Thoughtful Analysis...Responsible Policy

Examining How Georgia Spends Tobacco Settlement Revenues

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Since FY 2001, the tobacco Master Settlement Agreement (MSA) has been a significant funding stream for Georgia, with a total of $1.5 billion in revenue from FY 2001 through 2009. While Georgia spends its MSA funds in a variety of ways, including a significant portion on health care costs, the state has allocated a relatively small amount to smoking prevention activities. Furthermore, the state's smoking prevention allocation has declined in recent years, despite increases in tobacco-related revenues and health care costs attributable to smoking. Currently, Georgia's smoking prevention spending is far below levels recommended by the Centers for Disease Control and Prevention and also behind most other states.

Master Settlement Agreement Background

The tobacco Master Settlement Agreement (MSA) was the largest civil settlement in U.S. history and was negotiated and signed in November 1998 by 46 U.S. States, several U.S. Territories, and the four largest tobacco companies: Philip Morris USA, R.J. Reynolds Tobacco Company, Brown & Williamson Tobacco Corp., and Lorillard Tobacco Company.[*] The agreement was the product of several separate legal actions brought by individual states against the tobacco industry for Medicaid and other publicly borne costs associated with smoking-related diseases.[1]

Under the terms of the settlement, the settling tobacco companies received an exemption from past, present, and future tort liability while agreeing to:

- Make sizeable annual payments to settling states,
- Revise advertising and marketing practices to reduce underage smoking, and
- Finance a national foundation dedicated to public health interests.

Annual payments to the states under the MSA are technically perpetual, though the initial payment schedule lays out 25 years of payments that exceed $200 billion by 2025. Individual state payments depend on the number of Medicaid recipients, the cost of medical services, and the amount each state contributed to Medicaid coverage historically. Future year payments were not specified in the MSA; instead, they are based on a formula that adjusts the initial allocations based on inflation and cigarette sales.[2] Because domestic cigarette sales by the four settling tobacco companies have declined since the MSA was reached, annual payments to states have also declined.

In addition to payments, the MSA mandates certain marketing restrictions, including prohibiting the use of tobacco billboards and transit ads, the use of cartoon characters to promote tobacco products, the placement of tobacco brand names on some merchandise (e.g. hats, t-shirts), and tobacco brand

[*] Mississippi, Florida, Texas, and Minnesota settled their state lawsuits against the cigarette companies independently prior to the MSA. These individual settlements have their own language and provisions.

sponsorship at certain events.[3] Finally, the agreement required the tobacco companies to contribute $300 million a year for five years (from 1999 to 2003) to the newly created American Legacy Foundation as part of a public education program to reduce underage tobacco use and educate consumers about the causes and prevention of diseases associated with the use of tobacco products. The American Legacy Foundation funds small grants to states with tobacco prevention programs and is responsible for national anti-smoking media campaigns, such as The Truth®.[4]

Intent of MSA Funds

The MSA did not include any language specifically mandating how states spend their settlement awards. Thus, states are legally free to use MSA funds for any purpose. However, strong language written into the MSA indicates that states are expected to spend a significant portion to prevent and reduce tobacco use, especially among youth.[5] According to a legal brief filed by 37 state and territorial Attorneys General, "the [MSA] payments were intended to provide general monetary relief to the States, including past and prospective relief to the States for actual harm caused by cigarette smoking and to fund anti-smoking public health and educational programs."[6]

MSA Spending in Georgia

Georgia is one of only a few states that have not earmarked MSA payments for restricted use.[7] Instead, decisions on the use of MSA payments have historically been made by the Governor, though are officially subject to the annual appropriations process. As a result, the specific allocations of MSA funds vary from year to year, though the general categories have remained consistent. The chart below summarizes the allocation of MSA funds for FY 2009, while the following section examines MSA spending in the last several years in more detail.[8]

Figure 1

2009 Tobacco Settlement Allocations
(in millions)

Smoking Prevention, $2.3
OneGeorgia, $47.1
Health Care Services, $74.7
Cancer Related Programs, $35.0

Smoking Prevention Spending

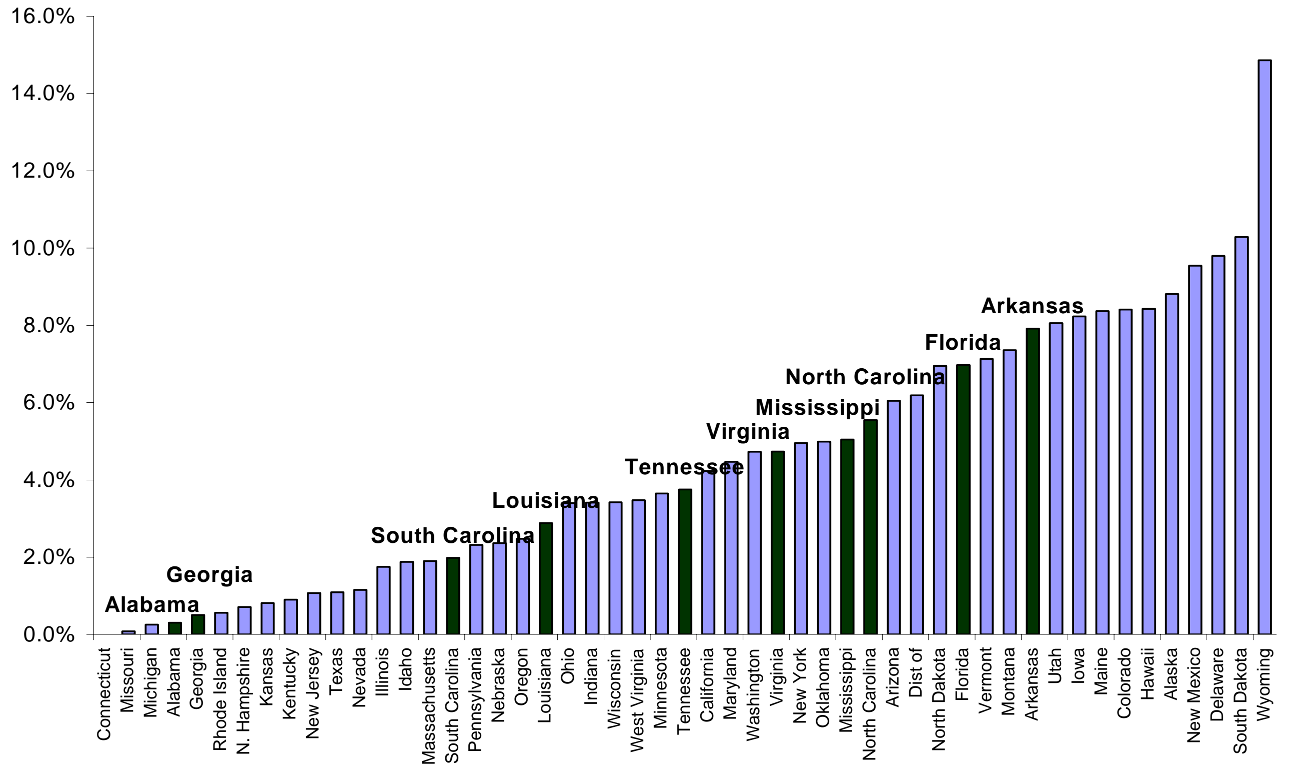
In 2007, the Centers for Disease Control and Prevention's (CDC) Office of Smoking and Health revised the previously released *Best Practices for Tobacco Prevention Control,* which provides guidance for state and community level intervention programs as well as financial recommendations for prevention and cessation activities. The 2007 report recommends that Georgia spend $116.5 million annually (with a minimum spending recommendation of $77.3 million and an upper spending level of $169.2 million) on smoking prevention and cessation activities.[9] This recommendation is significantly larger than the 1999 recommendation ($42.6 to $114.3 million) and reflects a number of Georgia-specific population measures, as well as data on youth smoking prevalence, smoking-attributable deaths, annual costs incurred from smoking, and state revenue from tobacco excise taxes and the MSA.

While the CDC recommends that Georgia spend $116.5 million each year on smoking prevention, Georgia has allocated less than this amount in total in the 9 years since the adoption of the MSA. Since the first MSA payments were received in FY 2001, Georgia has allocated roughly $90 million in total to smoking prevention programs.[10] From FY 2001 to FY 2005, annual allocations exceeded $12.2 million, with the FY 2002 allocation exceeding $26 million. Beginning in FY 2006, however, expenditures fell to roughly $2 million per year, where they have remained through FY 2009.[11]

These declines in smoking prevention allocations have occurred while the state's overall tobacco-related revenues have increased substantially, due to an increase in Georgia's cigarette taxes. In FY 2002, Georgia's $26.5 million allocation of MSA funds to prevention and cessation activities represented nearly 10% of the $273.2 million in tobacco-related revenues the state received ($89.1 million in tobacco taxes and $184.1 million in MSA funds).[12] By FY 2005, tobacco-related revenue had climbed to more than $400 million; however, the annual allocation to smoking prevention had fallen to $12.5 million.[13] Tobacco-related revenues are expected to exceed $400 million in FY 2009, but the FY 2009 budget only allocates $2.3 million (less than 1% of tobacco-related revenues) to smoking prevention activities.[14] The CDC recommended amount of $116.5 million would equal approximately 30% of Georgia's tobacco revenues.

While most states spend far less than the recommended amount on tobacco prevention, Georgia's spending on tobacco prevention as a percent of its tobacco revenues is particularly low. As shown in Figure 2, Georgia's spending falls near the bottom, as only 4 states spent a smaller portion of FY 2007 tobacco revenues on prevention.[15] Even compared to its neighbors, Georgia has among the lowest investment in smoking prevention. For example, Tennessee recently increased its spending levels to 3.7% of its total tobacco revenue, while Mississippi spent about 5.0%. In 2007, Florida took a significant step by passing a constitutional amendment requiring the state to spend at least 15% of its annual tobacco settlement money on tobacco prevention programs.

Georgia's low and declining investment in prevention comes despite significant and rising health care costs linked to smoking-related health issues. The Georgia Department of Human Resources estimates that tobacco use costs Georgia roughly $5 billion per year, in direct medical costs combined with lost productivity.[16] Smoking prevalence in Georgia has declined slightly since the MSA was settled, and the decline has roughly mirrored smoking prevalence declines nationally. Still, roughly 1 in 5 Georgians are considered smokers, and smoking rates remain higher among younger populations.[17] Furthermore, in 2006, smoking rates in rural Georgia continued to exceed rates in metro areas, and 8 of Georgia's 18 public health districts still claim smoking rates of at least 24%.[18]



Direct Health Care Services

Since FY 2001, Georgia has allocated nearly half of its MSA spending to direct and population-based health care services.[19] This trend continues in FY 2009, as $74.7 million of the $159.1 million in MSA spending is allocated to provide direct health care services.[20] Currently, these funds are used to fund programs in the Department of Community Health (DCH) and the Department of Human Resources (DHR), though in prior years health care services have also been funded in other agencies, such as the Department of Education.

The bulk of the state's Medicaid program is operated by DCH, and the majority of the MSA funds for direct health care services are allocated to aspects of the program located in DCH:

- $14 million for a FY 2001 Medicaid expansion for pregnant women and infants,
- $3.5 million for reimbursements to Critical Access Hospitals, and
- $30 million for inpatient hospital reimbursement funding.[21]

In addition to Medicaid spending within DCH, $10.6 million is allocated to rural primary care access initiatives by the Department.

Within DHR, $2.4 million is directed to the Community Care Services Program, $3.8 million for home and community based care for elderly Georgians, and $10.3 million for the Mental Retardation Waiver Program. In addition to these programs, DHR receives $150,000 for suicide prevention activities.[22]

While the above activities have historically been funded with MSA funds, several other programs and activities have been funded with MSA funds at some point since FY 2001. Some of the more prominent activities to receive MSA funds include School Nurses ($30 million per year from FY 2001-

2005 and nearly $20 million in FY 2007) and the PeachCare for Kids Program (total of $32.1 million from FY 2001-2007). Other activities and programs include:

- The Independent Care Waiver Program ($12.9 million from FY 2001-2006);
- Newborn hearing screening ($13.7 million from FY 2001-2006);
- Chronic disease prevention ($8.1 million from FY 2001-2006);
- Early intervention for at-risk families ($20 million from FY 2001-2006); and
- The AIDS Drug Assistance Program ($7.4 million from FY 2001-2006).[†]

Cancer Related Research and Education

In addition to direct health care services, MSA funds are allocated to a variety of programs and activities related to cancer. Since the first MSA payments in FY 2001, Georgia has directed more than $242 million to cancer-related activities (not including the roughly $90 million allocated to smoking prevention activities) through various programs in several agencies. This total represents roughly 16% of the total MSA allocations from FY 2001 to FY 2009.[23] In FY 2009, the $35 million allocation includes:

- $3.5 million to DCH for breast and cervical cancer treatment in the state's Medicaid program;
- Funds to DHR for cancer screening ($2.9 million), treatment services ($6.5 million), and the state's cancer registry ($115,637);
- Funds to the Board of Regents for the Eminent Cancer Scholar Endowment ($750,000) and cancer center mission enhancement ($5 million) at the Medical College of Georgia;
- Funds to the Georgia Cancer Coalition (GCC) for Eminent Cancer Scientists and Clinicians ($8.1 million) and to GCC staff and initiatives, including Georgia's 6 regional cancer coalitions ($8 million); and
- $150,000 to the Department of Revenue for enforcement and compliance activities aimed at underage smokers.[24]

Since FY 2001, the allocations that can be termed "cancer-related" have varied, though the allocations in recent years have been very similar to those of FY 2009. Much of the variation since FY 2001 has been with regards to the amount of the allocations, though particular initiatives and activities have seen sporadic funding in the last 9 years. For example, the GCC Center for Excellence at Grady Hospital received a significant one-time allocation of $28.4 million in FY 2001. Allocations for training, equipment, and network development were more prominent in the early years, and from FY 2002-2005 the state allocated approximately $5.5 million to a public education campaign.[25]

OneGeorgia Authority

Since the inception of the MSA, Georgia has allocated $493.6 million, or nearly one-third of total MSA revenue, to the OneGeorgia Authority for the purpose of economic development in rural Georgia. From FY 2001 to FY 2004, the annual allocation to the Authority varied greatly. Since FY 2005, however, the allocation has been consistently set at $47.1 million. In FY 2009, this allocation represents 30% of the total MSA allocation.

The Authority is governed by a board chaired by the Governor that includes the Lt. Governor (vice-chair), the Director of the Governor's Office of Planning and Budget (secretary), and the commissioners of the Departments of Community Affairs, Economic Development, and Revenue. The Authority is not a state agency but operates as an "instrumentality of the state" and is a "public corporation providing an essential government function." The Board of the Authority has discretion in

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[†] While these programs / activities have lost MSA funds in recent years, many if not all of these programs have had such funding replaced with general funds or another funding source. The loss of MSA funds has not necessarily meant termination of the programs or overall losses in funding.

awarding grants and loans; however, eligibility is limited to rural counties with population of fewer than 50,000.[26] In FY 2008, 111 counties qualified under these restrictions.[27]

From FY 2001 to FY 2007, the Authority awarded nearly $300 million in grants and loans, leaving a balance of unawarded funds of approximately $107 million prior to FY 2008.[‡] Originally, the Authority was set-up to award grants and loans through two funds: the Economic Development Growth and Expansion (EDGE) Fund (which helps rural communities in Georgia compete for business locations/expansions with communities outside Georgia) and the Equity Fund (which funds infrastructure development). The Authority now includes five additional funds:

- the BRIDGE Fund, which funds broadband infrastructure;
- the AIRGeorgia Fund, which funds airport infrastructure;
- the E 9-1-1 Fund, which funds efforts to set up 911 emergency telephone services;
- the Strategic Industries Loan Fund; and
- the Entrepreneur and Small Business Development Loan Guarantee (ESB) Fund.[28]

The EDGE Fund and Equity Fund are by far the largest funds, as awards from these funds made up approximately $172.5 million from FY 2001 to FY 2007.

The Authority has also funded projects indirectly, by passing-through funds to other agencies. Since FY 2001, approximately $106 million has been used for these indirect, pass-through projects, such as the Tobacco Control Board ($13 million annually from FY 2001-FY 2003), the Georgia Environmental Facilities Authority ($10 million in FY 2001), and the Technical College System of Georgia to assist in the construction of the Kia training facility ($21.5 million in FY 2007).

Conclusions

Since 2001, Georgia has allocated approximately $1.53 billion in revenues from the tobacco MSA. While the state has directed a substantial amount of these funds to health-related activities, recent years have seen a significant decline in the share of funds directed to tobacco cessation and prevention programs. While advocates across the nation have pressed states to invest more MSA funds in health care, cancer-related programs, and smoking prevention, Georgia ranks especially poorly in the percent of tobacco-related revenues it directs to smoking prevention. Furthermore, while other Southern states have recently increased the percent of tobacco-related revenues being directed to smoking prevention, Georgia has seen its smoking prevention allocation decline. In FY 2009, the state's smoking prevention allocation of $2.3 million represents less than 1% of the roughly $400 million in expected tobacco-related revenue and less than 3% of the amount recommended by the CDC.

Evidence-based, statewide tobacco control programs that are comprehensive, sustained, and accountable have been shown to reduce smoking rates, tobacco-related deaths, and diseases caused by smoking. The CDC estimates that if each state sustained its recommended level of funding for 5 years, an estimated 5 million fewer people in this country would smoke.[29] As a result, hundreds of thousands of premature tobacco-related deaths would be prevented. By spending less than 1% of its total tobacco revenue on tobacco prevention, instead of the CDC-recommended 30%, Georgia is missing an opportunity to save future lives and prevent a range of societal costs.

The Georgia Budget and Policy Institute (GBPI) is an independent, nonprofit, non-partisan organization engaged in research and education on the fiscal and economic health of the state of Georgia. The GBPI provides reliable, accessible and timely analyses to promote greater state government fiscal accountability as a way to improve services to Georgians in need and to promote quality of life for all Georgians.

[‡] Of this $107 million, approximately $71 million is in a reserve account that the Authority does not use to award grants. Approximately $36 million of the balance is therefore available for grants. (Data from Authority staff, July 2008.)

Endnotes

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[13] Georgia Governor's Budget 2008. Accessed March 2008. http://www.opb.state.ga.us/Budget/FY08_Book.pdf
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[15] **Revenue** taken from: *Best Practices for Comprehensive Tobacco Control Programs*. CDC Recommended Annual Total Funding Levels for State Programs, 2007. Office on Smoking and Health, Centers for Disease Control and Prevention.
Expenditures taken from: *A Broken Promise to Our Children: the 1998 State Tobacco Settlement Nine Years Later*, found at: http://www.tobaccofreekids.org/reports/settlements/2008/fullreport.pdf. GA specific data was taken directly from the state's Budgetary Compliance Report: https://www.audits.state.ga.us/internet/sgd/rosa_main.html. Slight differences were noted between the sources. However, the most conservative data was used and conclusions remain valid.
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[22] Ibid.
[23] MSA allocation data compiled by GBPI using Governor's Budget Books from FY 2002 through FY 2009.
[24] FY 2009 MSA Allocation data from the Governor's 2009 Budget Book, page 36. http://www.opb.state.ga.us/media/2179/gov_rec_fy09.pdf
[25] MSA allocation data compiled by GBPI using Governor's Budget Books from FY 2002 through FY 2009.
[26] Counties fall into 3 categories – ineligible, conditionally eligible, and eligible. Eligible counties must be outside a defined Metropolitan Statistical Area, have populations of less than 50,000, and have a poverty rate of at least 10%. Conditionally eligible counties may partner with eligible counties; however, they are not eligible to receive funds through OneGeorgia. Definition on OneGeorgia Authority website: http://www.onegeorgia.org/frequently-asked-questions/show/32/Which-counties-are-eligible-to-apply-for-OneGeorgia-funds-
[27] There are 111 eligible counties and 35 conditionally eligible counties, in 2008. Map showing eligible counties: http://www.onegeorgia.org/documents/detail/37
[28] http://www.onegeorgia.org/programs
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