Issue Brief

STATE GOVERNMENT AFFAIRS

Tobacco Control Funding

Overview

In 1998, the attorneys general of 46 states, Puerto Rico, the US Virgin Islands, American Samoa, the Northern Mariana Islands, Guam, and the District of Columbia signed an agreement with the 5 major tobacco manufacturers, settling all antitrust, consumer protection, common law negligence, statutory, and common law claims that the states had initiated against the tobacco companies. This agreement, which became known at the Master Settlement Agreement (MSA), will have provided states with over $246 billion by 2025, and the settling tobacco companies will continue to make payments to states in perpetuity.

The Centers for Disease Control and Prevention (CDC) Best Practices for Tobacco Control Programs 2007 outlines the amount of funding tobacco control programs in each state need to be effective in preventing tobacco related diseases and death. Despite efforts by some state policy-makers to use the MSA money for tobacco control programs, in the first 10 years since the agreement became effective, only 1.8% of state tobacco settlement money was allocated to tobacco prevention programs, and no states, except for **Alaska** and **North Dakota**, currently fund tobacco control programs at 100% of CDC recommended levels.

Tobacco companies spend approximately $12.8 billion on advertising tobacco products, which far exceeds the amount that states receiving MSA money spend on tobacco control programs. A 2011 report from the Campaign for Tobacco Free Kids estimates that for every $1 that states spend on tobacco control, tobacco companies spend $25 to market their products. In order to counteract the tobacco industry's goal of acquiring more tobacco consumers and increasing profits, states must increase spending on effective, comprehensive tobacco control programs.

AAP Recommendations

- According to the AAP Policy Statement – Tobacco Use: A Pediatric Disease, local, state and federal authorities should promote programs that contribute to the prevention and decrease of tobacco use by youth, including programs that discourage tobacco use, support antitobacco advertising, and teach skills to resist peer and advertising influences.
- Evidence-based antitobacco education, as recommended by the CDC, the US Surgeon General, and the Institute of Medicine, should be provided to students at all levels of education, including early childhood, elementary, secondary, and higher. It is important to differentiate between and among genuine effective tobacco prevention curricula and those developed and supported by the tobacco industry, which have been shown to encourage tobacco use.
- Local, state, and federal tax policies should support tobacco control. Higher taxes have been shown to deter the purchase and use of tobacco and prompt cessation attempts; accordingly, local, state, and federal taxes on tobacco products should be implemented and/or increased. The revenue from these taxes can be used to support evidence-based tobacco control programs. Tax deductions for advertising tobacco products and tobacco farming price supports and subsidies should be eliminated. Alternative revenue sources should be developed for and promoted to tobacco farmers.
- The evidence-based recommendations of *Best Practices for Comprehensive Tobacco Control Programs* should be fully

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funded and implemented. Proceeds of the MSA should be used for tobacco-control activities, as intended.

More information about state expenditures of funds from the MSA is available from the AAP Division of State Government Affairs.

State Activity

While some states have increased funding for tobacco prevention and cessation programs, states generally fail to meet the CDC recommended level of funding. As noted previously, in 2011, **Alaska** and **North Dakota** and were the only states to exceed the CDC's recommended tobacco prevention and cessation funding level. Only 4 other states (**Arkansas**, **Florida**, **Oklahoma**, and **South Carolina**) increased spending for tobacco prevention and cessation programs in 2010. In contrast, the majority of states fund such programs at a level 50% or below the level that the CDC recommends. Given the condition of state budgets, states are experiencing considerable pressure to draw MSA and other funding to general revenues.

In 2011, a number of states cut funding for prevention and cessation programs to the lowest levels since first receiving MSA payments. In FY 2012, states will collect $25.6 billion from the MSA, but will spend only 1.8 % of the money on tobacco prevention and cessation programs. In addition to spending such a meager amount on tobacco control programs, states have also cut funding for these programs by 36% in the past 4 years. The CDC recently reported that the adult smoking rate in 2010 was 19.3 percent – only a small decline since 2004 when 20.9 percent smoked. While smoking among high school students has declined by 46 percent from a high of 36.4 percent in 1997, 19.5 percent of high school students still smoke and declines have slowed in recent years, according to the CDC.

To assist with state tobacco control efforts, the federal government has provided states with approximately $196 million under the American Recovery and Reinvestment Act of 2009 (ARRA). Through the Communities Putting Prevention to Work (CPPW) program established under ARRA, the federal government selected the AAP, among other organizations, to implement evidence and practice based strategies to prevent chronic disease and promote wellness. Specifically, the program directs CPPW organizations to use the MAPPS (Media, Access, Point of Decision Information, Price, and Social Support Services) strategies to prevent youth smoking initiation, increase access to cessation services, and decrease secondhand smoke exposure. In addition to the CPPW grant, the CDC announced in May 2011 that $100 million in federal funding would be made available to states through Community Transformation Grants (CTGs). The CTGs will be distributed from the Prevention and Public Health Fund (which was established by the Patient Protection and Affordable Care Act [ACA]) and is reserved for 5 prevention priority areas, one of which includes tobacco prevention.

While the federal government is currently assisting states with funding for tobacco control programs, the CPPW program was a one-time only grant and CTGs are subject to annual appropriations; thus, there is no guarantee that federal money will adequately fund state tobacco control programs in the long run. Considering that the progress of declining smoking rates is at risk, continued state level funding is necessary to maintain and increase progress in reducing tobacco use.

Federal Activity

The Family Smoking Prevention and Tobacco Control Act (FSPTCA), which gave the Food and Drug Administration (FDA) strong authority to regulate tobacco products and marketing, established a user fee program for tobacco companies to fund the FDA's activities. Tobacco companies pay annual fees based on a formula to the FDA Center for Tobacco Products (CTP) as a precondition of marketing tobacco products. These fees completely support the FDA's tobacco regulation so that annual appropriations are not necessary. Federal activities outside of the FDA, such as the tobacco control work of the CDC, are subject to annual appropriations from Congress.

More information on federal tobacco activities is available from the AAP Department of Federal Affairs.

Advocacy Considerations

- **States should consider increasing taxes on tobacco products, funding tobacco control programs at CDC recommended levels, and enacting smokefree workplace laws.** Tax increases on tobacco products can alleviate budget gaps along with providing revenue to fund tobacco prevention and cessation programs. Increasing tobacco excise taxes is linked to a decrease in tobacco use by adolescents and is recommended by the CDC in MAPPS as part of an evidence-based pricing strategy to reduce tobacco use. Because adolescents have limited incomes, increases in tobacco excise taxes make tobacco use appear less attractive. Combining tobacco excise taxes, prevention and cessation programs, and smokefree laws into a longstanding tobacco control program maximizes the

chance that tobacco use will continue to decline in the nation.

- **States can use both tobacco excise tax revenue and MSA money to fund tobacco control programs.** If states were to fund tobacco control programs using revenue acquired through tobacco excise taxes and through the MSA, most states would be able to meet CDC recommended levels using less than half of such revenue (*see Table 1*). Less than 15% of the $25.3 billion states will receive this year would provide adequate funding for tobacco prevention and cessation programs at CDC recommended levels. States that have sustained and well-funded prevention and cessation programs have managed to reduce smoking by 45-60%, which translates into saved lives and saved health care costs.
- **Investing in tobacco prevention and cessation programs could eliminate the costs of treating tobacco related illnesses if states provided adequate funding.** Cigarette smoking in the US accounts for $96 billion in health care costs and $97 billion in productivity losses each year, for a total cost of $193 billion per year. Additional costs include income diverted to purchase tobacco products and fires resulting from smoking. Funding comprehensive tobacco control programs can help curb these costs, as demonstrated by **California**'s long-standing tobacco control program. From 1989 to 2004, **California** saved $86 billion in personal health care costs while spending only $1.8 billion on its program, a 50-to-1 return on investment. **California** experienced these savings even in light of a massive funding cut during the mid-1990s. Had there been steady funding during that time period, researchers estimate that the state could have saved $156 billion. Considering **California** alone could have realized a savings of $156 billion with adequate tobacco control funding, if all states funded such programs at or beyond levels recommended by the CDC, the states could eliminate the $193 billion per year in tobacco related costs while saving even more money.
- **Cuts in the funding of statewide tobacco control programs have negative implications for adolescents.** According to one study examining adolescent exposure to tobacco control interventions in **Florida**, the state's TRUTH campaign (a statewide, televised campaign emphasizing the death toll of tobacco use) had a profound effect on the decline in smoking among adolescents. Specifically, within 2 years of initiating **Florida**'s Tobacco Control Program (which included the TRUTH campaign), adolescent smoking declined significantly, with much of the decline attributable to the TRUTH campaign. Unfortunately, budget cuts eliminated the TRUTH campaign in 2004, and subsequently, there were significant declines in adolescents' ability to recall the antitobacco ads. **Massachusetts** also experienced a negative impact when funding cuts to its tobacco control program preceded a 74% increase in illegal sales of cigarettes to minors. Considering that the TRUTH campaign had such a profound effect on the decline in teen smoking and that **Massachusetts** saw a rise in adolescent tobacco purchases after a cut in funding, budget cuts eliminating similar campaigns may deprive adolescents of effective antitobacco concepts they can apply when confronted with the opportunity to use tobacco.
- **Even in the midst of our current national economic and state budget crises, it is possible for states to implement effective tobacco control programs.** States that have had success in maintaining effective tobacco control programs during difficult economic times have had several characteristics in common:
    - strong and experienced leaders who are familiar with policy-making and who develop clear strategies and plans for maintaining funding;
    - broad and deep organizational and community ties, which include supporting local government efforts, voluntary and civic organizations, health professional societies, businesses, and community based organizations;
    - coordination of efforts (eg, different missions working together for maintaining tobacco control programs);
    - strategic use of surveillance and evaluation data;
    - active dissemination of information to a variety of audiences about program successes (ie, ensuring that audiences regularly receive information about tobacco control programs); and
    - policymaker champions (eg, they can play a role in negotiations and discussions about program funding). (http://www2.aap.org/richmondcenter/)
- **Comprehensive tobacco prevention and cessation programs work.** States will certainly experience results if they allocate an adequate amount of money to tobacco control programs. When adequately funded, tobacco control programs lead to a decrease in smoking prevalence, a decrease in consumption of tobacco products, and smoking cessation. At least one study has shown this to be the case and concluded that increases in the funding of such programs are independently linked with total reductions in adult smoking (which also has implications for adolescent smoking). Success in states with longstanding, comprehensive tobacco control programs justifies

investment in tobacco control programs. For instance, **California**'s program reduced its lung and bronchus cancer rates 4 times faster than the rest of the U.S. from 1988-2004. **Maine**'s program decreased smoking by high school students by 54% between 1997-2009. Additionally, between 1990 and 2000, **Arizona**, **California**, **Massachusetts**, and **Oregon** (states that contributed a significant amount of funding to tobacco control programs) saw a decrease of approximately 43% in cigarette sales compared with a 20% decrease in all states. Ultimately, with adequate funding of tobacco control programs, states have the potential to see a dramatic decrease in tobacco use and a dramatic increase in the health of their citizens.

Resources

AAP Julius B Richmond Center of Excellence
http://www2.aap.org/richmondcenter/

AAP Policy Statement – Tobacco: A Pediatric Disease
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;124/5/1474

AAP Tobacco Policy Tool
http://www2.aap.org/richmondcenter/TobaccoPreventionPolicyTool/index.html

Campaign for Tobacco-Free Kids – A Broken Promise to Our Children: The 1998 State Tobacco Settlement 12 Years Later
www.tobaccofreekids.org/content/what_we_do/state_local_issues/settlement/FY2011/StateSettlementReport_FY2011_web.pdf

Campaign for Tobacco-Free Kids – The Impact of Reductions to State Tobacco Control Program Funding
www.tobaccofreekids.org/research/factsheets/pdf/0270.pdf

Campaign for Tobacco-Free Kids – New Study Finds California's Tobacco Control Program Has Saved Billions in Medical Costs, Shows Why States Should Increase Funding for Such Programs (August 26, 2008)
www.tobaccofreekids.org/press_releases/post/id_1098

Campaign for Tobacco-Free Kids – US State and Local Issues: Prevention and Cessation Programs
www.tobaccofreekids.org/what_we_do/state_local/%0Bprevention_cessation/

Centers for Disease Control and Prevention: Communities Putting Prevention to Work
www.cdc.gov/CommunitiesPuttingPreventiontoWork/about/more.htm

Centers for Disease Control and Prevention: Community Transformation Grants (CTGs)
www.cdc.gov/communitytransformation/

Centers for Disease Control and Prevention. Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses – United States, 2000-2004. *Morbidity and Mortality Weekly Report*. 2008;57[45]:1226-1228
www.cdc.gov/mmwr/preview/mmwrhtml/mm5745a3.htm

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Davis, Kevin C., MA; Crankshaw, Erik, PhD; Farrelly, Matthew C., PhD; Niederdeppe, Jeff, PhD; Watson, Kimberly, BS. The Impact of State Tobacco Control Program Funding Cuts on Teens' Exposure to Tobacco Control Interventions: Evidence from Florida. *Am J Health Promot*. 2011;25[3]:176-178

Farrelly, Matthew, PhD; Pechacek, Terry F., PhD; Thomas, Kristin Y., MsPH; Nelson, David, MD, MPH. The Impact of Tobacco Control Programs on Adult Smoking. *American Journal of Public Health*. 2008; 98[2]:304-309

Institute of Medicine Report – "Ending the Tobacco Problem: A Blueprint for the Nation" (2007) – Recommendation 1

Nelson, David E., et al. Successfully Maintaining Program Funding During Trying Times: Lessons from Tobacco Control Programs in Five States. *J Public Health Management Practice*. 2007;13[6]: 612-620

Robert Wood Johnson Foundation – Report and Podcast: States Continue Drastic Cuts to Tobacco Prevention Programs (November 17, 2010)
www.rwjf.org/publichealth/product.jsp?id=71454

Robert Wood Johnson Foundation – New Report: States Slash Funding for Tobacco Prevention Programs to Lowest Level since Tobacco Settlement (November 17, 2010)
www.rwjf.org/pr/product.jsp?id=71501

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NOTE: Issue Briefs provide AAP chapters with an introduction to state government issues and additional background information that can be used when communicating with legislators or other public officials. While they are not intended as a presentation for, or to be distributed to, legislators, the media, or the general public, excerpts of nonstrategic information may be utilized in your advocacy work.

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Table 1

State	Percentage of Tobacco Tax Revenue + MSA Settlement Revenue Needed to Fund Tobacco Control Program at CDC Recommended Levels*
AL	23%
AK	13%
AZ	18%
AR	18%
CA	24%
CO	18%
CT	12%
DE	13%
DC	18%
FL	25%
GA	30%
HI	12%
ID	23%
IL	17%
IN	17%
IA	25%
KS	19%
KY	21%
LA	20%
ME	9%
MD	15%
MA	13%
MI	9%
MN	10%
MS	25%
MO	30%
MT	12%
NE	20%
NV	19%
NH	11%
NJ	12%
NM	23%
NY	15%
NC	35%
ND	21%
OH	11%
OK	16%
OR	13%
PA	11%
RI	9%
SC	62%
SD	23%
TN	27%
TX	25%
UT	26%
VT	14%
VA	34%
WA	12%
WV	17%

* Percentages represent the most recent data available from the CDC, which was derived from 2007. This chart depicts the minimum percentage of funds from both tobacco excise taxes and MSA money needed to adequately fund tobacco control programs according to the CDC. In most cases, less than 50% of funds acquired through tobacco excise taxes and the MSA would satisfy CDC recommended levels for tobacco control programs.

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