Tobacco Q&A
March 5, 1999

Q: Will the President sign the Supplemental Appropriations bill if it contains Sen. Hutchison's amendment allowing the states to keep the entire $246 billion tobacco settlement?

A: The Administration strongly oppose Sen. Hutchison's amendment which would give up the federal share of the states' tobacco settlement, without any commitment by the states to use these monies to prevent youth smoking, protect farmers, improve public health, or assist children. An average of 57 percent of state recoveries is reimbursement for costs borne by the federal government, and I believe that these funds should be spent on purposes related to tobacco, public health, and children.

As the President has said many times, we want to work with Congress and the states on legislation that waives the federal claim in exchange for a commitment by the states to use the federal share to support these state and national priorities. We can reach this agreement in the context of the supplemental appropriations bill if Congress and the States choose to do so.

Q: Governors and state officials claim that since the federal government played no role in the legal fight that they are not entitled to a part of the settlement. What is the federal government's claim to the settlement?

A: Under Medicaid law, states have the legal obligation to seek Medicaid reimbursements on behalf of both states and the federal government. States cannot sue only for state Medicaid costs; they are obliged by Medicaid law to sue for the federal costs at the same time. Since the federal government pays on average 57 percent of Medicaid claims, the states are obliged to share those recoveries with the federal government. In the past five years, states have shared $1.5 billion in such Medicaid recoveries with the federal government.

The Department of Justice has determined that the tobacco settlement is a Medicaid settlement. By releasing the tobacco companies from all current and future claims in the settlement, the states gave up both state and federal Medicaid claims in exchange for the tobacco settlement funds. Even if states sued for other valid claims, federal law requires Medicaid claims to be paid first. Tobacco-related Medicaid costs are at least $13 billion a year, according to independent estimates, and the states are receiving only about $8 billion a year in exchange for giving up their claims.

DRAFT 3/5

Recoupment Legislative Proposal

Legislation would settle the entire federal claim (57%) against the tobacco settlement funds in exchange for a binding commitment that states spend those funds on shared national and state priorities to prevent youth smoking, protect tobacco farmers, improve public health, and assist children.

Menu: States would commit to dedicate the Federal share of the Settlement to the following. Except for the legislated minimum on tobacco control programs, states in their sole discretion determine the allocation of uses.

a. ***Tobacco prevention*** -- prevention, education, enforcement, cessation, evaluation. Require Secretary to review and certify state tobacco plan.

b. ***Tobacco farmers*** -- direct payments to quota owners and active producers; career development including financial planning and educational assistance; economic development grants

c. ***Public health*** -- community health centers and other providers of health care for the uninsured, CHIP and Medicaid outreach, maternal and child health, and mental health.

d. ***Anti-drug efforts*** – safe and drug free schools, substance abuse education, prevention, and treatment

e. ***Child care*** – child care block grant and early learning fund activities

Maintenance of effort: state must demonstrate spending on specified uses is in addition to historic spending.

DRAFT 3/5

Definitions for Medicaid Recoupment

1. Settling Federal Claims

   a. Define federal claims as 57 percent of all funds each state receives from tobacco industry each year, e.g., 57 percent of "any amount recovered or paid to a State as part of the comprehensive settlement of November 1998 between manufacturers of tobacco products, as defined in section 5702(d) of the Internal Revenue Code of 1986, and State Attorneys General, or as part of any individual State settlement or judgment reached in litigation initiated or pursued by State against one or more such manufacturers." [Language is from Hutchison bill.]

   b. Enforcement. If funds are not spent according to requirements, the Secretary shall recoup funds "which shall be deposited by the Secretary into a separate fund in the Treasury which shall be used and available to the Secretary, without further appropriation, to carry out Federal grant-in-aid programs to reduce tobacco use among minors" [from Weygand bill]. In addition, the state could be subject to recoupment of settlement funds from any or all years if it fails to spend 57 percent on specified purposes in any given year.

2. Shared National and State Priorities

   a. Tobacco prevention defined as "evidence-based efforts to reduce tobacco use, particularly among youth, including: 1) tobacco prevention and control activities at the school, community, and state levels; 2) enforcement of tobacco control laws and regulations; 3) public education programs, including the use of mass media; 4) cessation services consistent with AHCPR guidelines and cessation treatments approved by the FDA; 5) surveillance and evaluation programs to provide accountability." State spending plan to reduce tobacco use shall be certified by the Secretary.

   b. Assistance to tobacco farmers and their communities, defined as "1) direct payments to quota owners and active producers; 2) career development including financial planning and educational assistance; or 3) economic development grants."

   c. Public health defined as "funding for 1) coordinated efforts to provide health care for the uninsured through community health centers as defined in Section 330 of the Public Health Service Act (42 U.S.C. 254b), hospitals, primary care facilities, specialized care facilities, and individual practitioners; 2) outreach efforts to enroll children in the State Children's Health Insurance Program authorized under title XXI section 2105 (a)(2) of the Social Security Act (42 U.S.C. 1397aa et seq.) or title XIX of the Act; 3) maternal and child health services as defined under title V of the Social Security Act (42 U.S.C. 701 et seq.); 4) mental health services as defined under title XIX, part B of the Public Health Services Act."

d. Anti-drug efforts defined as "activities funded under the Safe and Drug-Free Schools and Communities State Grants under title IV, Part A, subpart 1 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7111 et seq.) and the Substance Abuse Block Grant - Title IXX, Part B, subpart II of the Public Health Service Act (42 U.S.C. 300x-2)."

e. Child care defined as "1) activities funded by the Child Care & Development Block Grant under section 418 of the Social Security Act, notwithstanding subsection (b)(2) of that section, and 2) grants to communities for activities that improve early childhood education and the quality and safety of child care for children under five years old."

3. Maintenance of Effort -- "Funds shall be used to supplement not supplant other Federal, State, or local funds provided for in any of the programs described in subparagraphs x through x of subsection x. Restricted funds ... shall not be used as State matching funds. Amounts provided to the State in such subparagraph shall not be reduced solely as a result of the availability of funds under this section.... To receive funds under this subsection, States must demonstrate a maintenance of effort. This maintenance of effort is defined as the sum of --

(1) an amount equal to 100 percent of Federal fiscal year 1998 State spending on the programs under subparagraphs x, x, and x of subsection x and

(2) an amount equal to the product of the amount described in paragraph (1) and

(A) for fiscal year 2000, the lower of -

(I) general inflation as measured by the consumer price index for the previous year; or

(ii) the annual change in the Federal appropriation for the program in the previous fiscal year; and

(B) for subsequent fiscal years, the lower of -

(I) the cumulative general inflation as measured by the consumer price index for the period between 1998 and the previous year; or

(ii) the cumulative change in the Federal appropriation for the program for the period between fiscal year 1998 and the previous fiscal year.

The maintenance-of-effort requirement in paragraph (1), and the adjustments in paragraph (2), apply to each program identified in paragraph (1) on an individual basis." [from McCain bill with updated dates and 100% MOE rather than 95%]

Meeting 3/1/99
5:30 pm

DRAFT 3/1

Medicaid Recoupment

1. Settle the federal claim (57% of the tobacco settlement funds) in exchange for a commitment that states spend the funds on shared national and state priorities to prevent youth smoking, protect tobacco farmers, improve public health, and assist children. This commitment, defined in legislation, would apply to all years of tobacco settlement (not just the five year budget window).

2. Define shared national and state priorities in legislation as:

   a. Tobacco prevention -- prevention, education, enforcement, cessation, evaluation

      → Floor of 15, 20, 25%? (15%=$720 mi/yr; 20%=$960 mi/yr; 25%=$1.2 bi/yr) - Counsel to decide
      → Require Secretary to certify tobacco plan which must include certain elements?

   b. Tobacco farmers -- a) payments to tobacco farmer trust funds established by recent settlement and/or b) direct payments to quota owners and active producers; career development, financial planning, or educational assistance; economic development grants → hold - Lew.

   c. Public health: community health centers and ~~other providers of health care for the uninsured~~, CHIP/Medicaid outreach, CHIP match (up to 6% of total), maternal and child health, and mental health
      1.2 - they'll get pressured to offer it; coverage add'l; competitive grant 250 mil/yr

      → Should CHIP presumptive eligibility language be included? (was in McCain) not in our budget

   d. Anti-drug efforts -- safe and drug free schools, substance abuse treatment

   e. Child care -- child care block grant and early learning fund

3. Maintenance of effort: state spending on specified uses must be in addition to historic spending.

4. States would remit to the federal treasury the $2.9 billion CBO-scored cost.

   → Do states get credit for this $2.9 bi payment, e.g., is the federal share they must spend on specified purposes lowered by the amount of the payment? If so, a given percentage set-aside for tobacco prevention would be smaller through 2004.

      15% = $600 mi/yr through 2004, then rising to $720 mi/yr;
      20% = $800 mi/yr through 2004, then rising to $960 mi/yr;
      25% = $1 bi/yr through 2004, then rising to $1.2 bi/yr.

   If we get this - do a new budget next yr.

9 or 10 billion - mean spending total in budget.
- say "assuming we get something like this" - reduce budget + use offsets accordingly.
+ opaque, but same relationship between our budget initiatives & this menu
menu options - actual admin efforts

Cynthia A. Rice 02/28/99 09:49:41 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc: J. Eric Gould/OPD/EOP
Subject: Tobacco Recpmnt Proposal--PLEASE REVIEW ASAP

med0228.wp Based on follow-up conversations I've had with some of you and with Bruce and Elena , I've developed this draft tobacco recoupment proposal, which amends the "straw man" OMB proposed at our meeting last week.

Bruce is holding a meeting on this topic Monday at 5:30. We may want to hand out the first page there, so please get me any suggested edits ASAP.

Pages 2-4 represents the backup paper I think we'll need to provide technical assistance to our friends on the Hill. The latest voice mail I got from Sen. Conrad's staff is that they want to have a bill introduced in time for the March 10th Finance Committee hearing. I want to be ready to help as soon as we get the go-ahead to do so. So please give me any suggestions on pages 2-4 by COB Monday.

In particular,

Chris/Jeanne/Devorah/Sarah -- please review what I've got on CHIP, and how I've defined public health in general (note I've added mental health)

Tom -- note the questions about tobacco farmers.

Nicole -- note the language I've used to describe the early learning fund

As usual with all tobacco paper, please hold this close.

Message Sent To:

Christopher C. Jennings/OPD/EOP
Jeanne Lambrew/OPD/EOP
Sarah A. Bianchi/OVP @ OVP
Devorah R. Adler/OPD/EOP
Thomas L. Freedman/OPD/EOP
Nicole R. Rabner/WHO/EOP

DRAFT 2/28

Medicaid Recoupment

1. Settle the federal claim (57% of the tobacco settlement funds) in exchange for a commitment that states spend the funds on shared national and state priorities to prevent youth smoking, protect tobacco farmers, improve public health, and assist children. This commitment, defined in legislation, would apply to all years of tobacco settlement (not just the five year budget window).

2. Define shared national and state priorities in legislation as:

   a. Tobacco prevention -- prevention, education, enforcement, cessation, evaluation

      → Floor of 15, 20, 25%? (15%=$720 mi/yr; 20%=$960 mi/yr; 25%=$1.2 bi/yr)
      → Require Secretary to certify tobacco plan which must include certain elements?

   b. Tobacco farmers -- direct payments to quota owners and active producers; career development, financial planning, or educational assistance; economic development grants

   c. Public health: community health centers and other providers of health care for the uninsured, CHIP outreach, maternal and child health, and mental health

      → Should CHIP presumptive eligibility language be included? (was in McCain)

   d. Anti-drug efforts -- safe and drug free schools, substance abuse treatment

   e. Child care -- child care block grant and early learning fund

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4. States would remit to the federal treasury the $2.9 billion CBO-scored cost.

   → Do states get credit for this $2.9 bi payment, e.g., is the federal share they must spend on specified purposes lowered by the amount of the payment? If so, a given percentage set-aside for tobacco prevention would be smaller through 2004.

   15% = $600 mi/yr through 2004, then rising to $720 mi/yr;
   20% = $800 mi/yr through 2004, then rising to $960 mi/yr;
   25% = $1 bi/yr through 2004, then rising to $1.2 bi/yr.

DRAFT 2/28

Definitions for Medicaid Recoupment

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   b. Enforcement. If funds are not spent according to requirements, the Secretary shall recoup funds "which shall be deposited by the Secretary into a separate fund in the Treasury which shall be used and available to the Secretary, without further appropriation, to carry out Federal grant-in-aid programs to reduce tobacco use among minors" (Weygand bill). In addition, the state could be subject to recoupment of settlement funds from any or all years if it fails to spend 57 percent on specified purposes in any given year.

   → Must language be written as state option, e.g., providing state with option to forgo recoupment and instead keep federal funds in state so long as they are spent on specified purposes? (possible constitutional issue).

2. Shared National and State Priorities

   a. Tobacco prevention defined as "evidenced-based efforts to reduce tobacco use, particularly among youth, including: 1) tobacco prevention and control activities at the school, community, and state levels; 2) enforcement of tobacco control laws and regulations; 3) public education programs, including the use of mass media; 4) cessation services consistent with AHCPR guidelines and cessation treatments approved by the FDA; 5) surveillance and evaluation programs to provide accountability."

      → Must state plan to reduce tobacco use be certified by the Secretary and include all of these elements?

   b. Assistance to tobacco farmers and their communities, defined as "1) direct payments to quota owners and active producers; 2) career development, financial planning, or educational assistance; or 3) economic development grants."

      → Do we want language to require funds to be spent through trusts established by recent $5 billion settlement? If so, what reference should be included in legislative language?

c. Public health defined as "funding for 1) coordinated efforts to provide health care for the uninsured through community health centers as defined in Section 330 of the Public Health Service Act (42 U.S.C. 254b), hospitals, primary care facilities, specialized care facilities, and individual practitioners; 2) outreach efforts to enroll children in the State Children's Health Insurance Program authorized under title XXI section 2105 (a)(2) of the Social Security Act (42 U.S.C. 1397aa et seq.); 3) maternal and child health services as defined under title V of the Social Security Act (42 U.S.C. 701 et seq.); 4) mental health services as defined under title XIX, part B of the Public Health Services Act."

d. Anti-drug efforts defined as "activities funded under the Safe and Drug-Free Schools and Communities State Grants under title IV, Part A, subpart 1 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7111 et seq.) and the Substance Abuse Block Grant - Title IXX, Part B, subpart II of the Public Health Service Act (42 U.S.C. 300x-2)."

e. Child care defined as "1) activities funded by the Child Care & Development Block Grant under section 418 of the Social Security Act, notwithstanding subsection (b)(2) of that section, and 2) grants to communities for activities that improve early childhood education and the quality and safety of child care for children under five years old."

3. Maintenance of Effort -- "Funds shall be used to supplement not supplant other Federal, State, or local funds provided for in any of the programs described in subparagraphs x through x of subsection x. Restricted funds, except as provided for in subsection x, shall not be used as State matching funds. Amounts provided to the State in such subparagraph shall not be reduced solely as a result of the availability of funds under this section.... To receive funds under this subsection, States must demonstrate a maintenance of effort. This maintenance of effort is defined as the sum of --
(1) an amount equal to 95 percent of Federal fiscal year 1997 State spending on the programs under subparagraphs x, x, and x of subsection x and
(2) an amount equal to the product of the amount described in paragraph (1) and
    (A) for fiscal year 1999, the lower of -
        (I) general inflation as measured by the consumer price index for the previous year; or
        (ii) the annual growth in the Federal appropriation for the program in the previous fiscal year; and
    (B) for subsequent fiscal years, the lower of -
        (I) the cumulative general inflation as measured by the consumer price index for the period between 1997 and the previous year; or
        (ii) the cumulative growth in the Federal appropriation for the program for the period between fiscal year 1997 and the previous fiscal year.
The 95-percent maintenance-of-effort requirement in paragraph (1), and the adjustments in paragraph (2), apply to each program identified in paragraph (1) on an individual basis." [from McCain bill]

4. Payment of CBO-scored cost: For FY 2000-2004, states shall remit to the federal treasury the yearly cost as scored by CBO of the legislation to waive recoupment. The cost shall be divided among all states according to their share of tobacco settlement funds. It shall be a payment by the state to the federal treasury and shall not be a reduction in the state's Medicaid grant.

   → Do states get credit for this $2.9 bi payment? Is it part of the 57 percent they must spend on specified purposes?

Programs to Prevent Tobacco use Among Youth

Enforcement Initiatives

- Systematic, regular programs of random "sting" operations, including local and regional initiatives designed to detect tobacco possession and sale, reduce youth smoking.[1]

- Strong enforcement initiatives along with a strong anti-smoking advertising campaign might have synergistic effects.[2]

Counteradvertising

- Strong advertising campaigns -- with large budgets akin to the campaigns by private companies -- can dramatically reduce smoking rates.[3]

- An anti-smoking advertising campaign may be more effective when combined with strong limits on advertising and promotional activities that appeal to adolescents.[4]

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[1] For a study which found that a vigorous inspection program could increase retailer compliance substantially, see Rigotti, N.A., J.R. Di Franza, Y. Chang, T. Tisdale, B. Kemp, and D.E. Singer, "The Effect of Enforcing Tobacco-Sales Laws on Adolescents' Access to tobacco and Smoking Behavior," *The New England Journal of Medicine*, vol. 337, no. 15, October 9, 1997, pp. 1044-1051. For a discussion of the teen sales reductions possible through strict licensing and monitoring requirements, see Below and P. Klemperer, "Tobacco policy Options," *Brookings papers on Economic Activity: Microeconomics*, forthcoming 1998. Another study found that vendor non-compliance rates in one area were more than halved once vendor education programs were backed by citations for sales to minors. See Feighery, E., D.G. Altman, and G. Shaffer, "The Effects of Combining Education and Enforcement to Reduce Tobacco Sales to Minors," *Journal of the American Medical Association*, vol. 266, no. 22, December 11, 1991, pp. 3168-3171.

[2] As discussed above, the impressive results that particular communities have seen have generally come from combinations of measures, and may also reflect the intangible effects of strong anti-smoking sentiment that led these communities to adopt strong programs. The Flynn (1992) study which found one-third reductions in youth smoking was designed to test whether a local anti-smoking campaign could reinforce a school-based education program and yield long-lasting results. The successes in Woodridge, Illinois -- a 69% reduction in smoking among young adolescents -- reflected the combined effects of strongly enforced access restrictions along with community support and publicity and education efforts. Similarly, successful international efforts like those in Norway have included a range of anti-smoking measures.

[3] Goldman, L., and S. Glantz, "Evaluation of Anti-smoking Advertising Campaigns," *Journal of the American Medical Association*, vol. 279, no. 10, March 11, 1998, pp. 772-777; Hu, T., et. al., "Reducing Cigarette Consumption in California: Tobacco Taxes vs. An Anti-Smoking Media Campaign," *American Journal of Public Health*, vol. 5, no. 9, September 1995, pp. 1218-1222.

[4] Flynn, B.S., et. al., "Prevention of Cigarette Smoking Through Mass Media Intervention and School Programs," *American Journal of Public Health*, vol. 82, no. 6, June 1992, pp. 827-834; and Flynn, B.S., et. al., "Mass Media and School Intervention for Cigarette Smoking Prevention: Effects Two Years After Completion," *American Journal of Public Health*, vol. 84, 1994, pp. 1148-1150. Department of Health and Human Services, " Preventing Tobacco Use Among Young People: A Report of the Surgeon General," 1994, p. 188.

School Based Programs

- School-based prevention programs can have large effects on smoking rates.[5]

- School based programs to prevent the use of tobacco will help accomplish one of the six National Education Goals. ("By the year 2000, every school in America will be free of drugs and violence will offer a disciplined environment conducive to learning.")[6]

- More recently, Flynn, et. al., (1992) conducted a study of middle-school students to determine whether a program involving both anti-tobacco education and a media campaign was more effective than the education program itself. They found that over a five year period, that students exposed to a school-and-media program were 34% less likely to have smoked in the previous day and 35% less likely to have smoked in the previous week than those in the education program alone.[7]

- Students need the opportunity to practice skills and strategies that will help them remain nonusers.[8]

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[5] For example, a 1980 study found that a peer counseling program to resist pressures to smoke reduced smoking among junior high students by more than 50% in the first year, but the effects dissipated after the 10th grade: see McAlister, A, et al., "Pilot Study of Smoking, Alcohol, and Drug Abuse Prevention," *American Journal of Public Health*, vol. 70, no. 7, 1980, pp. 719-721. Botvin found short-term reductions of 40-80 percent from a similar study; see Botvin, G.J., "Substance Abuse Prevention Research: Recent Developments and Future Directions," *Journal of School Health*, vol. 56, no. 9: 1986, pp. 369-374. One study has estimated that programs with certain design features could actually reduce long-term smoking prevalence by 25%, not just delay its onset; see Rooney, B., " A Meta-analysis of Smoking-Prevention Programs after Adjustment for Study Design," dissertation, University of Minnesota, 1992.

[6] National Education Goals Panel. The *National Education Goals Report*. Washington, D.C.: National Education Goals panel, 1991.

[7] Flynn, B.S., et. al., " Prevention of Cigarette Smoking Through Mass Media Intervention and School Programs," *American Journal of Public Health*, vol. 82, no. 6, June 1992, pp. 827-834; and Flynn, B.S., et. al., "Mass Media and School Interventions for Cigarette Smoking Prevention: Effects Two Years After Completion," *American Journal of Public Health*, vol. 84, 1994, pp. 1148-1150.

[8] Brink SG, Simmons-Morton DG, Harvey CM, Parcel GS, Tiernan KM. Developing *Comprehensive Smoking-Control Programs in Schools*. J Sch Health 1988; 58: 177-80.

Community Based Programs

- Parents and community organizations can both reinforce and complement school-based programs.[9]

Cessation Programs

- There's some limited evidence that cessation programs may help teenagers.[10]
- Effective cessation programs provide social support that teach avoidance, stress management, and refusal skills.[11]

2/24/99

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[9] Perry CL, Pirie P., Holder W., Halper A., Dudovitz B. *Parental Involvement in Cigarette Smoking Prevention: Two Pilot Evaluations of the "Unpuffables Program."* *J Sch Health* 1990; 60: 443-7. Glynn, T.J., D.M. Anderson, and L. Schwartz, " Tobacco-Use Reduction among high-Risk Youth: Recommendations of the national Cancer Institute Expert Advisory panel," *Preventive Medicine*, vol. 20, no. 2, 1991, pp. 279-91. For a more detailed discussion of community-based approaches, see *Health and Human Services* (1994), pp. 233-9, which also notes that further evaluations of the teen smoking effects of promising community programs are needed.

[10] For example, a 1983 study found that 23% of teen smokers who started a cessation program had stopped three months later, but it did not provide for a longer follow-up period; see Perry, C.L., et. Al., " High School Smoking Prevention: The Relative Efficacy of Varied Treatments and Instructors," *Adolescence*, vol. 18, no. 71, 1983, pp. 561-66. Other unpublished studies cited in the Surgeon General's 1994 report on youth smoking found smaller or no effects of cessation programs, though in one case over half of the participants were required to participate as a punishment for violating school smoking policies, and this was identified as a factor that could have decreased the program's success rate. See Health and Human Services 919940, pp. 228-230.

[11] Flay BR. *Youth Tobacco Use: Risks, Patterns and Control.* In: Nicotine Addiction: Principles and Management. New York: Oxford University Press, 1993.