Oklahoma Health Sciences Center and the Oklahoma State University College of Osteopathic Medicine, for educational programs and residency training to maintain or improve the health of Oklahomans or to enhance the provision of health care services to Oklahomans, is hereby deemed to be an allowable purpose for which earnings from the trust fund may be expended pursuant to the provisions of paragraph 3 of subsection E of Section 40 of Article X of the Oklahoma Constitution. Pursuant to its authority as set forth in subsection G of Section 40 of Article X of the Oklahoma Constitution, the Legislature hereby authorizes the Board to expend earnings from the trust fund for such purposes, in addition to other purposes provided by law.

C. The Board shall develop a multiyear strategy by January 1, 2002, and annually update it in order to guide the Board's funding for those programs set forth in Section 40 of Article X of the Oklahoma Constitution. The strategy shall be used to maximize the outcomes of the grants awarded by the Board of Directors.

D. The Board of Directors shall develop grant programs for private, nonprofit, and public entities for the purposes set forth in Section 40 of Article X of the Oklahoma Constitution. Oklahoma Statutes - Title 62.

1. The selection and awarding of grants, whether in the form of professional service contracts or any other funding mechanism developed by the Board of Directors, awarded pursuant to grant

160 62 O.S. § 34.2 (oscn.net)
programs developed under this subsection, shall be exempt from the requirements of The
Oklahoma Central Purchasing Act.
2. The Board of Directors shall develop competitive processes for awarding grants under
programs developed under this subsection. Such competitive processes for selection shall not
be required for contracts awarded for program support services, including, but not limited to,
professional service contracts to evaluate, audit or provide budgeting, accounting, auditing or
legal services for specific programs or program grantees, contractors or participants.
3. The Board of Directors may promulgate rules to assist in the implementation and
administration of grant programs developed under this subsection.
4. The terms of any request for proposals, request for applications, invitation for bid, bid notice,
or grant proposal or any other solicitation issued by the Board of Directors to solicit or invite
applications, proposals, bids or responses to obtain funding under grant programs developed
under this subsection shall be confidential until the date and time at which the solicitation is to
be made equally and uniformly known to all prospective applicants and the public, at which
point all such documents and information shall be uniformly known to all prospective
applicants and the public, at which point all such documents and information shall be subject to
the Oklahoma Open Records Act and Oklahoma Open Meeting Act. Any application, proposal,
bid, or any other document to obtain funding responsive to any solicitation of the Board of
Directors under grant programs developed under this subsection shall be confidential until the
date and time of award of the grant or contract, at which point all such documents and
information shall be subject to the Oklahoma Open Records Act and Oklahoma Open Meeting
Act. Any unsolicited application, proposal, bid, or any other document to obtain funding shall
not be considered to be confidential and shall be subject to the Oklahoma Open Records Act
and Oklahoma Open Meeting Act at all times.

E. The Board of Directors shall encourage grantees to match grant monies awarded with monetary
commitments and in-kind matches.
F. The Board of Directors shall be required to develop a performance evaluation component for the
Board of Directors’ activities and those of its grantees so that the performance of grantees can be
measured by their attainment of outcomes.
G. The Board of Directors shall contract periodically for performance evaluations. Copies of the
evaluations shall be filed with the Governor, the Speaker of the House of Representatives, and the
President Pro Tempore of the Senate.

Oklahoma Statutes - Title 62. Public Finance Page 620
H. The Board of Directors shall prepare an annual report detailing the Board of Directors’ activities and
reporting its expenditures and the outcomes achieved by the expenditures. A copy of the report shall be
submitted to the Governor, the Speaker of the House of Representatives, and the President Pro
Tempore of the Senate.
I. All records associated with the expenditure of monies received by the Board of Directors or its
grantees pursuant to the Tobacco Settlement Endowment Trust Fund Act shall be subject to the
Oklahoma Open Records Act.

1, 2006; Laws 2009, c. 194, § 1, eff. Nov. 1, 2009; Laws 2015, c. 98, § 1, eff. Nov. 1, 2015.
# Appendix K. TSET Budget vs. Categories

**Table 18: TSET Budget Funding vs. CDC’s Best Practices and TSET’s Program Categories.** Table indicates that TSET’s budget items do not cover either CDC’s best practices nor agency’s own program categories.\(^{161}\)

<table>
<thead>
<tr>
<th>TSET FY21 Class Funding</th>
<th>FY21 Bud</th>
<th>CDC Best Practices</th>
<th>TSET Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>100001 Administration</td>
<td>$1,318,123</td>
<td>Not Categorized - TSET Admin</td>
<td>Not Categorized - TSET Admin</td>
</tr>
<tr>
<td>200001 Administration</td>
<td>$157,990</td>
<td>Not Categorized - TSET BOI</td>
<td>Not Categorized - TSET BOI</td>
</tr>
<tr>
<td>200002 Investments</td>
<td>$4,053,129</td>
<td>Not Categorized - TSET BOI</td>
<td>Not Categorized - TSET BOI</td>
</tr>
<tr>
<td>3000099 Program Support</td>
<td>$1,545,441</td>
<td>Infrastructure, administration and management</td>
<td>Healthy Lifestyle Grants</td>
</tr>
<tr>
<td>301000 TC Health Communications</td>
<td>$10,028,750</td>
<td>State and Community Interventions</td>
<td>Health Communication Interventions</td>
</tr>
<tr>
<td>3010501 Tobacco Control Helpline</td>
<td>$4,187,451</td>
<td>Cessation Interventions</td>
<td>No TSET Program Match</td>
</tr>
<tr>
<td>302000 N&amp;H Health Communications</td>
<td>$3,300,000</td>
<td>Cessation Interventions</td>
<td>Health Communication Interventions</td>
</tr>
<tr>
<td>303000 Wellness Technical Assistance</td>
<td>$1,585,000</td>
<td>Infrastructure, administration and management</td>
<td>No TSET Program Match</td>
</tr>
<tr>
<td>303020 Wellness Health Communication</td>
<td>$1,562,692</td>
<td>Health communication interventions</td>
<td>Health Communication Interventions</td>
</tr>
<tr>
<td>303030 Wellness Community Grants</td>
<td>$2,700,000</td>
<td>State and Community Interventions</td>
<td>Health Communication Interventions</td>
</tr>
<tr>
<td>303031 Health Comm-Program Outreach</td>
<td>$445,000</td>
<td>State and Community Interventions</td>
<td>Health Communication Interventions</td>
</tr>
<tr>
<td>3030401 Community Grants</td>
<td>$9,911,027</td>
<td>State and Community Interventions</td>
<td>Healthy Lifestyle Grants</td>
</tr>
<tr>
<td>3031501 Wellness Stwide Grants Contract</td>
<td>$1,864,376</td>
<td>Cessation Interventions</td>
<td>Health Systems Initiative</td>
</tr>
<tr>
<td>303700 Wellness Consultation</td>
<td>$55,000</td>
<td>Infrastructure, administration and management</td>
<td>Healthy Lifestyle Grants</td>
</tr>
<tr>
<td>3050901 Tobacco Related Research</td>
<td>$9,021,000</td>
<td>No CDC Match</td>
<td>Research</td>
</tr>
<tr>
<td>3050903 Adult Stem Cell Research</td>
<td>$2,910,000</td>
<td>No CDC Match</td>
<td>Research</td>
</tr>
<tr>
<td>306000 Conference Sponsorships</td>
<td>$24,000</td>
<td>No CDC Match</td>
<td>Healthy Lifestyle Grants</td>
</tr>
<tr>
<td>8800010 ISD DP - Board of Dir</td>
<td>$222,500</td>
<td>No CDC Match</td>
<td>No TSET Program Match</td>
</tr>
<tr>
<td>8880010 ISD DP - Programs</td>
<td>$10,000</td>
<td>No CDC Match</td>
<td>No TSET Program Match</td>
</tr>
</tbody>
</table>

**Budget without BOI** $50,728,360  
**Budget Grand Total** $54,938,379

Source: Legislative Office of Fiscal Transparency based on CDC TSET and data from PeopleSoft

**Table 19: TSET Budget Funding vs. CDC’s Tobacco Direct spending.** Table reflects TSET’s breakdown of the tobacco cessation budget class funding/departments and their percentile allocation.\(^{162}\)

<table>
<thead>
<tr>
<th>TSET - Tobacco Cessation Designated FY21 Budget Departments (Class Funding)</th>
<th>Budget Dept #</th>
<th>Budget Dept $</th>
<th>Tobacco Cessation Designation</th>
<th>Contribution $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helpline</td>
<td>3010301</td>
<td>$3,900,000.00</td>
<td>100%</td>
<td>$3,900,000.00</td>
</tr>
<tr>
<td>Helpline oversight</td>
<td>3010301</td>
<td>$287,451.00</td>
<td>100%</td>
<td>$287,451.00</td>
</tr>
<tr>
<td>Health Comm - TC plus OHCA match</td>
<td>3010300</td>
<td>$7,315,000.00</td>
<td>100%</td>
<td>$7,315,000.00</td>
</tr>
<tr>
<td>RSGC - Free the Night</td>
<td>3010300</td>
<td>$213,750.00</td>
<td>100%</td>
<td>$213,750.00</td>
</tr>
<tr>
<td>TA, Training and Consultation</td>
<td>3030200</td>
<td>$1,562,692.00</td>
<td>50%</td>
<td>$781,346.00</td>
</tr>
<tr>
<td>Health Systems Initiatives</td>
<td>3030500</td>
<td>$1,864,575.00</td>
<td>50%</td>
<td>$932,187.50</td>
</tr>
<tr>
<td>Health Comm - PAN</td>
<td>3020300</td>
<td>$5,800,000.00</td>
<td>50%</td>
<td>$1,160,000.00</td>
</tr>
<tr>
<td>Health Comm - Program Outreach &amp; Promotion</td>
<td>3030301</td>
<td>$570,000.00</td>
<td>50%</td>
<td>$185,000.00</td>
</tr>
<tr>
<td>Health Comm - Wellness/Fulfillment center</td>
<td>3030300</td>
<td>$250,000.00</td>
<td>50%</td>
<td>$125,000.00</td>
</tr>
<tr>
<td>Community based grants</td>
<td>3030410</td>
<td>$9,529,026.00</td>
<td>50%</td>
<td>$4,764,513.00</td>
</tr>
<tr>
<td>Evaluation</td>
<td>3030100</td>
<td>$1,585,000.00</td>
<td>50%</td>
<td>$792,500.00</td>
</tr>
<tr>
<td><strong>Subtotal Total</strong></td>
<td></td>
<td><strong>$32,677,294.00</strong></td>
<td></td>
<td><strong>$20,456,747.50</strong></td>
</tr>
</tbody>
</table>

Source: Legislative Office of Fiscal Transparency based on data from OSDH

\(^{161}\) TSET Programs | Tobacco Settlement Endowment Trust (ok.gov)  
\(^{162}\) Best Practices for Comprehensive Tobacco Control Programs—2014 | CDC  
PeopleSoft  
OSDH Responses to LOFT Questions. Lung form and Campaign for Tobacco Free Kids (1).xlsx, 04/12/2021
Appendix L. State Excise Tax Rates Per 20-Pack of Cigarettes

Figure 13: State Excise Tax Rates Per 20-Pack of Cigarettes as of 2021

Source: Legislative Office of Fiscal Transparency using Tobacco Free Kids data

STATE CIGARETTE EXCISE TAX RATES (tobaccofreekids.org)
Appendix M. Statistical Summary Outputs

Table: 20: MR - TR, CA, CDC. This is a multiple regression analysis comparing Tax Rate, Smoke Free Work, and Percent of CDC Recommendation across all 50 states and Washington, D.C.

| Multiple Regression Analysis (Tax Rate, Smoke Free Work, Percent of CDC Recommendation) |
|----------------------------------|------------------|--------------------|--------------------|
| Multiple R                       | 0.584337403      |                    |                    |
| R Square                         | 0.341450201      |                    |                    |
| Adjusted R Square                | 0.299413107      |                    |                    |
| Standard Error                   | 0.027606978      |                    |                    |
| Observations                     | 51               |                    |                    |

ANOVA
<table>
<thead>
<tr>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>Significance F</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.0018666975</td>
<td>0.000222325</td>
<td>8.1229754490</td>
<td>0.0001838874</td>
</tr>
<tr>
<td>Regression</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residual</td>
<td>47</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>0.054669686</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Coefficients
<table>
<thead>
<tr>
<th>Coefficients</th>
<th>Standard Error</th>
<th>t Stat</th>
<th>P-value</th>
<th>Lower 95%</th>
<th>Upper 95%</th>
<th>Lower 95.0%</th>
<th>Upper 95.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>0.173737027</td>
<td>0.0060267944</td>
<td>2.882743551</td>
<td>0.005927529</td>
<td>0.052493562</td>
<td>0.294980492</td>
<td>0.294980492</td>
</tr>
<tr>
<td>2021 Cigarette Tax Per Pack</td>
<td>-0.016051148</td>
<td>0.08353945</td>
<td>-4.70444457</td>
<td>2.26778E-05</td>
<td>-0.023771604</td>
<td>-0.009530692</td>
<td>-0.009530692</td>
</tr>
<tr>
<td>2015 Percent of Smoke Free Work Environments</td>
<td>0.032648833</td>
<td>0.077870591</td>
<td>0.419270384</td>
<td>0.676928696</td>
<td>-0.12400659</td>
<td>0.189304255</td>
<td>0.189304255</td>
</tr>
<tr>
<td>2021 Percent of Suggested CDC Spending</td>
<td>0.009697745</td>
<td>0.017579539</td>
<td>-0.551495455</td>
<td>0.583801969</td>
<td>0.845663216</td>
<td>0.025667726</td>
<td>0.025667726</td>
</tr>
</tbody>
</table>

Source: Legislative Office of Fiscal Transparency

Table: 21: MR - Tax Rate. This is a regression analysis comparing Adult Smoking Prevalence with Cigarette Tax Rates across all 50 states and Washington, D.C.

Tax Rate Regression Analysis

| Multiple R | 0.579127799 |
| R Square   | 0.335389008 |
| Adjusted R Square | 0.321825518 |
| Standard Error | 0.027220713 |
| Observations | 51 |

ANOVA
<table>
<thead>
<tr>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>Significance F</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.018335612</td>
<td>0.018335612</td>
<td>24.72733914</td>
<td>8.49617E-06</td>
</tr>
<tr>
<td>Regression</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residual</td>
<td>49</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>0.054669686</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Coefficients
<table>
<thead>
<tr>
<th>Coefficients</th>
<th>Standard Error</th>
<th>t Stat</th>
<th>P-value</th>
<th>Lower 95%</th>
<th>Upper 95%</th>
<th>Lower 95.0%</th>
<th>Upper 95.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>0.197065852</td>
<td>0.007332525</td>
<td>26.87557887</td>
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<td>0.182330591</td>
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<tr>
<td>2021 Cigarette Tax Per Pack</td>
<td>-0.016283507</td>
<td>0.003274608</td>
<td>-4.972659161</td>
<td>8.49617E-06</td>
<td>-0.022864078</td>
<td>-0.009702937</td>
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</tr>
</tbody>
</table>

Source: Legislative Office of Fiscal Transparency
Table: 22: MR - TR & SI. This is a multiple regression analysis comparing Adult Smoking Prevalence with Cigarette Tax Rates and Stress Index (data from Wallet Hub) for all 50 states and Washington, D.C.

Multiple Regression Analysis (Tax and Stress Index)

<table>
<thead>
<tr>
<th>Coefficients</th>
<th>Standard Error</th>
<th>t Stat</th>
<th>P-value</th>
<th>Lower 95%</th>
<th>Upper 95%</th>
<th>Lower 95.0</th>
<th>Upper 95.0</th>
</tr>
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<tr>
<td>Intercept</td>
<td>0.142386614</td>
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<td>5.751106312</td>
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<td>0.092607066</td>
<td>0.192166163</td>
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<tr>
<td>2021 Cigarette Tax Per Pack</td>
<td>0.015800693</td>
<td>0.003146392</td>
<td>-5.023822583</td>
<td>7.43301E-06</td>
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<tr>
<td>2020 Stress Index</td>
<td>0.001200103</td>
<td>0.000521026</td>
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<td>0.000152511</td>
<td>0.0002247696</td>
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</tr>
</tbody>
</table>

Source: Legislative Office of Fiscal Transparency

Table: 23: MR - TR, SI, MPC. This is a multiple regression analysis comparing Adult Smoking Prevalence with Cigarette Tax Rates, Stress Index (data from Wallet Hub), and Medicaid Expense Per Capita for all 50 states and Washington, D.C.

Multiple Regression Analysis (Tax Rate, Stress Index, Medicaid Per Capita)

<table>
<thead>
<tr>
<th>Coefficients</th>
<th>Standard Error</th>
<th>t Stat</th>
<th>P-value</th>
<th>Lower 95%</th>
<th>Upper 95%</th>
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<td>2021 Cigarette Tax Per Pack</td>
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<tr>
<td>2020 Stress Index</td>
<td>0.000623251</td>
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<tr>
<td>2020 Medicaid Per Capita</td>
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<td>3.14405876</td>
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<td>8.911691-06</td>
<td>3.80081E-05</td>
<td>3.80081E-05</td>
</tr>
</tbody>
</table>

Source: Legislative Office of Fiscal Transparency
Appendix N. Benchmarking Study

Utah – Ranked 1st

Utah’s population is approximately 700,000 less than Oklahoma’s. Utah is the only state with single digit adult smoking prevalence at 7.9 percent. Utah’s cigarette tax is $1.70, which is the national average. Additionally, this tax rate is the fourth-highest among neighboring states. For Fiscal Year 2020, Utah collected $84.8 million in tobacco tax, including e-cigarette tax. These funds are deposited into Utah’s general fund, with $7.95 million designated as “restricted” for tobacco prevention, and the remaining $76.9 million designated as “unrestricted.” Utah additionally received payment of approximately $25.7 million in fiscal year 2019 from the MSA. During Utah’s 2004 state sessions, §51 was established to govern the distributions of funds from the MSA. This statute was later updated in §51-9-201 in 2020. Utah, like TSET, is allocated interest from the Trust formed when the State first started receiving MSA payments. Payments from the Trust to tobacco prevention and cessation totaled $3,847,100 in FY2019. An additional $3,159,700 was distributed from the Cigarette Tax Restricted Fund Account. Additional funding sources are a $6.4 million Synar block grant and $1,147,167 from the CDC.

Utah offers numerous tobacco cessation programs through their “Quit Line” as well as covering many of the costs of treatment, similar to Oklahoma. Utah distinguishes itself through their numerous “Clean Air” laws. Utah passed the Second Hand Smoke Amendments (SHSA) in 1997. Under §78B-6-1101-(3), any tobacco smoke which drifts into residential or commercial units is considered a nuisance. According to Utah’s “Good Health, Good Benefits” report, Utah has four other statutes pertaining to secondhand smoke.

Utah also has an Indoor Clean Air Act (UICAA), §UC 26-38-3 (1) that prohibits smoking in all enclosed indoor places of public access and publicly owned buildings and offices. Utah also includes all e-cigarettes/vaping under their SHSA and UICAA statues.

Utah’s approach to cessation is heavily influenced with their legislation, however it does include 70 partnerships, with the vast majority being county health departments and state agencies. These partnerships provide community level data and services for areas of need for Utah. Additionally, these partnerships include a promotion and prevention campaign focusing on clear air and the costs to property owners, especially multi-housing units. Utah offers both financial impact analysis for business owners, but also legal guidance in how to structure leases, legal protections/advice, and further reading material for business owners.

Connecticut – Ranked 4th

Connecticut’s population is approximately 400,000 less than Oklahoma’s. As shown in Table 09, Connecticut has an adult smoking prevalence of 12.2 percent, which is approximately 7.7

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164 Tax Commission FY2020 Annual Report (utah.gov)
165 FY19_LegislativeReport_v3 - Copy.indd (tobaccofreeutah.org)
166 Utah Code Section 51-9-201
167 GoodHealth-GoodBusiness_2014Ed.pdf (utah.gov)
168 Ibid
169 2020-Legislative-Report.pdf (tobaccofreeutah.org)
170 GoodHealth-GoodBusiness_2014Ed.pdf (utah.gov)
percent lower than Oklahoma’s. Connecticut’s cigarette tax is among the highest in the nation and is relatively close to their neighboring states’ tax rates.\textsuperscript{171} For Fiscal Year 2020, Connecticut collected $322,179,153 in tobacco tax revenue and $3,371,121 on e-cigarette tax revenue.\textsuperscript{172} Additionally, Connecticut received approximately $118.8 million in MSA distribution payments.\textsuperscript{173} Research suggests both sources of revenue are deposited into Connecticut’s general fund, with no specific allocation of these revenues towards cessation and prevention.\textsuperscript{174} Connecticut receives federal funding through the FDA’s Tobacco Prevention and Enforcement Program, which is used to operate the State’s “help line.”\textsuperscript{175}

Connecticut funds their State’s cessation and prevention through the Department of Mental Health and Addiction Services (DMHAS).\textsuperscript{176} DMHAS was formed in 1995 when the Addiction Services Division of the Department of Public Health and Addiction Services and Department of Mental Health merged with Alcohol, Tobacco, and other drug (ATOD) prevention services placed within the new department. The focus on DMHAS is prevention and health promotion. At the time of this report, LOFT’s conversations with officials from Connecticut are ongoing. Information for the total efforts and impact of the prevention and health promotion is still being gathered, however, Connecticut allocated $4,873,302 state towards and received $6,822,719 in federal funding for \textbf{all} prevention efforts ($11,696,021).\textsuperscript{177} State funds are provided through their State’s Substance Abuse Prevention & Treatment Block Grant, General Funds, and Drug Asset Forfeiture Funds.

Prevention and promotion efforts are implemented through a 5-step Strategic Preventive Framework (SPF) and is spearheaded by the State Epidemiologist Outcome Workgroup (SEOW). The 5-steps include needs assessments, capacity building, planning, implementing evidence-based strategies, monitoring, and evaluation. SEOW is comprised of representation from Department of Children and Families, Consumer Protection Liquor Control Unit, Corrections, Education, Motor Vehicles, Public Health, Public Safety, Social Services, Transportation, Judicial Branch Court Support Services, Multicultural Leadership Institute, Office of Policy and Management, and researchers from the University of Connecticut Health Center. This group meets quarterly to examine to discuss current data which is tracked, promote strategic use of data, and examine new sources of prevention and treatment need indicator data.

\textbf{Colorado – Ranked 11\textsuperscript{th}}

Colorado’s population is approximately 1.7 million more than Oklahoma’s. Colorado’s adult smoking prevalence is approximately 13.5 percent which is 5.4 percent lower than Oklahoma’s. Colorado’s cigarette tax is currently $1.94, which is the fourth highest among Colorado’s bordering states. In November of 2020, Colorado taxpayers voted to increase current taxes on nicotine and tobacco products. Cigarette taxes increased 9.7 cents to the current rate $1.94 beginning in January of 2021 and will continue to increase over time to until the tax reaches

\footnotesize{\textsuperscript{171} See Appendix L for map of state tax rates. \\ \textsuperscript{172} \url{DRS-FY20-Annual-Report.pdf (ct.gov)} \\ \textsuperscript{173} \url{Actual MSA Payments to States (tobaccofreekids.org)} \\ \textsuperscript{174} \url{Connecticut | State of Tobacco Control | American Lung Association} \\ \textsuperscript{175} Ibid \\ \textsuperscript{176} \url{Prevention and Health Promotion Division Compendium 2020 (ct.gov)} \\ \textsuperscript{177} Ibid}
$2.64 by July 1, 2027.\textsuperscript{178} For FY2020, Colorado collected $139,993,248 in cigarette tax and an additional $47,057,526 in tobacco products excise tax. In accordance with the Colorado Constitution, 85 percent of all excise tax (excluding transportation-related) is deposited into the Old Age Pension Fund (OAPF).\textsuperscript{179} Any revenues above what is needed to fully fund the OAPF are placed in Colorado’s general funds of the tobacco funds deposited into Colorado’s general fund. 27 percent is required to be distributed to local government unless local governments and special districts levy a cigarette tax. An amendment passed in 2004 directs an additional 20 percent to local government health care and tobacco use prevention programs.

Colorado produces an annual forecast report on the status of the MSA payments paid to the State. According to the MSA, payments to the states are adjusted for inflation and decrease as the number of cigarette sales decrease. Providing this level of details allows Colorado to derive a more informed state budget and assist in the development of the Department of Public Health and Environment’s four-year strategic health initiative plan, which includes tobacco cessation and prevention.\textsuperscript{180} Colorado received $82.4 million in MSA payments in FY2020 and anticipates the payments to decline to $76.5 Million by FY2023. Exhibit 05 illustrates how Colorado allocates its distributions.

As noted previously, Colorado’s strategic four-year plan is based on an evidence-based public health framework which includes a seven-stage process incorporating epidemiologic data and metrics to formulate specific stakeholder plans that address cessation and prevention. The evidence-based decision. Using the evidence-based framework (illustrated in Figure 12), Colorado developed five tobacco priorities which focus on covering a mixture of policy and funding initiatives such as; focus on youth access with more strict licensure, eliminate secondhand smoke exposures through smoking bans in public housing, strengthening the State’s clean indoor air regulations, expanding cessation programs by developing and deploying new methods to improve success rates, unified messaging across state agencies and partnerships, and reducing health disparities through education and price strategies (raise cigarette taxes and education public and policy makers about the benefits of increased prices combined with tobacco cessation).

\textsuperscript{178} Tax Profile and Expenditure Reports | Department of Revenue (colorado.gov)
\textsuperscript{179} The criteria for this program were not researched for this report as it was determined to reside outside of scope of this project.
\textsuperscript{180} Tobacco education, prevention and cessation grant program | Department of Public Health & Environment (colorado.gov)
New Mexico – Ranked 26th

New Mexico’s population is about half that of Oklahoma. In 2020, New Mexico received $33.9M in tobacco settlement funds while Oklahoma received $66.3M.\textsuperscript{182} Fifty percent of New Mexico’s settlement is deposited into a program fund used for tobacco prevention and cessation and other health-related programs, while the other half serves as the State’s reserve fund. In FY20, TSET’s operating budget was $57M. In 2019, CDC indicated that adult smoking prevalence in New Mexico was lower by 2.9 percent points than Oklahoma (16% vs. 18.9%) while New Mexico tobacco cessation budget is about four times lower.\textsuperscript{183}

Some of New Mexico’s outcomes result from seeking to “de-normalize” the use of nicotine products. The pivotal point for New Mexico was shifting its approach from tobacco cessation to combating nicotine addiction. The change materialized by taking the following actions: First, Quitline workers aligned questions to focus on a caller’s need solely instead of unrelated data.

\textsuperscript{181} [r20-1816_2021_tobacco_msa_forecast.pdf (colorado.gov)]
\textsuperscript{182} [Actual Annual Tobacco Settlement Payments Received by the States, 1998-2020 (tobaccofreekids.org)]
\textsuperscript{183} [Current Cigarette Smoking Among Adults in the United States (cdc.gov)]
collection. Second, the State expanded its tobacco policies to be inclusive of vaping products leading to medical facilities asking patients questions correctly embracing all nicotine products and capturing behaviors, and by licensing and taxing the sale of all nicotine products. Finally, the state increased the legal smoking age to twenty-one.

All these strategies are part of the 2020-2025 action plan for which goals include prevention of tobacco use initiation among young people, promotion of nicotine addiction treatment services to adults and youth, exposure elimination to secondhand smoke and e-cigarette aerosols: identification and elimination of tobacco-related disparities.
Agency Responses

- LOFT response to TSET’s response, April 29, 2021
- TSET Response to LOFT, April 27, 2021
LOFT’s comments on the response from TSET

As part of LOFT’s protocol, agencies are granted the opportunity to respond to the evaluation report and findings. For this priority program evaluation, LOFT examined the spending and outcomes of key programs and services provided by the Tobacco Settlement Endowment Trust (TSET). Portions of TSET’s response warrant further clarification and correction, which will be addressed. With this response, LOFT seeks to address questions of fact, and not differences of opinion.

Scope of Project

Priority program evaluations provide a detailed, multi-faceted review of State programs. Over the course of several months, LOFT performed extensive topic-specific research, evaluated agency records, conducted interviews, obtained data sets from national tobacco-prevention organizations, and conducted a benchmarking study to compare Oklahoma’s spending and outcomes to top-ranked states, bottom-most ranked states, and regional states.

The scope of this evaluation sought to evaluate how and where TSET funds are spent and quantify related outcomes for the State. TSET’s response suggests the scope of evaluation should have instead focused on the broad public policy issue of tobacco use and prevention, and that the agency’s programs should not be isolated for evaluation.

TSET’s response provides examples of “notable successes in improving the health of Oklahomans,” including funding research, funding physicians through a medical loan repayment program, and awarding grants to communities and schools. However, spending is an output, not an outcome. Throughout this evaluation, LOFT found TSET quantifies its outputs (dollars spent, grants awarded, calls received) but very few resulting outcomes.

TSET cites CDC best practices as the guidance for its work, referencing research demonstrating effectiveness of these practices in promoting behavior change that leads to improved health outcomes. LOFT did not evaluate the effectiveness of CDC recommendations, but concluded this approach - as executed – does not appear to be yielding the intended change for Oklahoma. Additionally, TSET does not measure or demonstrate behavior changes or long-term outcomes related to implementation of CDC best practices.

TSET’s response states the agency’s focus is on public education, supporting tobacco-free polices, and encouraging healthy choices. LOFT’s evaluation sought to establish if this approach is yielding measurable outcomes in areas central to TSET’s constitutional mission.

Clarification of Agency’s Response:

TSET claims LOFT made “haphazard comparisons“ of Oklahoma to other states. LOFT selected comparison states based on observed best practices and successful outcomes. Two of the four states selected are also within Oklahoma’s region.
LOFT’s response to claims of inaccuracy within report:

In response to Finding 1: “Oklahoma’s Ranking for Tobacco Use Remains One of the Worst Despite High Levels of Spending and Continued Protection of the Settlement Fund,” TSET disagrees with LOFT’s assessment, stating that if not for TSET’s programs, Oklahoma’s tobacco prevalence would be much higher. There is no data to substantiate this statement. LOFT’s analysis (Chart 16 of the report) demonstrates that Oklahoma has followed regional and national trendlines over the past 20 years, and the decrease in smoking rates cannot be attributed to any specific actions or programs funded by TSET.

TSET refutes LOFT’s observed lack of evidence demonstrating correlation between state spending on tobacco cessation and prevention and smoking prevalence within states, citing a study based on survey data collected from 8th, 10th and 12th grade students between 1991 to 2000. While LOFT acknowledges spending is part of any effective public policy initiative, not all spending is effective. There is also a conflicting body of research regarding the effects of tobacco control spending on smoking prevalence, with some finding no significant effect.

TSET incorrectly claims LOFT’s evaluation lacks comparative analysis of Oklahoma’s state laws to other states with better health outcomes. In the “Benchmarking Study and Regional Trends” section of the report, LOFT examined state policies for clean indoor air or secondhand smoke, as well as regulation of e-cigarettes and other emerging tobacco-derived products.

TSET asserts the unsubstantiated claim that Oklahoma’s state laws “place Oklahoma at a disadvantage” for reducing the toll of tobacco, with emphasis on a lack of statewide smoke-free (or clean air) laws and municipalities’ inability to enact smoking restrictions. This report includes a statistical analysis of the tax rates, clean air laws, and spending relative to CDC-recommended levels for best practice states. From this, LOFT found that clean air laws and degree of CDC-recommended spending had minimal impact (.6%) on smoking prevalence rates.

TSET states LOFT arrives at a false conclusion by combining combustible cigarette and e-cigarette usage to depict the overall use of tobacco products. LOFT acknowledges some smokers may be using both traditional and electronic products. TSET could begin capturing data that would allow for unduplicated analysis. The inclusion of Chart 05 demonstrates that tracking only the decline in combustible cigarette smoking may be misleading. If e-cigarettes and combustible cigarettes are economic substitutes, as indicated in the report, Oklahoma may be experiencing displacement of traditional smokers and not actual cessation.

TSET incorrectly states that LOFT did not identify a state that has a successful model. LOFT stands by its review of states with best practices, as detailed in Finding 4 of the report (Table 10 of the report).

In response to Finding 2: “Oklahoma Ranks Among Worst States for Critical Health Outcomes,” TSET claims LOFT asserts that one single program or expenditure can reduce death from preventable disease. As TSET does not have long-term health outcome data, LOFT evaluated the overall status and trends of major health initiatives that TSET prioritizes through funding to reasonably determine impact. LOFT requested from TSET, but did not receive, the agency’s definition of “health outcomes.”
TSET disagrees with many of the recommendations in Findings 2 and 4, incorrectly claiming they run counter to the Oklahoma Constitution. With the passage of State Question 692 in 2000, the Tobacco Settlement Endowment Trust Fund was created. Article X, Section 40, paragraph G also provides that, “The Legislature may enact laws to further implement the provisions of this section.” Current statutes reflect the utilization of this constitutional provision, notably, O.S. Title 62 Section 2309 enumerates the powers of the Board of Directors and defines allowable expenses.

TSET also claims the report draws “an impossible conclusion” in comparing TSET’s expenditures to state health outcomes, such as cancer rates. This section of the report demonstrates that Oklahoma is not achieving critical health improvements and that TSET’s broad programmatic spending does not appear to be positively influencing those outcomes.

In response to the recommendations in Finding 2, TSET claims to report data for health outcomes directly attributable to agency programs and spending. With the exception of quit data from the Helpline evaluations, LOFT did not observe intermediate or long-term data reported and tied directly to TSET programs, services or activities. TSET also claims the report’s omission of TSET materials related to evaluating media campaigns “perpetrates an incomplete understanding of the potency of public education campaigns.” LOFT reviewed the provided material and found that it did not measure behavioral change or long-term outcomes. Additionally, the results were not statistically relevant, with non-random, small sample sizes that were not representative of Oklahoma.

In response to Finding 3: “TSET’s Resources Are Not Aligned to Oklahoma’s Greatest Needs,” TSET disagrees with the facts as presented, stating LOFT’s research “provides incomplete information and understanding of TSET budget priorities.” LOFT includes within its report (Table 06) TSET’s budgeted program categories as compared to TSET’s publicly stated programmatic priorities. Budget data was obtained from and confirmed by TSET.

TSET also rejects the recommendations within Finding 3, stating the agency’s programs focus on those with the highest rates of smoking and premature death. LOFT’s analysis did not find evidence of this programmatic approach.

TSET contends the outcomes of the Oklahoma Tobacco Helpline exceed national averages. Three percent of tobacco users within Oklahoma utilize the helpline, and the 34.4% of those who quit equate to approximately 1% of Oklahoma’s total smoking population. LOFT recognizes a significant number of smokers receive help from the line, but poses the question of whether this intervention is the most effective (cost or otherwise) way to change behavior.

TSET incorrectly claims LOFT’s comparison of Oklahoma’s spending for the Helpline is misleading, with spending increases attributable to more people using and receiving services. LOFT’s analysis found that of smokers who reach out to the helpline, a declining percentage of those callers elect to sign up for services (11.5% in FY 20; 12.6% in FY19 and 20.1% in FY18). For a point of comparison, Oklahoma’s helpline serves 10% more callers than Texas’ line, but Oklahoma spends 1,500% more than Texas to provide services.
In response to Finding 4: “Oklahoma Has Opportunities to Improve Outcomes Through Policy Changes, Prioritization of Spending, and a Unified Statewide Strategy,” TSET states LOFT’s conclusion about Oklahoma’s sensitivity to cigarette tax rate increases is inaccurate. The agency cites national reports stating that a 10% increase in cigarette prices will result in a 3-5% reduction in cigarette use. LOFT examined Oklahoma’s smoking rates and tax rates over time and did not find these results borne out. Chart 06 of the report presents longitudinal data on how tax rates have impacted smoking rates.

Additionally, without collecting data on e-cigarette use, smokers may not be quitting but instead changing their method of consumption. TSET incorrectly states that “significant stockpiling” occurred prior to the last tax rate increase, which took effect July 2018. LOFT analyzed sales tax receipts from FY17 and FY18 and found an increase of approximately 1% in cigarette tax revenue.

With its response to Finding 4, TSET provides new information to LOFT regarding process improvement projects in place and therefore, these projects were not included in this evaluation.
I. Introductory comments from TSET regarding the subject of LOFT’s evaluation:

Thank you for the opportunity to provide a response to LOFT’s review of TSET’s work.

The initial scope of the LOFT evaluation sought to review TSET’s expenditures in tobacco cessation and took a narrow view of the complexities of tobacco use prevention, reducing secondhand smoke and cessation. While this is a topic worthy of investigation, especially as Oklahoma continues to have a higher smoking rate than most states, it is shortsighted to assume that reducing the toll of tobacco in Oklahoma can only relegated to a handful of programs. A systemic approach is required.

Every program and every partnership TSET engages in has explicit goals to reduce tobacco use and support policy adoption at the state, local and business level to protect Oklahomans from secondhand smoke, keep people from starting smoking and support smokers in their quit attempts. The scope of this evaluation also failed to acknowledge that tobacco use is an addiction and does not follow a linear path for reduction and relapses are likely.

LOFT engaged in robust review and research, yet did not fully address the role of state law in helping to achieve goals in the reduction of tobacco use. The report does not demonstrate an understanding in public health practice, evaluation or the fundamentals of prevention. This deficit leads to haphazard comparisons with other states and furthers the misunderstandings about the value of prevention and the cost of poor health in Oklahoma.

Any examination of TSET’s work should start with TSET’s constitutional mandate, which was re-affirmed by Oklahoma voters in November 2020. The Oklahoma Constitution authorizes the TSET Board of Directors to fund:

1. Clinical and basic research and treatment efforts in Oklahoma for the purpose of enhancing efforts to prevent and combat cancer and other tobacco-related diseases;
2. Cost-effective tobacco prevention and cessation programs;
3. Programs other than those specified in paragraph 1 of this subsection designed to maintain or improve the health of Oklahomans or to enhance the provision of health care services to Oklahomans, with particular emphasis on such programs for children;
4. Programs and services for the benefit of the children of Oklahoma, with particular emphasis on common and higher education, before- and after-school and pre-school programs, substance abuse prevention and treatment programs and other programs and services designed to improve the health and quality of life of children;
5. Programs designed to enhance the health and well-being of senior adults; and
6. Authorized administrative expenses of the Office of the State Treasurer and the Board of Directors.
The seven members of the TSET Board of Directors are appointed by five statewide elected officials, the Speaker of the Oklahoma House of Representatives and the President Pro Tempore of the Oklahoma Senate.

While Oklahoma has an enviable constitutionally protected trust that provides earnings for use in preventing and reducing the use of tobacco there are factors that continue to place Oklahoma at a disadvantage when it comes to reducing the toll of tobacco. Those factors include:

- a lack of 100 percent smokefree laws to protect workers from toxic secondhand smoke;
- state laws that prohibit municipalities from passing local policy related to tobacco use and sales;
- active tobacco industry influence in legislation and protection of laws that benefit the tobacco industry and its allies.

With these hurdles in place, TSET’s work focuses on educating the public on the harms of smoking and second hand smoke, providing free cessation resources as well as working in local communities and health systems to support tobacco free policies and environments where healthy choices are available and supported.

TSET’s work adheres to CDC best practices, which decades of peer-reviewed research have shown to be effective in promoting behavior change that leads to improved health outcomes.

Since its creation, TSET has achieved notable successes in improving the health of Oklahomans:

- TSET’s investment in research at the Stephenson Cancer Center (SCC) has been instrumental in bringing $182.5 million additional grant dollars to Oklahoma. Treatment was provided to more than 2,700 new patients in 2019. Since 2010, with help from TSET funding the SCC has recruited 55 researchers and 40 new physician oncologists to Oklahoma institutions, including placement within the University of Oklahoma Health Sciences Center, the University of Oklahoma and the Oklahoma Medical Research Foundation.

- TSET’s partnership with the Physician Manpower Training Commission to fund the Medical Loan Repayment Program is currently funding 37 physicians in rural and underserved areas of the state and will be funding 42 physicians in FY22. Forty-eight other doctors have participated in the program, and, of those who complete the program, more than half continue to practice medicine in rural Oklahoma. Since 2013, there have been 324,669 total patient visits, of which 103,777 patient visits were insured by SoonerCare or Medicaid. Physicians in this program referred nearly 11,000 patients to the Oklahoma Tobacco Helpline (OTH).

- TSET’s first Healthy Living Program worked in 62 counties across the state and covered 94% of the state’s population and resulted in the passage of more than 2,000 health policies. The current round of five-year grants, that started July 1, 2020, will specifically target service areas and populations that experience the greatest health disparities.

- TSET has also awarded 222 incentive grants to school and school districts throughout the state, impacting more than 300,000 Oklahoma students.

Finding 1: Oklahoma’s Ranking for Tobacco Use Remains One of the Worst Despite High Levels of Spending and Continued Protection of the Settlement Fund
<table>
<thead>
<tr>
<th>Does the agency agree with the facts as presented?</th>
<th>Does the agency agree with the recommendations related to this finding?</th>
</tr>
</thead>
<tbody>
<tr>
<td>TSET agrees Oklahoma’s tobacco use ranking is high, but we do not agree with LOFT’s state comparisons and limited health outcome assessment. Without TSET programs, Oklahoma’s rates of tobacco use would be much higher.</td>
<td>Yes, and TSET is already engaged in many of these recommendations including the use of logic models for programs.</td>
</tr>
</tbody>
</table>

**Agency Comments and Clarifications (Technical response)**

Improving health and reducing preventable disease calls for a comprehensive, population-based approach. TSET’s work seeks to change the environment so healthy choices are available and Oklahomans have information on the importance of healthy choices and can make those choices. The LOFT evaluation of our work assumes health is an isolated pursuit that can be fixed with one intervention. Health is an interplay of many choices throughout the course of a day supported by policies, norms, culture and environment. TSET programs and services are designed to reduce the risk factors that can lead to cancer and heart disease. By preventing and reducing tobacco use and obesity through locally supported solutions, TSET’s programs seek to create sustainable change and reduce health disparities.

TSET disagrees with LOFT’s statement that “LOFT observed a lack of evidence demonstrating correlation between state spending on tobacco cessation and prevention and smoking prevalence within states.”

In fact, this has been demonstrated a number of times. A 2015 study, “State Tobacco Control Spending and Youth Smoking” found that “that real per capita expenditures on tobacco control had a negative and significant impact on youth smoking prevalence and on the average number of cigarettes smoked by smokers.”

This report did not detail the laws that Oklahoma lacks compared to other states with better health outcomes. The top ten states with the lowest smoking rates all have more favorable policy environments to reduce smoking prevalence than Oklahoma does.

It has also been documented that the tobacco industry exerts considerable influence over legislation development and state laws on the books in Oklahoma. Large tobacco companies, such as Altria, report contributions to a variety of organizations active at the state Capitol. This may be one of the reasons Oklahoma is one of two states with limits on local control of tobacco regulation.

As LOFT states, there are several variables that influence adult smoking rates including per capita income, educational attainment, poverty, current state laws, price of cigarettes, policy environment and cultural factors.

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1. [https://www.researchgate.net/publication/8061282_State_Tobacco_Control_Spending_and_Youth_Smoking](https://www.researchgate.net/publication/8061282_State_Tobacco_Control_Spending_and_Youth_Smoking)
Page 16 says that the study “Assessing the Impact of Tobacco Settlement Endowment Trust” doesn’t establish a causality to directly attributable declines in smoking to any specific program and that the study is outdated. This assessment by LOFT is misguided as no data or evaluation can establish causality as TSET programs are statewide and prevention-focused with a strong confidence interval. In Oklahoma, the rate of smoking has decreased from 26% in 2011 to 18.9% in 2019. A strong correlation can and has been made between sustained funding for prevention infrastructure, which TSET with its unique funding structure, has been able to provide the state through the ebbs and flows of state revenue and appropriations. As such, Oklahoma’s smoking rate declined 10 time faster than states with similar price and policy environments.

In comparing the smoking rates of bordering states on page 18, the map points out that bordering states have lower smoking rates than Oklahoma (except for Louisiana, Missouri, and Arkansas). However, it does not mention that Kansas, Colorado, and New Mexico have statewide smokefree air laws, while Texas municipalities have the authority to pass local smoke-free laws. Tobacco control methods, including smoke-free laws have been proven to reduce smoking prevalence.

LOFT states that the Oklahoma smoking rate has not improved when looking at the prevalence of cigarette smoking and e-cigarette smoking. This is not a conclusion that can be drawn from the chart on page 20. Simply adding rates of cigarette smokers and e-cigarette users does not take into account that many tobacco users use both products or “dual use.” Combining smoking and e-cigarette use and

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5 https://no-smoke.org/gaps-oklahoma/
reporting it as the adult smoking prevalence does not follow standard public health methodology and is a false conclusion.

While Oklahoma municipalities are limited in their ability to protect citizens from tobacco initiation and secondhand smoke exposure, this report fails to quantify the significant impact TSET’s programs have had on tobacco-free policy adoption.

In 2015, the Legislature adopted a statewide law called the 24/7 Tobacco Free Schools Act that made school property tobacco free. This legislation was supported by TSET and the Oklahoma State Department of Health. This state law change was made after a majority of school districts already had voluntary policies in place. TSET grants, beginning 2004, led the way in working with districts to ensure that children were protected from tobacco use and secondhand smoke. Today, all children, patrons and staff enjoy the benefits of a tobacco-free campus. In 2019, the 24/7 Tobacco Free Schools Act was expanded to include a vapor free policy as well. Tobacco free policies support the goal of ensuring that young people do not start tobacco use. Research shows most adult tobacco users started using tobacco before age 18.

Through the TSET Healthy Living Program (HLP), more than 2,000 local wellness and tobacco-free policies have been enacted by municipalities, schools, businesses and community organizations impacting 2.46 million people. Since local communities cannot regulate smoking at the local level, grantees worked to enact ordinances that mirrored state law.

**Policy Considerations**

- The Legislature may consider requiring adoption of a coordinated funding plan across all state agencies supporting tobacco cessation, prevention, and related health outcomes.

As the LOFT reports states, there is not a duplication of services. TSET participates in agency partnerships, convenes workgroups with other agencies and actively looks for opportunities to leverage work to prevent and reduce tobacco use. This work will continue and TSET welcomes the opportunity to update the Legislature on these efforts and discuss policy improvements and programmatic outcomes.

- To achieve desired outcomes for the State, the Legislature may consider empowering one of the State’s health agencies to determine state-specific spending priorities and identify measurable, observable outcome data for tracking and reporting progress for key health metrics, including tobacco use.

TSET collaborates with the Oklahoma State Department of Health (OSDH) and has actively participated in the development of the Oklahoma Health Improvement Plan, contributed to the State Tobacco Plan which includes long- and short-term goals for statewide prevention and cessation efforts. TSET is also an agency in the Health Cabinet and participates in cabinet meetings and goal setting exercises. Current Health Cabinet goals as stated on the Governor’s Dashboard of Metrics emphasize a reduction in opioid deaths and childhood obesity. No specific goal on preventing or

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6 [https://oklahoma.gov/health/health-promotion/tobacco-initiatives/24-7-tobacco-free-schools.html](https://oklahoma.gov/health/health-promotion/tobacco-initiatives/24-7-tobacco-free-schools.html)
reducing tobacco use is identified, but TSET welcomes the opportunity to continue to inform those conversations.

**Agency Recommendations**

- **TSET should reorient its logic models to measure for behavioral change. These models should be publicly available and include data-collection plans that measure statewide impact success metrics at every level; short-term, intermediate, and long-term.**

TSET uses logic models, SMART objectives and monitors those outcomes annually. Logic models, theories of change and evaluation design are all part of program development.

- **TSET should partner with the State Department of Health to conduct more rigorous statistical analysis to better understand relationships between variables that impact smoking prevalence.**

TSET has an ongoing cooperative agreement with the OSDH for analysis, data expertise and consultation. In an effort to provide richer local data, TSET has begun local data collection through the TSET Healthy Living Program. OSDH is a partner in this effort. While the LOFT report highlights the limitations in data, it does not show a state that has successfully implemented a model that achieves this goal.

In addition, the development of a data analytics framework for TSET is also underway to provide additional analysis useful in making funding decisions. TSET, like other agencies, would welcome the opportunity to participate in data sharing agreements across multiple state agencies that would provide a rich understanding of programs being utilized. Increased data sharing across health serving agencies, commerce and other agencies would enhance this work. TSET would be a willing partner in this effort to better meet and quantify the needs of Oklahomans.

- **TSET should begin collecting data to understand e-cigarette use across the state, as well as other tobacco products and emerging trends.**

TSET currently utilizes data collected annually on statewide surveys. TSET and OSDH work collaboratively to add questions to the annual Oklahoma BRFSS survey to insure annual data collection about e-cigarette use. This comes at an added cost that TSET funds in an effort to attain data to inform programmatic investments. Additional information is collected through media evaluations and other surveys. A lack of licensing regulations and a specific tax structure for e-cigarette products hampers statewide efforts to understand sales trends. This LOFT report aptly points to other states where the Legislature has adopted laws and regulations to track this product and provide additional information. Data around dual use of e-cigarettes and cigarettes is tracked among OTH participants and ongoing research studies are being conducted at the TSET Health Promotion Research Center to better understand e-cigarette use and addiction.
Finding 2: Oklahoma Ranks Among Worst States for Critical Health Outcomes

<table>
<thead>
<tr>
<th>Does the agency agree with the facts as presented?</th>
<th>Does the agency agree with the recommendations related to this finding?</th>
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</thead>
<tbody>
<tr>
<td>Yes, Oklahoma’s health outcomes are among the worst. TSET disagrees with the assertion that one single program or expenditure can reduce death from preventable disease.</td>
<td>Many of the policy considerations in this section run counter to the Oklahoma Constitution. Many agency recommendations reflect work TSET is already doing.</td>
</tr>
</tbody>
</table>

Agency Comments and Clarifications (technical response):

Oklahoma does have some of the nation’s worst health outcomes. However, the premise behind this section of the report is misguided. LOFT attempts to link TSET dollars to cancer or heart disease deaths. This is not possible, and poor outcomes avoided are difficult to measure.

For example, page 24 notes that “These health outcomes do not show TSET budgetary expenditures have had a measurable impact on reducing cancer rates.” That is an impossible conclusion to draw as it ignores the benefit of prevention, cost reduction and the cost of doing nothing. TSET interventions are in line with research by national groups such as the CDC, National Cancer Institute and the Institute of Medicine. These organizations provide recommendations for states and organizations based on evaluation, meta-analysis and the experience of other states and communities.

In addition, it is worth noting that TSET’s work saves the state money by supporting an overall healthier population – including Oklahomans likely to be enrolled in SoonerCare. Smoking is attributed to roughly 15 percent or more of Medicaid expenditures.

TSET’s investment in educating the public on healthy choices and providing resources to support those healthy choices through marketing campaigns is limited in scope and information.

The basic premise of health communication public education campaigns, such as TSET’s Tobacco Stops With Me campaign, is to move knowledge and attitudes to ultimately effect positive behavior change⁷. Behavior change is a long-term investment with the final result is a change in a person’s lifestyle to include healthier choice(s) such as quitting tobacco, adopting smokefree home and vehicle policies, parents discussing dangers of tobacco use with youth, to comprehensive public policy that supports healthier lifestyle choices and protects citizens⁸.

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⁸ NCI TOBACCO CONTROL MONOGRAPH SERIES, Monograph 19 The Role of the Media in Promoting and Reducing Tobacco Use. https://cancercontrol.cancer.gov/sites/default/files/2020-06/m19_complete_0.pdf
Evaluation data show that exposure to these public education campaigns change attitudes and behavior:

- Exposure to Tobacco Stops with Me messages doubles quit attempts among tobacco users.
- Tobacco Stops with Me increases knowledge about the harms of secondhand smoke (SHS).
- Tobacco Stops with Me changes attitudes about tobacco. Non-tobacco users exposed to Tobacco Stops with Me were more likely to report that tobacco is a serious problem in Oklahoma as compared to unexposed non-tobacco users. These findings were statistically significant and independent of competing explanations.
- Tobacco Stops with Me motivates non-tobacco users to help tobacco users quit. Non-tobacco users exposed to Tobacco Stops with Me were 50% more likely to help someone quit using tobacco as compared to non-tobacco users not exposed to Tobacco Stops with Me.

**Policy Considerations**

- The Legislature may consider defining within statutes specific areas of spending on health programs consistent with TSET’s mission and the original purpose of the Master Settlement Agreement, such as Medicaid.
- The Legislature may consider addressing the constitutional broadness of TSET’s mission by placing clarifying language in statute.
- The Legislature may consider amending O.S. Title 62, Section 2306 to provide clearer guidance to the Board of Directors for TSET regarding the type of allowable expenditures related to executing its duties.

Article 10, Section 40 of the Oklahoma Constitution vests full authority for independent funding decisions with the appointed Board of Directors as approved by voters in 2000 and 2020. Voters in every county affirmed TSET’s structure with the rejection of the legislatively initiated State Question 814 in November 2020.

Members of the TSET Board of Directors are appointed by elected officials including the Speaker of the House and President Pro Tempore of the Senate. TSET sees the Legislature as a powerful partner in shaping the health landscape of Oklahoma.

TSET welcomes the opportunity for discussion about priority projects and offers multiple opportunities for funding proposals to be submitted and has on multiple occasions partnered with state agencies to offset budget cuts or support projects that are mission-aligned.

**Agency Recommendations**

- **TSET should report data related to health outcomes directly attributable to TSET programs and spending.**

TSET does report this information. TSET’s programs seek to change the health behaviors of all Oklahomans. TSET programs are population based, statewide efforts and interventions are not implemented in isolation.
TSET tracks and evaluates the long-and-short-term outcomes for Oklahomans who participate in the Oklahoma Tobacco Helpline. That evaluation data is noticeably absent from this report and does not provide an accurate accounting for the ongoing program evaluation.

**TSET should measure outcome data, both intermediate and long-term, to determine the statewide efficacy of media campaigns.**

This information is tracked, reported annually to the TSET Board of Directors and is on the TSET website. Annual metrics are developed for public education campaigns and annual evaluation reports are shared with the TSET Board of Directors in public meetings. The LOFT report recommends using CDC guidance for evaluating campaigns. Those metrics are used and TSET staff are among the members who write the national evaluation recommendations. This material was provided to the LOFT group as requested, yet it remains absent from this report and perpetrates an incomplete understanding of the potency of public education campaigns.

**Finding 3: TSET’s Resources Are Not Aligned to Oklahoma’s Greatest Needs**

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<tbody>
<tr>
<td>No. LOFT research provides incomplete information and understanding of TSET budget priorities. The report fails to define the state’s most pressing health needs.</td>
<td>No. TSET programs focus on groups of that have the highest rates of smoking and premature death.</td>
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</table>

**Agency Comments and Clarifications (Technical response)**

In Oklahoma, three behaviors (tobacco use, sedentary lifestyle, and poor nutrition) lead to four conditions (cancer, diabetes, lung disease, and heart disease and stroke) that cause 65% of the deaths in our state. Many of those deaths are premature and preventable.

TSET’s work is focused on changing those three behaviors, because behavior is the single largest determinant of a person’s health. Health communications, community grants, the Oklahoma Tobacco Helpline (OTH) and other programs work together to create an environment that empowers Oklahomans to make healthier decisions.

The OTH has shown measurable outcomes and behavior changes, outpacing national benchmarks. The 6-month quit rate was 34.4% in FY20. External evaluation of the Helpline estimates that more than a third of Helpline registrants are tobacco-free 6 months after registering for services. This rate exceeds the national benchmark for Quitlines set by the North American Quitline Consortium (NACQ) making the Oklahoma Tobacco Helpline one of top ranked Quitlines in the country for providing services to tobacco users in need of treatment9.

9 [NAQC_Reach_revised.indd](ymaws.com)
Page 37 says that Oklahoma spends five times more per smoker than the national average on its tobacco helpline. This comparison is misleading—spending on the OTH is higher because more people are using it and receiving services. The 2019 NACQ annual survey showed that Oklahoma had 44,606 callers to its Helpline, while Texas only had 40,231. With a far greater population (including more smokers) but fewer quitline callers, Texas’ spend per smoker is much lower.

To date the Oklahoma Tobacco Helpline has served over 450,000 Oklahomans.

The maps on page 34-35 do not capture all of TSET’s work, nor its nuances. Statewide health communication spending is not accounted for, nor is the targeting of specific populations within counties. Additionally, these maps only look at one year of spending when TSET’s work takes place over 18 years of program investments. TSET awards grants on a competitive basis to ensure grantee organizations have the capacity to do the work and achieve outcomes over a given funding cycle. In some instances, there are have been no qualified applicants to serve areas where grant funding is not listed.

**Agency Recommendations**

- **TSET should prioritize tobacco prevention and control programs based on Oklahoma-specific outcomes and needs.**

TSET prioritizes tobacco control interventions to include local grant programs and public health education campaigns target specific groups or regional areas with high rates of tobacco use.

To meet the individualized needs of Oklahomans, we are among a handful of states that provide a specific quitting protocol for callers who identify with a mental health disorder. In addition, Oklahoma is one of the few states that has incorporated tobacco cessation into its mental health service delivery and all mental health facilities are tobacco free. As Oklahoma is among the top states for individuals reporting poor mental health days, investing in this system demonstrates a keen eye to the unique cessation and prevention needs in our state.

In addition, TSET also funds a text-based youth cessation program, My Life My Quit, which was funded after data showed an increasing rate of youth use of e-cigarettes and lack of state laws to license and regulate the sale of these highly addictive products.

- **TSET should examine the cost effectiveness of its Helpline, looking to other states for examples of cost-saving measures.**

The Oklahoma Tobacco Helpline is one of the top quitlines in the country, with quit rates that exceed national benchmarks and a 95% satisfaction rate among registrants. Other states should look to Oklahoma and take steps to replicate our success. This section of the report did not address healthcare savings realized when looking at cost effectiveness. Roughly 8.7 percent of healthcare spending (up to $170 billion) was attributable to cigarette smoking in 2010. Of that amount, 60 percent of the spending was by public programs, such as Medicare or Medicaid.

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The OTH is saving the lives of Oklahomans, adding years to their lives, improving the quality of life during those years and reducing healthcare costs. The Helpline’s success highlights TSET’s investment in helping Oklahomans overcome addiction to tobacco.

Finding 4: Oklahoma Has Opportunities to Improve Outcomes Through Policy Changes, Prioritization of Spending, and a Unified Statewide Strategy

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<tr>
<td>Yes, with exceptions.</td>
<td>Yes, with exceptions.</td>
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Agency Comments and Clarifications (Technical response)

The Oklahoma Legislature has incredible power to set statewide policy that would improve the health of Oklahomans. TSET and Tobacco Stops With Me have educated the public about such CDC recommended tobacco control polices for several years. Many of these include repealing pre-emption, 100% clean indoor air, prohibiting smoking in cars with children present, banning menthol and flavored tobacco, strengthening enforcement against underage tobacco sales, cigarette and e-cigarette tax increases and removing smokers as a protected class of employees.

The chart on page 42 compares 2021 cigarette taxes with 2019 smoking rates. Oklahoma increased its cigarette tax rate $1 per pack in 2018, so the full effect of that increase would not be reflected in the 2019 smoking rate data. The chart also does not account for the myriad of factors that influence smoking rates, or a decrease in consumption per capita. It is also not accurate to link the smoking rate to price, as price seeks to impact consumption (total number of cigarettes smoked) first and foremost. The conclusion that “Oklahoma is less sensitive to tax rate increases” is ill-founded and not accurate.

A report from the U.S. Department of Health and Human Services, “The Health Consequences of Smoking – 50 Years of Progress” notes that “A 10% increase in cigarette price will result in a 3–5% reduction in overall cigarettes consumed. Increases in cigarette prices will decrease not only the prevalence of smoking but also the average number of cigarettes smoked by smokers.”

In fact, calls to the Oklahoma Tobacco Helpline increased substantially in the months after the tax increase went into effect in 2018. There was also significant stockpiling that occurred as the tax was being put into place with no limits on quantity that could be purchased prior to effective date of tax.

The report listed an Evidence-Based Public Health Framework that Colorado uses on page 45. This is similar to the Social-Ecological Model we have used for our framework. LOFT highlighted the need for additional coordination with other health agencies and the benefits of locally collected data. These are areas that TSET already has several process improvements projects in place, including increased investment in data analytics expertise and strategic planning process across multiple agencies.
Policy Considerations

- The Legislature may consider reorganizing TSET within an existing state agency focused on health outcomes aligned with TSET’s constitutional duties. Options include the Department of Health, the Health Care Authority, and the Department of Mental Health and Substance Abuse Services.

This proposal would run counter to the Oklahoma Constitution and the will of the voters, as expressed in 2000 when they created TSET and in 2020 when they reaffirmed its independent structure and mission.

- The Legislature may consider expanding the definition of smoking in statutes to include e-cigarettes and emerging technologies for ingesting nicotine and tobacco-related products. (note: currently, some product definitions are included in Executive Orders, leading to poor enforcement.)

Yes, as the data shows, Oklahoma has a nicotine addiction and people will often use more than one product to ingest nicotine.

- The Legislature may consider creating or repurposing an existing governmental body with the authority to create and execute a statewide strategy for improving the health and wellness of Oklahomans, including reducing tobacco use to below the national average. One option could be to build on the existing Advancement of Wellness Advisory Council, which is led by the Commissioner of Health.

TSET currently collaborates with the Oklahoma State Department of Health and other stakeholders on such a plan, but we welcome opportunities for increased collaboration.

- The Legislature may consider requiring the production of an annual report about tobacco products and trends in the region, including taxation, use, sales, illegal sales and emerging products, including e-cigarettes. The current State Plan produced by the State Department of Health could be adapted.

TSET works with several agencies that seek to prevent and reduce tobacco use. The Oklahoma State Department of Health under OS 63-1-229.5 has the statutory authority to publish and disseminate the Oklahoma State Plan for Tobacco and serves as the official agency of the State of Oklahoma in matters related to public health that require cooperation with the federal government.

TSET works in coordination with the State Department of Health in aligning goals of a comprehensive tobacco control program, and both agencies ensure that services are being leveraged not duplicated.

- The Legislature may consider requiring licensure for the distribution and sale of e-cigarettes. Options for the enforcement agency could include the ABLE Commission or the Attorney General’s Office.
This policy would be beneficial to Oklahoma and would particularly help to protect Oklahoma’s youth from nicotine addiction.

- The Legislature may consider utilizing a percentage of the share of MSA funds currently allocated to the Attorney General’s for the enforcing agency, if enforcement of other cigarette products is enacted.

TSET does not have a position on this policy recommendation but is in favor of increased enforcement of tobacco control regulations.

- The Legislature may consider requiring an annual forecast for MSA payments be provided. For example, Colorado’s Department of Public Health and Environment currently provides this to the public.

- According to the MSA, a key component to the funding formula is a state’s cigarette sales. MSA payments to a state decrease as cessation and prevention programs achieve success. A forecast of MSA payments will ensure adequate funding for programs and agencies.

TSET’s budget is based on earnings from the endowment and is not directly affected by the annual MSA payment. However, this would provide more certainty to the Legislature and the Attorney General’s office, which do use yearly MSA revenues.