Have Our Settlement Funds Gone Up In Smoke?
The Master Tobacco Settlement, Use of Referenda & Tobacco Growing Status Ten Years After: A Four-State Comparison

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Forty-six states took part in the master tobacco settlement in 1998, the largest civil suit in U.S. history. Terms of the settlement did not require that the ensuing funds be spent on tobacco prevention and cessation, but public health advocates (Jones and Silvestri 2010) and the general public (Snyder et al. 2003) believed that such would be the case. The study compares Arkansas, Georgia, Mississippi and Tennessee in order to tell the diverse stories of how they have obtained and consequently spent their settlement dollars. The authors find that states that negotiated separately with the tobacco companies gained a great deal more money for their citizens, recommend that public health advocacy groups consider utilizing avenues of direct democracy, and note that tobacco-growing states spent considerably less money on tobacco control programs. Overall, some of these states are spending their settlement funds on public health matters; however, only Arkansas is presently doing so in a way that emphasizes tobacco control.

Introduction

Public policy is what government either does or does not do. It follows, then, that non-decisions are as worthy of analysis as the more newsworthy, proactive sorts of events commonly associated with governmental action. In this study, we choose to examine the actions and inactions of four states—Arkansas, Georgia, Mississippi and Tennessee—to see if there are lessons we may learn from the way they have chosen to obtain and spend their tobacco settlement monies. It has often been said that the states are laboratories for

democracy, meaning in part that they can serve as models for each other in determining what course of action to take and, conversely, not to take. Therefore, let us see what we can learn from these four states.

Tobacco Lawsuit Background. On November 23, 1998 the Attorneys General of 46 states settled a lawsuit with the five largest cigarette companies in the U.S. Mississippi, the first state to file suit against Big Tobacco in 1994, had settled previously and separately with the tobacco firms along with Florida, Minnesota and Texas.

The purpose of the lawsuit, the largest civil settlement in U.S. history, was for the states to recover monies spent under their individual Medicaid programs for smoking-caused and smoking-related expenses, which are by all accounts very high (Johnson 2004). Tobacco use is the leading preventable cause of death in the U.S. and kills between 440,000 and half a million people a year (CDC 2007). As the National Institute on Drug Abuse notes, this is "more than alcohol, cocaine, heroin, homicide, suicide, car accidents, fire, and AIDS combined" (NIDA 2003, p. 4).

At the time of the master settlement, cigarette manufacturers were still steadfastly claiming to have no knowledge of any effects of cigarettes either on smokers or, especially, on those around them. Technically, the Attorneys General who signed the settlement documents were not legally required to specify how their respective states would spend the money. Thus, the Master Settlement Agreement (MSA) actually does not restrict spending, leaving that matter up to the individual state legislatures. Figure 1 shows the amount each state will receive from its participation in the MSA, as in the case of Arkansas, Georgia and Tennessee, or its individual settlement, as in the case of Mississippi. However, in Mississippi, which negotiated separately from other states, the ways in which settlement money could be spent were specified. Mississippi Attorney General Moore viewed his victory on behalf of the state as implying a promise to spend settlement money on health-related programs when he later wrote, in his subsequent role as Chairman of The Partnership for a Healthy Mississippi (hereafter, "The Partnership"):

> I, as Mississippi's Attorney General, promised that we would spend an adequate portion of the settlement money on healthcare and tobacco prevention programs…. [T]here was almost an amendment to the law that would have required a set amount to be spent by each state on prevention and healthcare, but the Republican Governors argued states' rights and Congress acceded to our promise to spend the money on healthcare and prevention. (Partnership 2004, p. 3).

Thus, the Mississippi agreement *In Re Mike Moore* (1997) contains a section on the use of funds and stipulates that settlement funds are "reimbursement for public health expenditures made by the State of Mississippi" and that "the parties hereto anticipate that funds provided….will be used for health-related expenses of the State of Mississippi" (*In Re Mike Moore*, 1997, pp. 12-13). The MSA, on the other hand, does not contain similar language (*Master Settlement Agreement,* 1998).

Our goal is to learn from the allocation decisions used for tobacco settlement funds as utilized by four states. In addition to (1) comparing the states by whether they were part of the MSA or not, our primary research questions are: (2) by what means did they make their allocative decisions, and (3) what kinds of programs or level of programming are they supporting?

Literature

We did not find specific literature addressing how MSA participants fared versus the four states, including Mississippi, which negotiated separately. There are generally efficiency advantages to joining class actions as opposed to waging lawsuits individually. We were also unable to find studies specifically on the use of direct democracy by public health/tobacco control advocates. However, there is a voluminous literature on the use of direct democracy in general. Overall, initiatives are being used more than they were in the previous century (Macomber 2004). Political scientists

debate whether or not direct democracy makes government more responsive to public opinion (Bowler, Donovan and Karp 2007) or is an example of the excesses of mob rule (Macomber 2004; *Economist* 2011) and the kinds of factions feared by James Madison.

As far as the kinds of programs that have been chosen by the different states, we can roughly measure state activity levels by noting which of the CDC-recommended elements of comprehensive tobacco control programs they have in place. The CDC's recommendations for a comprehensive tobacco control program encompass nine elements. The most significant of these are (1) restricting youth access to tobacco, (2) passing clean air laws, (3) funding prevention and cessation programs, and (4) raising tobacco excise taxes (CDC 1999, 2007).

There is a vast related literature on whether tobacco control programs are effective at reducing smoking. There are too many studies to review in great detail here. Much of the prior research on tobacco control as a public policy has focused on the effectiveness of tobacco control programs in single states, particularly those with longer-term tobacco control programs in place like California (Fitchtenberg and Glantz 2000; Messer et al. 2007). On the other end of the spectrum, there have been several international analyses of the effects of various tobacco-related policies (Wakefield et al, 2008; Chapman, 2007; Fernando, 2007). There have also been some multi-state public health overviews and technical reports, most notably by The Campaign for Tobacco-Free Kids, and a few large studies that have attempted to tease out the effects of tobacco control program spending on public health by controlling for other factors (Tauras et al, 2005; Farrelly et al., 2008). Thus, analyses focus more on the effectiveness of tobacco control programs or policies rather than the methods by which spending decisions were reached. These studies thus ask questions such as, "Does tobacco control spending affect smoking rates?" or, alternatively, a similar question may be asked regarding exposure to secondhand smoke.

Overall, scholarly research strongly suggests that tobacco control programs negatively influence how much people smoke, particularly for young, non-college educated adults (Farrelly et al. 2008, Gilpin et al. 2006, Messer et al. 2007, Rowan 2008, and Tauras et al. 2005). There are several areas of future policy direction suggested by the literature, including addressing exposure to secondhand smoke in cars, multi-family dwellings, and outdoor public spaces (Eriksen and Cerak 2008). Leadership from top-level government officials is key to implementing new public health initiatives in these areas. A lesson that can be drawn from international

experience is that eliminating the "bar exception" to some states' tobacco control laws would have a significant reductive effect on secondhand smoke exposure for those who work in or otherwise frequent them (Koh 2007; WHO 2008; Wakefield 2008; Fernando 2007). Overall, raising tobacco excise taxes and regular exposure to anti-smoking media campaigns appear to be leading effective strategies to influence tobacco consumption.

Goals and Diversity of the Study States

The literature thus defines tobacco use as a public issue in that individuals smoking cost society financially and in other ways. What these four states—Arkansas, Georgia, Mississippi and Tennessee--have in common is that they all have relatively high smoking rates and associated healthcare costs (see Table 1 for detail). They all, therefore, have a need to take care of their citizens by reducing tobacco dependence. The four states are attempting to do this to varying degrees.

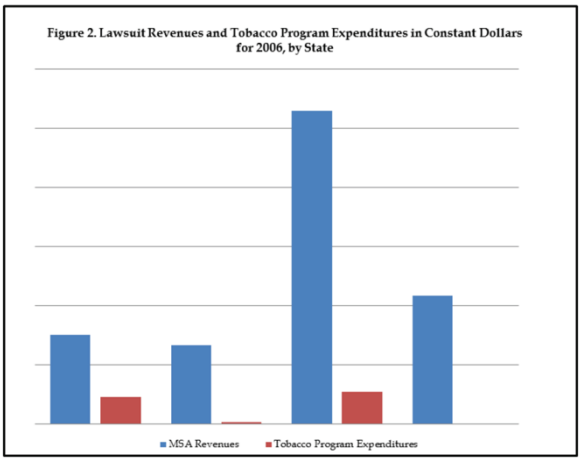
Table 1. Estimated Select Smoking-Related Data by State

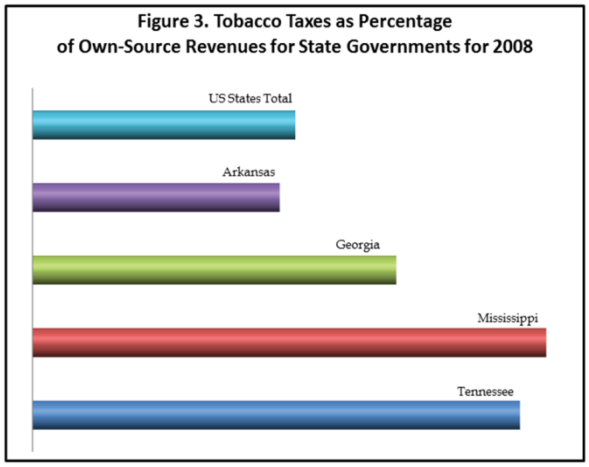
	AR	GA	MS	TN	US States Total	Per State Average
Annual Deaths from Smoking	4,900	10,300	4,700	9,500	443,000	8,860
Annual Medical Costs from Smoking	$812M	$2,252M	$719M	$2,166M	$95.9B	$1.9B
FY 2006 Tobacco Settlement Payment	$48.3M	$143.2M	$100.5M	$142.4M	$24.6B	$500M
CDC-Recommended Spending (A)	$36.4M	$116.5M	$39.2M	$71.7M	$3.70B	$74M
Current/Actual Annual Spending (B)	$16.9M	$3.2M	$10.7M	$6.1M	$718.1M	$14.4M
FY 2009 "B" as a Percentage of "A"	46.4%	2.7%	27.3%	8.5%	19.4%	19.5%
FY 2009 National Rank in Spending	10	50	23	40	—	—

SOURCES: First four rows of data from Centers for Disease Control. Best Practices for Comprehensive Tobacco Control Programs – 2007. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control, 2008. Last three rows of data derived from *A Decade of Broken Promises: The 1998 State Tobacco Settlement Ten Years Later*. Campaign for Tobacco-Free Kids, American Heart Association, American Cancer Society Cancer Action Network, American Lung Association and Robert Wood Johnson, November 2008.

Figure 2 shows MSA (or individual lawsuit, in the case of Mississippi) funds from 2001-2006 by state, along with amount spent by the states on tobacco-related expenditures. Note that all figures are constant and per capitized. The amount of money taken in by the states from tobacco lawsuits

is not used much, overall, for tobacco-related expenditures. The situation would appear worse if we showed MSA revenues plus tobacco excise tax





revenues versus tobacco program expenditures.[2] Furthermore, tobacco taxes do not at present amount to much more than 1.5% of own-source revenues for any of our four states or for the U.S. average, as Figure 3 shows.

[2] This latter approach is usually utilized by the aforementioned Campaign for Tobacco-Free Kids, and in our estimation serves mainly to make the states look artificially bad since tobacco excise tax revenues were hardly dedicated to anything but general purposes when they were initially implemented by the states.

Methods

Our original interest grew out of a desire to compare the states of Arkansas and Mississippi—two neighboring states that often interchangeably occupy the 49th and 50th places on many socioeconomic or quality-of-life indicator lists. Our initial assumption was that these two states, which have much in common, would support similar levels of tobacco control programming. However, we soon found that this was not the case. Our focus turned to an interest in understanding the policy differences between these states. It is a central requirement of case study research that in order to try and generate understanding of a dependent variable, in this case level of tobacco control programming, one must ensure that there is some variation in said dependent variable (Yin 2009). Georgia and Tennessee were added to the study to gain the dimension of tobacco growers on the dependent variable. In addition, Mississippi is a non-MSA state and the other three are MSA states and, as far as we have observed, no one has previously compared those categories of states. Our goal is to try and understand the differences in policy choices that these states have made by reviewing public records, in-house documents where available, news coverage, in-house program participation, external program evaluations, and external comparative financial data. In so doing, we hope to analyze the actions and inactions of four states over the post-MSA decade—1999-2008--in a bit more depth than permitted under multistate research designs and report card-style listings.

Thus we are using a Most Similar Systems Design Study (MSSD). The states we selected—Arkansas, Georgia, Mississippi and Tennessee—all share similar political, social and institutional structures. Borrowing from comparative politics research, which is more often utilized in comparisons of different countries, we apply the idea here by determining and isolating factors that account for differences on how each of these states dealt with tobacco settlement issues. By examining the histories of each state as they dealt with tobacco money, we hope to determine what factors led the states to adopt divergent strategies and programs. This research design is often used in seeking to identify features or variables that are different among similar cases, which account for the observed political outcomes (see Landman 2008; Mill 1973).

Table 2 provides a variety of tobacco program data by state. The four states are compared on how close they come to the CDC's recommended tobacco spending target, whether they have a smoke-free law, the amount of their tobacco excise taxes and whether those have increased in the

intervening decade, and whether their tobacco control programs are independently valued or not. In addition, the four states are compared on their position on the National Cancer Institute's Youth Access Ratings. These ratings range from 5 to 29, where a higher number indicates greater difficulty in youth accessing tobacco in a state (National Cancer Institute, 2006). States are also compared as to whether they have state tobacco-free school laws and smoke-free car laws, both of which are relatively recent innovations in comprehensive tobacco control programming (Summerlin-Long & Goldstein, 2008).

Table 2. Comparison of Arkansas, Georgia, Mississippi, and Tennessee Across Selected Comprehensive Tobacco Control Elements, 2009

	State			
Program Element	**AR**	**GA**	**MS**	**TN**
Comprehensive Tobacco Control Program	Yes	No	No	No
Prevention Program Spending at ____% of CDC Recommendation	84.3%	5.4%	0.0%	0.0%
State Smoke-Free Law & Year Effective	2007	2006	None	2008
Tobacco Excise Tax Per Pack Compared to Federal Median of $.80 for 2007	$.59	$.37	$.18	$.20
Increases in Tobacco Excise Rate from 1999-2007	$.29	$.25	None	$.07
Restriction of Access to Minors Code*	16	15	6	12
State Tobacco-Free School (TFS) Law**	Yes	No	Yes	No
State Smoke-Free Car Law	Yes	No	No	No
Programs Independently Evaluated	Yes	No	No	No

Notes: Data derived from American Heart Association, American Cancer Society, Campaign for Tobacco-Free Kids, and American Lung Association. A Broken Promise to Our Children: The 1998 State Tobacco Settlement Eight Years Later. Washington, D.C., 2006.

**Youth Access Ratings are from the National Cancer Institute, State Cancer Legislative Database Program, Bethesda, MD: 2006. The 2006 range on youth access ratings is from 5 to 29, where a higher number indicates greater difficulty in youth accessing tobacco in a state.*

***TFS designations compiled from Summerlin-Long, Shelley K. and Goldstein, Adam O. "A Statewide Movement to Promote the Adoption of Tobacco-Free School Policies." Journal of School Health 78(12): December 2008: 625-632.*

Our research questions, which all involve the central question regarding how these four states chose to spend their tobacco settlement monies, are as follows: (1) do MSA states support similar tobacco control funding/ programming levels to non-MSA states? (2) how did the four states make their allocative decisions? And (3) what kinds of programs or level of programming are they supporting?

The histories of these four states are examined with an eye toward focusing on the four primary elements of a comprehensive tobacco control program by the CDC: (1) restricting youth access to tobacco, (2) passing clean air laws, (3) funding prevention and cessation programs, and (4) raising tobacco excise taxes (CDC 1999, 2007). We expect that correlative research questions will be suggested by our narratives describing each state's decade-long history of spending its tobacco lawsuit monies.

Arkansas. Arkansas is the only one of the four states that has a relatively comprehensive tobacco control program at present. In Arkansas the people of the state voted via referendum on how its MSA monies should be spent. Specifically, Initiated Act 1 of 2000 was spurred by a white paper by the Health Policy Board of the Arkansas Center for Health Improvement, which noted that Arkansas had the third-highest proportion of adult smokers in the U.S. (ACHI 2009). The paper was presented to the governor and leaders of the state legislature, which then resulted in a group called the Coalition for a Healthier Arkansas Today or CHART that developed a plan for spending the MSA funds on the health of Arkansans. The legislature was called into special session in 2000, but did not endorse the CHART proposal. Subsequently CHART, led by the governor, introduced the Tobacco Settlement Proceeds Act and it was passed by 65% of the people of the state (ACHI 2009). Progress toward meeting short- and long-term goals is assessed by an independent evaluator (RAND Corp.) each biennium for the seven programs, which are overseen by the Arkansas Tobacco Settlement Commission or ATSC. The programs, along with their corresponding funding levels for fiscal year 2006, are presented in Table 3 along with the funding for administering the ATSC itself.

Only the first program, the Tobacco Prevention and Education Program or TPEP, is solely dedicated to tobacco control but it does receive a little over 30% of the state's MSA funds (Farley et al. 2007, p. xv). For the most part, the biennial evaluation prepared by the RAND Corp. indicates that Arkansas' tobacco control and otherwise health-related programs are making at least satisfactory progress toward achieving their stated goals, with a few exceptions particularly noted in the TPEP program.

Table 3. Seven Components of Arkansas' Initiated Act For Tobacco Master Settlement Agreement Funding—FY 2006 Funding Including for the Tobacco Settlement Commission

I. *II.* **Program**	**III. Funding**
Tobacco Settlement Commission (ATSC)	$ 969,000
Tobacco Use Prevention & Education (TPEP)	$15,097,000
Medicaid Expansion (MEP)	$14,237,000
Arkansas Biosciences Institute (ABI)	$10,892,000
College of Public Health (COPH)	$ 2,491,000
Minority Health Initiative (MHI)	$ 1,736,000
Delta Area Health Education Center (Delta AHEC)	$ 1,661,000
Arkansas Aging Initiative (AAI)	$ 1,661,000
Total	**$47,774,000**

SOURCE: Farley, Donna O.; Engberg, John; Carroll, Brian; Chinman, Matthew; D'Amico, Elizabeth; Hunter, Sarah; Lovejoy, Susan; Shugarman, Lisa R.; Yu, Hao; and Kahan, James P. Evaluation of the Arkansas Tobacco Settlement Program: Progress during 2004 and 2005. Arlington, VA: RAND Corporation, 2007, p. xvi.

The evaluators found that, "smoking has decreased substantially among middle school and high school students since programming began." (Farley et al. 2007, p. 215). The evaluation highlights consequently say, "Tobacco Settlement programming has reduced smoking among young people compared with what would be expected based on pre-program trends." (Farley et al. 2007, p. 215) However, it may be that smoking among young adults is declining for other reasons not controlled for by the Youth Tobacco Survey (YTS) analysis conducted by the Arkansas Division of Health (ADH), upon which the RAND evaluation is based. The decline in smoking rates is dramatic—a 41.9% decrease from 15.8% in 2000 to 9.3% in 2005 for middle school students, for example—but one may not infer causation from a trend.

Other highlights of the TPEP evaluation include an improvement in legal compliance with state laws prohibiting sales of cigarettes and other tobacco products to minors, an ambiguous result on whether adult smoking has declined, an unclear result on whether localities in the state with the most TPEP activity have fewer smokers than those without much TPEP activity, and "declines in the prevalence of a variety of diseases that are affected by smoking and by secondhand smoke….strongest in the cases of strokes and acute myocardial infarctions (heart attacks)." (Farley et al. 2007, p. 215). Regarding the improvement in compliance with state laws prohibiting sales to minors, which is one of the key components of a successful comprehensive tobacco control program according to the CDC,

the evidence is that in Arkansas a great increase in law enforcement has yielded a much lower overall violation rate. The state has fairly strong minor access laws in place but had not been adequately enforcing them in the past (National Cancer Institute 2006).

As far as the ambiguous results on adult smoking are concerned, the biennial evaluation's authors and the state's politicians are waiting for clear results (see Farley et al., 2007 and Smith, Democrat-Gazette 11.17.06). In some prior case studies of comprehensive tobacco control programs, particularly in the case of California, results were seen earlier than 5 years. However, the evaluators for Arkansas posit that the state's smaller size and the fact that it had no statewide smoke-free law in place (like California did) at the onset of its tobacco control program may account for Arkansas's lack of clear results. According to the state's own data, Arkansas is one of the top ten states in the U.S. for tobacco use, although around half of smoking Arkansans attempted to quit in 2007 (UAMS April 2008).

Like many other states of late, Arkansas passed a statewide smoke-free law (Act 8, "The Arkansas Clean Indoor Air Act of 2006"), along with a statewide ban on smoking in vehicles when anyone in a child restraint is riding (Act 13, "An Act to Protect Children Restrained in Arkansas from Secondhand Smoke"); both were passed during a special legislative session called by Governor Mike Huckabee in 2006 and became effective in 2007. Thus, if the RAND evaluators are correct, the state may show results for adult smoking rates in the next few years. Traditionally, workplace smoking bans are associated with a modest decrease in statewide smoking (Fitchtenberg & Glantz 2002). However, the decrease is generally not as great if exceptions are made to that ban for smoking in bars and restaurants, as is the case in Arkansas, where smoking is still allowed in bars and restaurants that prohibit those under 21 years of age from entrance at all times.

Arkansas was the first state to pass a law to ban smoking in cars when children are present (Act 13, the Arkansas Protection from Secondhand Smoke for Children Act of 2006). As of 2007, the movement to ban smoking in cars when children are present includes only four states, Puerto Rico, and four communities thus far in the U.S. Arkansas' law is the weakest of the state laws; specifically, it bans smoking in a car when a person under the age of 6 and weighing under 60 pounds in a child safety seat, where Louisiana, California and Maine ban smoking in cars with persons under age 13, 16 or 18 (Americans for Nonsmokers' Rights, 2009).

Increases in tobacco excise tax rates are associated with relatively minor smoking decreases, particularly among youth. States have been increasing their tobacco excise tax rates of late; the average state cigarette tax rate in 2003 was $.68 per pack and today it is $.83 per pack (see Farrelly et al. 2003 and American Heart Association et al. 2006). The CDC recommends an increase in state tobacco excise taxes as a cornerstone of its "best practices" for tobacco control (CDC 1999). Accordingly, Arkansas has raised its rate twice in recent years but, like much of the South--where the bulk of U.S. tobacco is grown, although not in Arkansas--its rate remains below the national average (Federation of Tax Administrators 2007).

If the four key components of the CDC's recommended program elements are

- promoting tobacco prevention and cessation,
- implementing statewide smoke-free laws,
- raising tobacco excise taxes, and
- curbing youth access to tobacco,

then Arkansas seems to be on track. Specific recommendations for improvement are to enhance the programs and funding of the tobacco prevention and cessation programs, eliminate the bar exception on the statewide smoke-free law, and raise the excise tax on tobacco further. The state is spending over 80% of its CDC-recommended minimum funding level and the state has much to commend its referendum-based approach to deciding the funding issues; still, there is a fairly long way to go, as most recent research and evaluation indicates.

> IV. **Georgia.** We included Georgia in our analysis because it is a tobacco-growing state, as indicated previously. Georgia has devoted much of its settlement funding to shoring up the economic position of its tobacco farmers. The state ranked 44th in the nation in terms of its financial commitment to tobacco control according to the Broken Promises Report issued in 2007; by 2008's report, only one state in the U.S. funded tobacco prevention and cessation at a lower rate, South Carolina.

Specifically, one third of the state's MSA funds go to the One Georgia Fund, which was established to fund economic development in the state, with an initial particular focus on economic development for tobacco-growing regions. Decisions about the remainder of the funds are primarily made by the governor and go into the state's general fund, with around half

of the funds used in FY 2007 to support Medicaid expansion and other health-related concerns. Originally, then-Governor Roy Barnes committed a greater portion of MSA funds to tobacco control, but the current governor, Sonny Perdue, has not done the same. Under Governor Barnes the plan was for the state gradually to attain its CDC-recommended minimum funding goal for maintaining a tobacco control program. Even under his administration, though, that commitment was eventually eroded. Under the Georgia Cancer Coalition a Smoking Prevention and Cessation Program was funded at $12,482,622 for FY 2005 but that was recommended for a dramatic cut to $3,205,245 for FY 2006. The state does fund a tobacco quit line (Atlanta Journal-Constitution December 25, 2003). However, state funding for its media campaigns advertising the quitline has been reduced so that comparatively few Georgians use it (3,595 in 2007) now as opposed to five years ago (23,000) (Schneider 2008, p. 2).

Overall, the state spent less than 1 percent of its MSA funds collected in 2008 on preventing tobacco use, leading the president of the Campaign for Tobacco-Free Kids to call Georgia "one of the most disappointing states" in the nation at preventing youth smoking (Schneider 2008, p. 2). A report by the Georgia Budget and Policy Institute in October 2008 called the state's rate of tobacco prevention funding "particularly low," only declining in recent years despite increasing smoking-related health care costs (Sweeney and Ray, 2008).

As far as the big four program components recommended by the CDC—restricted youth access, increased excise taxes, smoke free laws, and prevention and cessation programs—Georgia does not rate well. The state's minor access code is 15 out of a range up to 29, and this is the state's strongest suit (Youth Access Ratings from the National Cancer Institute, 2006). The state's cigarette excise tax is at .37 per pack, well below the national median of .80 but in company with the rest of the South, particularly the other tobacco growing states. The state did pass a statewide smoke-free law in 2005 (American Heart Association et al., 2006). Finally, as mentioned, the state has reduced the funding of its prevention and cessation programs dramatically of late.

Mississippi. The most dramatic story in this group of states belongs to the Magnolia State. It was Mississippi's Attorney General Mike Moore who led the nation in 1994 to sue the tobacco industry on behalf of the state's taxpayers for punitive damages.

The actions of some of the state's officials make it ironic that Mississippi became the early leader of the battle against big tobacco. Specifically, after Attorney General Moore filed suit, Governor Kirk Fordice filed suit against Moore for filing suit without asking the governor's permission. The lawsuit was filed at the request of a lobbyist for Phillip Morris, the large tobacco firm. The Mississippi Supreme Court dismissed that case in 1997 (Givel and Glantz 2002).

Initially a trust fund was created for tobacco lawsuit monies with the proceeds to be spent on health and tobacco control (*In Re Mike Moore*, 1994, pp. 12-13). A Jackson County Chancery Court order was in place by 2000, designed to protect The Partnership and its programs. During the early years of the new century, Mississippi was repeatedly recognized for its leadership, research, work and progress in tobacco control.

Subsequent governors and other high officials of the state continued to want to divert the tobacco trust monies to other uses, most successfully a large Medicaid bailout that occurred in 2003 when House Public Health and Welfare Chairman Bobby Moody stated that there was just no other place to get the money needed to keep the program running (Sawyer Jan. 10, 2003).

Eventually Attorney General Mike Moore was persuaded to ask the Chancery Court to continue to fund The Partnership. Next, Governor Haley Barbour, a former tobacco lobbyist, requested that the legislature study the issue of whether the Chancery Court order to continue The Partnership's funding was legal. In a report entitled, "A Review of the Legality of the Chancery Court Order Directing Annual Payments of Twenty Million Dollars in Perpetuity to the Partnership for a Healthy Mississippi" (2003), the Joint Legislative Committee on Performance Evaluation and Expenditure Review or PEER recommended that the State Attorney General request that the Chancery Court Order be dissolved. Thus, The Partnership's legal protection was eliminated by state officials and with it the last barrier to a major raid on its funds.

The tobacco lobby is very powerful in Mississippi in comparison to other states. As a study of the power of the tobacco lobby in the state in the 1990s asserts

> Due to the power of the tobacco lobby, state clean indoor [air] legislation has remained very weak. The one major exception was a bill enacted in 2000 that prohibited tobacco use on all school property including teachers' lounges and at athletic events. Major lobbying for this bill came

from youth associated with Partnership for a Healthy Mississippi programs. (Givel and Glantz 2002, p. 4)

Regarding the four key components of the CDC's recommended program elements—reducing youth access to tobacco, promoting tobacco prevention and cessation, implementing statewide smoke-free laws, and raising tobacco excise taxes—Mississippi is not a strong performer in recent years. Mississippi's laws for restricting tobacco access to minors are rated only a 6 on the scale developed by the National Cancer Institute. In contrast, Arkansas rated a 16 and Georgia a 16. In addition, Mississippi has not raised its excise tax on tobacco in many years. Governor Barbour vetoed a big tax swap proposed by the state legislature in 2006 that would have raised the cigarette excise tax from $.18—among the lowest in the nation—to a higher rate in return for a reduction in the portion of the general sales and use tax that is currently applied to food. The measure failed. Unlike the other states in this sample, Mississippi has not passed a statewide smoke free law. A smoke-free law and a cigarette tax increase to $.82 were introduced in the state House in early 2009; by the end of the legislative session, the tobacco tax had been increased by $.50 although the smoke-free law did not pass (RWJF, 2009).

Finally, the status of the state's once-comprehensive tobacco control program has been up in the air since the legislature and governor preempted the tobacco control trust fund proceeds in 2006. There will be an Office of Tobacco Control in the Health Department controlled by a Board of Directors called the Tobacco Control Advisory Board. During 2008, the first year in which the state legislature had the authority to appropriate funds that originally went to The Partnership, planned appropriations include $8,000,000 for the Health Department's program and another $650,000 for the statewide tobacco cessation program.

Tennessee. Tennessee is a tobacco-growing state; it is a state that has devoted almost none of its tobacco settlement monies to tobacco control. Tennessee has used its MSA funds—or approximately 99.9% of them--to put into its General Fund in order to balance the budget. Two smoking residents of the state attempted—unsuccessfully--to have its MSA funds legally set aside because they thought the people of the state who were injured by tobacco should be compensated before the state should be allowed to use the funds to balance its budget (Gerome, 2002).

The four key elements of the CDC's recommended program elements for a comprehensive tobacco control program are (1) promotion tobacco

prevention and cessation, (2) implementing statewide smoke-free laws, (3) raising tobacco excise taxes, and (4) curbing youth access to tobacco. Tennessee is middle-of-the-road of this group on its restriction of youth access to minors, with a 12 on the scale out of a possible 29 points; Mississippi only scored 6 points on the scale, while Arkansas and Georgia both scored sixteen. The state's tobacco excise tax rate per pack was $.20 until 2008 when it was raised to $.62, making it 36th in the nation. The state did pass a new smoke-free law that took effect in 2008. The state also funded a smoking cessation program in 2008 at $10,000,000 but cut that funding in half for 2009 (Memphis Business Journal, 2008); these expenditures are small by comparison to any state but Georgia.[3]

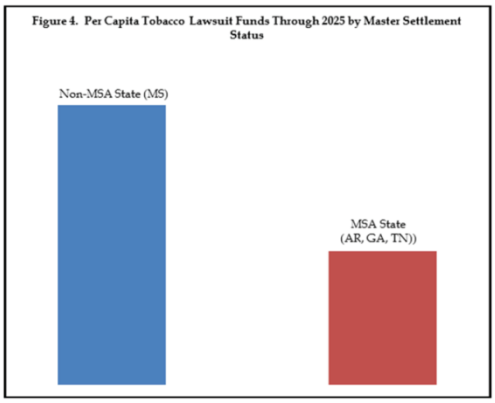
Comparison

Hypotheses. The diversity of these four states lends itself to comparison (see Table 2 for comparative data). Specifically, the history of each of the four states' tobacco settlement spending in the decade following the MSA suggests the need for additional comparisons to those originally posited. We now have a sense of how the four states compare to each other in a general way. The literature combined with the four individual case histories suggests the following null hypotheses:

> *H_1: A state that negotiated its tobacco lawsuit individually will support similar levels of tobacco control programming to states that took part in the MSA, as measured by per capita tobacco lawsuit funds through 2025 (the latest year for which forecasted funding figures are available).*
>
> *H_2: A state that utilized a public referendum to decide how to spend its tobacco settlement funds will support similar levels of tobacco control programming to states that did not utilize referenda, as measured by fiscal year 2009 tobacco control spending.*
>
> *H_3: States that are tobacco growers will support similar levels of tobacco control programming to states that are not tobacco growers, as measured by fiscal year 2009 tobacco control spending.*

[3] It may appear that we are giving the Volunteer State short shrift. In actuality there is very little to report regarding the state of Tennessee.

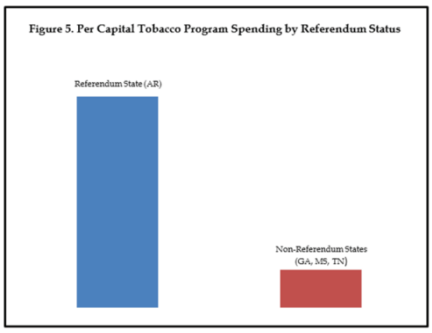
Results. *H_1: Lawsuit Status.* Mississippi is the only state in the group that settled separately with the big four tobacco companies. In addition then, Mississippi is the only state in this group that started out ten years ago with a restriction on how its settlement funds could be spent; specifically, as noted, settlement funds must be spent to benefit the public health. As a result of the work of then-Attorney General Moore, Mississippi enjoys substantially greater tobacco lawsuit funds on a per capita basis, as shown against an average of Arkansas, Georgia and Tennessee's settlement funds in Figure 4. Whether the additional settlement monies are worth the time and other valuable resources that would have to be devoted to pursuing an individual lawsuit is something each state has to decide on its own, weighing total costs and benefits of each course of action. As the results are clear and statistically significant, H_1 is disproved.

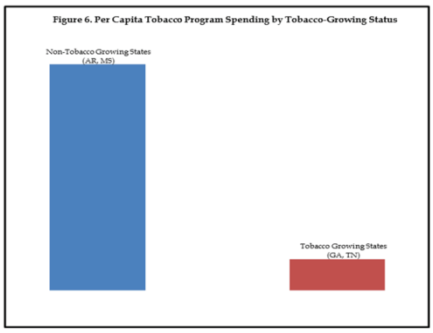


H2: Referendum Status. Arkansas is the only state that resolved its funding dilemma by utilizing an initiative. Arkansas is also the only state that has consistently maintained a comprehensive tobacco control program throughout the ten years since the settlement was passed. Tennessee merely uses the money obtained through the MSA for general funds. Mississippi gained a great deal more tobacco lawsuit revenue than the other states in our study on a per capita basis; however, in recent years little has been spent in that state on tobacco control. Georgia hardly tries to run a tobacco control program. Figure 5 compares per capita program spending for Arkansas against an average of program spending in fiscal year 2009 dollars for the three non-referendum states, Georgia, Mississippi and Tennessee. In around half of the U.S. states voters can pass popular referenda or initiatives on their own (Smith et al., 2008). It stands to reason that winning a lawsuit is only part of the battle; deciding how the money is to be spent is an area of policy

development that needs to be given more attention by public health advocates. As the results indicate, H_2 is also disproved.

H_3: Tobacco Growing Status. This study has two tobacco growing states and two non-tobacco growing states. Figure 6 shows an average of FY 2009 tobacco program spending for the two tobacco growing states (Georgia and Tennessee) against the two non-tobacco growing states (Arkansas and Mississippi). As the results show, the two groups are strongly different, so H_3 is also disproved.





Conclusions and Policy Implications

States that negotiate lawsuits on their own behalf rather than joining in with others may get more money for their citizens. This could be valuable knowledge in an almost certainly litigious future for cash-strapped state governments. In addition, public health advocacy groups in the future may benefit from the knowledge that their leadership may help persuade citizens to become partners in the quest for improved public health via the initiative process. It may be beneficial to utilize avenues of direct democracy where allowed in order to advance public health concerns.

Tobacco settlement funds were not initially restricted except in Mississippi, where they were to be used for public health. Whether a state had restricted the use of settlement funds or not may not be as significant for the public health as what state leaders decided to do with the funding after they got it. Thus, in Arkansas funds were not restricted under the terms of the MSA but restrictions of a sort were later put into place by the people of the state via the initiative process. Presently, Arkansas is one of only five states in the nation to which the American Lung Association gave passing grades in tobacco prevention in a recent report (Reiburg 2011). Thus, what

Arkansas does may be regarded as a "best practices" category as regards the use of public health funds.

Research shows that preventive measures taken now by the states would pay off for the states in reduced Medicaid and other related health care costs later (Rowan 2008). On the other side of the coin, the benefits from smoking prevention and cessation programs claimed by public health analysts need a fuller examination. Spending money on a public problem will likely will help in some way, but it may be that smoking rates are declining for reasons other than the smoking programs in place in some states.

Limitations of the study include that results from these four states may not generalize to the remaining 46 states. We hope to give suggestions here about how and why spending decisions were made in the post-MSA decade

The Future. Was the tobacco MSA a harbinger of future attempts by the states to recoup other health-related costs? We have already seen many lawsuits against pharmaceutical manufacturers. Perhaps dairy farms, fast food restaurants, automobile manufacturers, and other companies might be held liable in the future for health-related costs to society (see Brownell & Warner 2009); perhaps other nations will file lawsuits against big tobacco as well. Cigarettes would have to cost somewhere between $11 and $25 per pack—depending on which estimate you believe—for society to fully recoup their costs (American Heart Association et al., 2008).

The MSA states received a large funding increase—called the 2008 bonus payments, in the amount of $1 billion per year--beginning in April 2009 (American Heart Association et al., 2008; Campaign for Tobacco Free Kids email 2009). These increases were absorbed into most states' general funds. These additional monies would have been sufficient in many states to fully fund tobacco control programs at CDC-recommended levels and were added to state coffers with little fanfare, public acknowledgement, or media scrutiny.

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