State Tobacco Control and Prevention Expenditures: FY 2008 – 2011

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Executive Summary

The State Tobacco Control Expenditure Database (STCED), compiled by the Health Policy Center (HPC) at the University of Illinois at Chicago (UIC), is the first national surveillance and monitoring system that collects, tracks, and reports all 50 states and the District of Columbia's actual spending on tobacco control and prevention activities. It provides an accurate measure of states' investments in reducing tobacco use among youth and adults. Additionally, it tracks and reports states' spending on state, community, and school initiatives; quitline and cessation interventions; anti-tobacco advertising campaigns; tobacco surveillance and evaluation efforts; and spending on tobacco control programs administration and management.

This report provides an overview of the methods and processes used to compile the STCED. In addition, it presents state tobacco control and prevention expenditure data that the research team of HPC collected from all 50 states and the District of Columbia for fiscal years 2008 through 2011. The state tobacco control expenditure data are presented, as overall and per capita, by the five program components of the CDC's 2007 *Best Practices for Comprehensive State Tobacco Control Programs* (Best Practices) (CDC, 2007). The five program components of the CDC's 2007 Best Practices are: state and community interventions, health communication interventions, cessation inventions, surveillance and evaluation, and administration and management. To put state tobacco control and prevention spending into context, this report also compares state tobacco control spending with the CDC's recommended tobacco control and prevention spending levels in fiscal years 2008 through 2011 for all 50 states and the District of Columbia.

In fiscal year 2008, states spent approximately $712 million, or $2.34 per capita, on tobacco control and prevention activities, representing only 19% of the CDC's recommended spending levels for states. A similar spending level was observed in fiscal year 2009, in which states spent approximately $718 million, or $2.34 per capita, representing only 19% of the CDC's recommended levels. In fiscal year 2010, states spent approximately $650 million, or $2.17 per capita, representing 18% of the CDC's recommended spending levels. In fiscal year 2011, states spent approximately $658 million, or $2.11 per capita, on tobacco control and prevention activities, 18% of the CDC recommended levels. In comparison, in 2011 tobacco companies spent $8,366 million on cigarette advertising and promotion (FTC, 2013), more than 12 times the amount of spending on tobacco control and prevention made by the states.

The largest investment of state tobacco control programs from 2008 to 2011 was consistently on state and community interventions. This category includes spending on state, community, and school initiatives to change local and statewide smoke free air policies; efforts to reduce exposure to second-hand smoke; efforts to eliminate tobacco-related disparities; and implementation of community and/or school programs aimed at influencing youth. In fiscal year 2008, states invested a total of $316.34 million on state and community interventions; in 2009, states' investment was $303.82 million in total; in 2010 and 2011, state spending on state and community interventions were $263.81 million and $272.38 million, respectively. Health communications interventions investment- including paid television, radio, billboard, print, and web-based advertising; media advocacy; health promotion activities; efforts to reduce or replace tobacco industry sponsorship and promotions; and focused messages targeting specific audiences through appropriate channels- slowly decreased between 2008 and 2011: $154.52 million in the

2008 fiscal year, $148.17 million in 2009; $128.50 million in 2010, and $123.53 million in 2011. Cessation interventions- including counseling services, quitline cessation services, and pharmacotherapies provided to smokers- remained fairly consistent in the study period. States' spending on cessation interventions was $132.77 million in 2008, $136.61 million in 2009, $135.54 million in 2010, and $134.09 million in 2011. Spending on surveillance and evaluation includes expenditures on surveys and/or research that monitor(s) tobacco-related attitudes, behaviors, and health outcomes, it also includes expenditures on evaluation of the achievement and effectiveness of various tobacco control program interventions and goals. States' spending on surveillance and evaluation interventions was $49.27 million in 2008; $66.42 million in 2009, $61.24 million in 2010, and $61.35 million in 2011. Administration and Management expenditures include the salary and fringe benefits of those who manage and operate state tobacco control programs. Spending on administration and management was $59.16 million in 2008, $61.65 million in 2009, $60.92 million in 2010, and $66.79 million in 2011.

States' spending in each of the CDC's Best Practices categories represented only a small fraction of the CDC recommended amount. Spending on state and community interventions, the largest program component by spending, represented only approximately 22% of the CDC's recommended spending levels between 2008 and 2011. Similarly, spending on health communication interventions and spending on surveillance and evaluation represented only about one fifth of the CDC's recommended spending levels. Spending on cessation interventions represented only 13% of the CDC's recommended spending levels. Spending on administration and management represented a little over one third of spending levels recommended by CDC.

Tobacco control spending and individual component spending varied greatly across states, both in per capita terms and as a percentage of the CDC's recommended spending levels. Considerable variations also exist in spending levels on each program component across states and over time.

Investing in comprehensive tobacco control programs and implementing evidence-based interventions have been shown to reduce youth initiation, tobacco-related disease and death, and tobacco-related health care costs and lost productivity. Moreover, if states allocate funding for tobacco control at CDC's Best Practices levels, they have the potential to achieve larger and more sustainable reductions in all forms of tobacco use and associated morbidity and mortality (CDC, 2014; DHHS, 2014).

The data presented in this report demonstrate a considerable gap between state investments in tobacco prevention and control and CDC's Best Practices recommendations. Although all states derive revenues from cigarette excise taxes, few states have a statutory requirement requiring that a portion of these revenues be dedicated to tobacco prevention and control (CDC, 2012). Instead, most cigarette tax revenues are used for general purposes. Additionally, although in recent years state cigarette excise taxes have nationally increased, these tax increases largely have come in response to shortfalls in state budgets, rather than as initiatives to increase tobacco control spending (CDC, 2007; CDC, 2014). Many state programs have experienced and are facing substantial state government cuts to tobacco control funding, resulting in the near-elimination of tobacco control programs in those states (CDC, 2014). In 2014, despite combined revenue of more than $25 billion from settlement payments and tobacco taxes for all states, states

have appropriated only $481.2 million (1.9%) to comprehensive tobacco control programs (Tobacco Free Kids, 2015), an amount <15% of the CDC-recommended level of funding for all states combined (CDC, 2014). Only two states, Alaska and North Dakota, currently fund tobacco control programs at CDC-recommended levels (Tobacco Free Kids, 2015). Implementing comprehensive tobacco control programs at CDC-recommended levels could have a substantial impact: millions fewer persons in the United States would smoke and hundreds of thousands of premature tobacco-related deaths could be prevented; long-term investments could have even greater effects (CDC, 2014; DHHS, 2014).

The analyses in this report are subject to at least three limitations. First, some expenditure data might not have been captured because it was spent by agencies or organizations that were not tracked, which could result in underestimation. For example, direct service expenditures on cessation by private insurers were not captured, neither were the direct expenditures on cessation made by state Medicaid in most states. However, aggregated state tobacco control expenditures were comparable with state tobacco control funding data reported elsewhere (CDC, 2012). Second, expenditure data were self-reported. As a result, variations might exist with regard to expenditure classifications across states. Finally, private organizations or foundations using private funds to conduct tobacco prevention and control activities were not included in the reported expenditures, which would lead to underestimation.

Each day in the United States, the tobacco industry spent nearly $24 million to advertise and promote cigarettes and smokeless tobacco (FTC, 2013). During the same period, more than 3,200 youth younger than 18 years of age smoked their first cigarette and another 2,100 youth and young adults who are occasional smokers progressed to become daily smokers (DHHS, 2014). If current rates continue, 5.6 million Americans younger than 18 years of age who are alive today are projected to die prematurely from smoking-related disease (DHHS, 2014). However, the tobacco-use epidemic can be markedly reduced by implementing interventions that are known to work. Full implementation of comprehensive tobacco control policies and evidence-based interventions at CDC-recommended funding levels could result in a substantial reduction in tobacco-related morbidity and mortality and billions of dollars in savings from averted medical costs and lost productivity in the United States (CDC, 2014; DHHS, 2014).

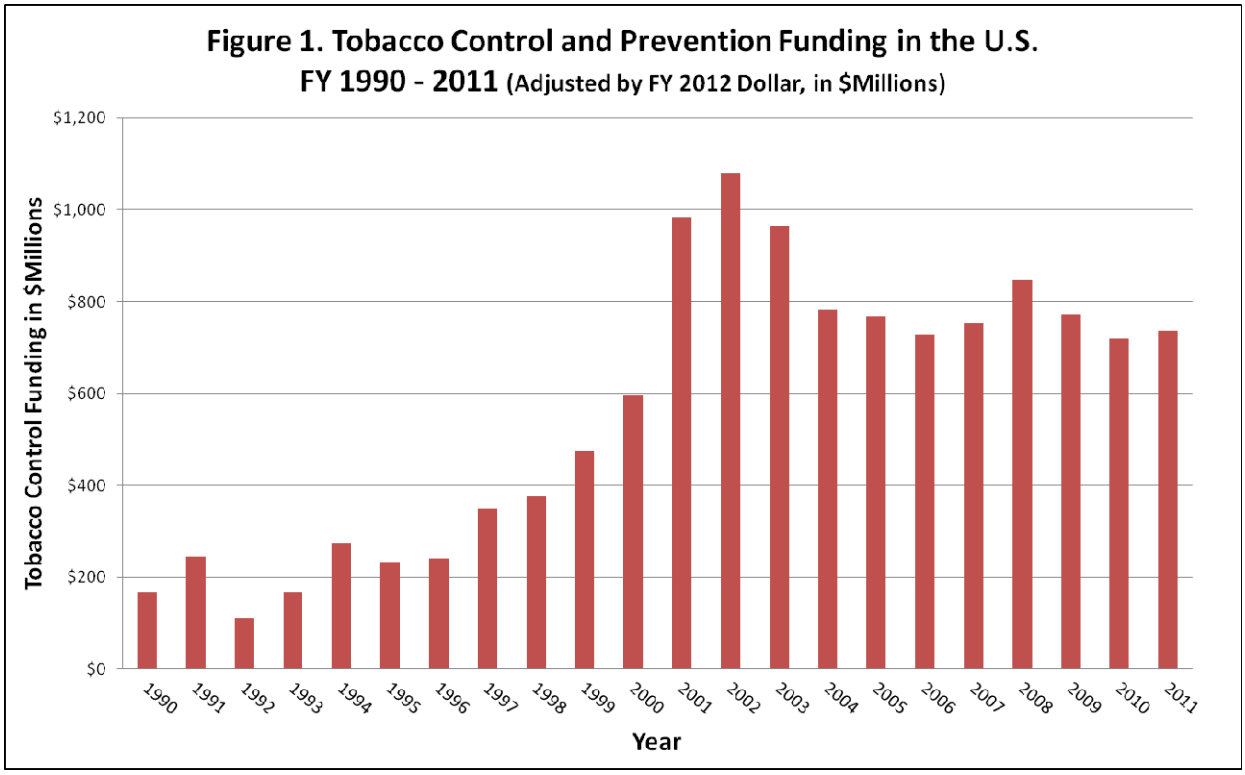
State Tobacco Control and Prevention Expenditures: FY 2008 – 2011

1. Introduction

Every year in the United States, smoking and exposure to secondhand smoke results in nearly one-half million premature deaths and a loss of $289 billion in health care expenditures and productivity (DHHS, 2014). 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 (CDC, 2014). Historically, funding for state tobacco control programs came from a variety of sources, including state cigarette excise taxes, appropriations by state legislatures, voluntary organizations (e.g. the American Lung Association, the American Cancer Society), private foundations (e.g. the Robert Wood Johnson Foundation), and federal programs. Since the late 1990s and early 2000s, many states have used part of their MSA payments to fund state tobacco control programs.

Despite a significant increase in state tobacco control funding after the MSA (see Figure 1), only a few states have sustained funding at or close to the CDC recommended minimum funding level for several years (TFK, 2012). State funding for tobacco control efforts have been shown to be effective in reducing youth and adult smoking prevalence and consumption. For instance, Farrelly and his colleagues (2003) analyzed the impact of tobacco control funding on aggregate cigarette use in all 50 states and the District of Columbia from 1981 through 2000. They found that increases in funding for state tobacco control programs reduced overall cigarette consumption. In addition, they estimated that if all states had begun investing at the CDC's recommended minimum funding level in 1994, aggregate sales would have dropped up to an additional 9% by the year 2000. Using a nationally representative sample of middle and high school students, Tauras et al. (2005) examined the relationship between state-level tobacco control expenditures with youth smoking prevalence and cigarette consumption. They found that real per capita expenditures on tobacco control not only had a negative and significant impact on youth smoking prevalence, but also on the average number of cigarettes smoked by smokers. They estimated that if states spent the minimum amount of money recommended by the CDC throughout the 1990s, the prevalence of smoking among youths would have been between 3.3% and 13.5% lower than the rates observed from the 1991 to 2000 period. Sly et al. (2001) investigated the effects of Florida's well-funded "truth" campaign on teen smoking initiation from 1998 to 2000. They found that within 1 year after Florida's "truth" campaign was launched, the prevalence of smoking for youth declined by 18% in the middle school population and 8% in the high school population. Two years after the "truth" campaign launched, smoking prevalence fell by 40% among middle school students and 18% among high school students. Farrelly et al. (2008) used data from the Tobacco Use Supplement to the Current Population Survey in a quasi-experimental design to examine the association between cumulative state tobacco control program funding and changes in adult smoking prevalence. They found that increases in state per capita tobacco control program expenditures were independently associated with declines in prevalence from 1985 to 2003. Their results also supported that program funding was more effective in reducing smoking prevalence among those aged 25 or older than for those aged 18 to 24 years. They estimated that if all states had funded their tobacco control programs at the minimum or optimal levels recommended by the Centers for Disease Control and Prevention starting in 1995, there would have been 2.2 million to 7.1 million fewer smokers in 2003. In a

more recent study, Ciecierski and her colleagues (2011) investigated the effects of state tobacco control program funding on tobacco use behaviors among college students. Using data from the 1997, 1999, and 2001 waves of the Harvard School of Public Health College Alcohol Study (CAS), they found that a higher level of state spending on tobacco control programs in the prior year was associated with a statistically significant increase in the probability that current daily smokers reported at least one attempt to quit smoking in the past year. They also found evidence that higher state funding on tobacco control programs in the prior year was associated with reductions in the prevalence of daily smoking and 30-day cigar use among college students. Lightwood et al. (2008) investigated the impact of California's cumulative expenditures on state tobacco control programs and per capita personal health care expenditures from 1989 to 2004. Their results revealed that due to tobacco control programs, California saved $86 billion dollars in health care related expenditures. A similar study was conducted in Arizona by Lightwood and Glantz (2011). Investigators examined the relationship between per capita expenditure and health care expenditures from 1976 to 2004. It should be noted that Arizona's tobacco control program focuses primarily on youth prevention, whereas California's is not limited to this population. The findings, however, were similar, with Arizona cumulatively saving $2.33 billion dollars in health care costs due to tobacco control spending.



Given the nature of tobacco control interventions, characterizing tobacco control programs using aggregated funding data is challenging. State tobacco control programs vary considerably from state to state and usually consist of a variety of interventions, including but not limited to: television, radio, and/or print public education campaigns; school-based tobacco prevention programs; smoking cessation materials and telephone quitlines; community grants to promote

smoking cessation and tobacco control policy change; and enforcement of existing policies targeting exposure reduction to smoke in public places as well as youth access to tobacco. In 2007, the CDC updated its guidelines for the *Best Practices for Comprehensive Tobacco Control Programs* (CDC, 2007). It proposed an integrated and programmatic structure for implementing tobacco control interventions that have proven to be effective. The updated guidelines also provided recommended levels of investments for each state. In particular, based on evidence documented in scientific literature, this new version articulated the most effective population-based approaches defined within the following overarching categories: (1) state and community interventions, (2) health communication interventions, (3) cessation inventions, (4) surveillance and evaluation, and (5) administration and management.

Given the evidence demonstrating the effectiveness of tobacco control and prevention spending, it is not surprising that major tobacco control policy surveillance systems (e.g. the CDC's State Tobacco Activities Tracking and Evaluation System [STATE], the American Lung Association's State Legislated Actions on Tobacco Issues [SLATI], and the Campaign for Tobacco Free Kids' State Tobacco Control Funding database) have tracked the total state tobacco control and prevention funds since the late 1990s and early 2000s. Unfortunately, state tobacco control funding data tracked in these systems only report the total/aggregated appropriations/allocations to state tobacco control related activities. Disaggregated spending data by the CDC's Best Practices categories were never tracked or reported. As a result, it is impossible to evaluate both the impact of each program component and the synergistic effects of a comprehensive tobacco control program. With these critical data missing, efforts to produce evidence in support of continued funding for state comprehensive tobacco control programs are impeded, particularly at a time when a large number of states have been reducing, and are currently attempting to reduce tobacco control funding in response to state budget crises. It also hinders state tobacco control practitioners from identifying and preserving critical tobacco control program elements when funding is decreased. Furthermore, the current state aggregated tobacco control funding measures found in major tobacco control policy surveillance systems reflect budgeted (appropriated/allocated) funds, which are different from the actual expenditures on tobacco control activities. The funds initially budgeted for tobacco control may be reduced or used for other non-tobacco control related purposes. In addition, funds allocated to tobacco control that are not fully spent in a given year may be carried forward to the next year in and/or returned to the general fund. As a result, the current aggregated state funding measures may not accurately reflect the resources used for state tobacco control efforts.

In this context, the American Legacy Foundation funded the research team at UIC's Health Policy Center (HPC) in 2007 to build a surveillance database that tracks state tobacco control and prevention spending based on the five categories of the CDC's *Best Practices for Comprehensive Tobacco Control Programs*. It expands and compliments the State Tobacco Control Policy Surveillance System (STCPSS), which tracks major state level tobacco control policies, created and maintained by UIC HPC research team as part of the Bridging the Gap (BTG)/ImpacTeen project. A pilot study was conducted in 2007 to investigate the feasibility of constructing a surveillance database that tracks state tobacco control and prevention expenditures. In 2008, the HPC research team began constructing the State Tobacco Control Expenditure Database (STCED). The team executed this task by replicating the process used to collect data in the 2007 pilot study. The initial data collected in this study was based on the

CDC's 1997 Best Practices categories and later adapted to the revised 2007 Best Practices version.

2. Methodology and Data Collection Process Overview

The goal of the State Tobacco Control Expenditure Database (STCED) is to collect, track, and report actual state expenditures on tobacco control and prevention activities- a measure of the true investments states make in tobacco control and prevention. This technique differs from data which uses state appropriated and allocated funds for tobacco control, as these dollar amounts do not accurately reflect the resources actually spent on state tobacco control efforts.

Given the vast variations in state tobacco control programs, STCED systematically tracks and reports state tobacco control and prevention expenditures consistent with the five program components of the CDC's 2007 Best Practices for Comprehensive Tobacco Control Programs. CDC's 2007 Best Practices (CDC, 2007) define the five program components as:

(1) State and Community Interventions- including supporting and implementing programs and policies to influence societal organizations, systems, and networks that encourage and support individuals to make behavior choices consistent with tobacco-free norms. State and community interventions involve a range of integrated programmatic activities, including local and statewide policies and programs, chronic disease and tobacco-related disparity elimination initiatives, and interventions specifically aimed at influencing youth, as well as policy implementation and enforcement.

(2) Health Communication Interventions- including traditional health communication interventions and counter-marketing strategies that employ a wide range of efforts, including paid television, radio, billboard, print, and web-based advertising at the state and local levels; media advocacy through public relations efforts, such as press releases, local events, media literacy, and health promotion activities; efforts to reduce or replace tobacco industry sponsorship and promotions; and innovations in health communication interventions that include a more focused targeting of specific audiences as well as fostering message development and distribution to the target audience through appropriate channels.

(3) Cessation Interventions- including cessation quitlines that have the potential to reach large numbers of tobacco users and system-based initiatives which ensure that patients seen in the health care system are screened for tobacco use, receive interventions to help them quit, and are offered more intensive counseling services and FDA-approved cessation medications.

(4) Surveillance and Evaluation- the process of monitoring tobacco-related attitudes, behaviors, and health outcomes at regular intervals, including monitoring the achievement of overall program goals and assessing the implementation and outcomes of a program in order to increase efficiency and impact over time.

(5) Administration and Management- including the operation, administration, and management of state tobacco control programs that provide capacity, leadership, program oversight, technical assistance, and training to implement the first four components in a sustained, efficient, and effective manner.

Spending data were gathered, collected, and reported based on these five program components. State tobacco control expenditures were broken down into five program components using the following criteria:

(1) State and Community Interventions– all expenditures on the initiatives to change local and statewide smoke free air policies; reducing exposure to second-hand smoke; eliminating tobacco-related disparity; implementing community and/or school programs aimed at influencing youth; and enforcing youth access laws and smoke-free air policies. This category also includes all related consultant fees.

(2) Health Communication Interventions– all expenditures on anti-tobacco media campaigns, including paid television, radio, billboard, print, and web-based advertising at the state and local levels, regardless its content (i.e. it doesn't matter whether the ads are cessation ads, prevention ads, policy ads, or youth-oriented ads) This category also includes the costs of producing, carrying, and broadcasting those ads and related consultant fees.

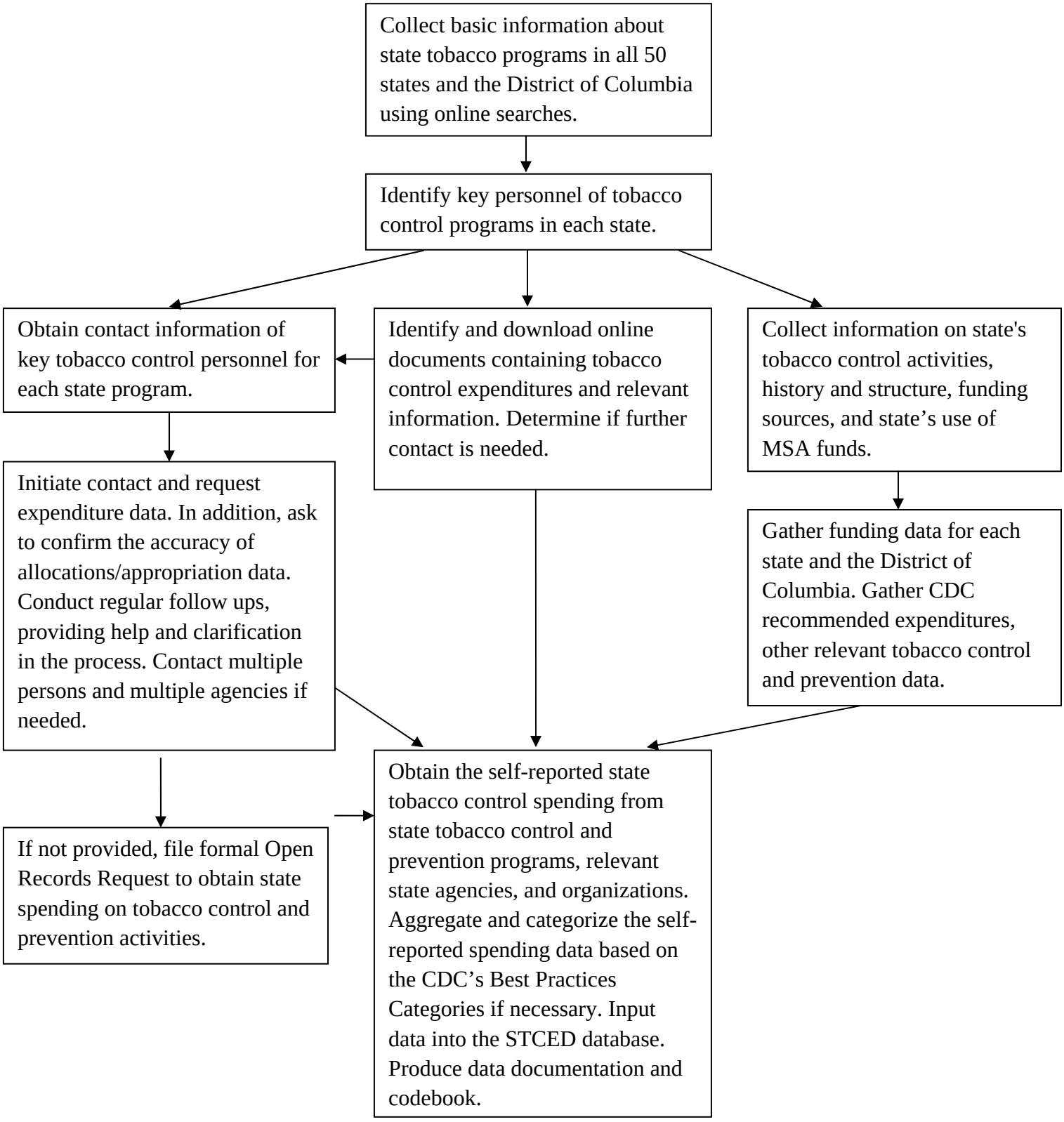
(3) Cessation Interventions– all expenditures on state quitline, cessation services, and pharmacotherapies provided to smokers.

(4) Surveillance and Evaluation– all expenditures on surveys and/or researches that monitor tobacco-related attitudes, behaviors, and health outcomes; and the evaluation of the effectiveness of various tobacco control and prevention interventions.

(5) Administration and Management– all expenditures on salary and fringe benefits of the personnel that manage and operate state tobacco control programs.

The data collection process of STCED is illustrated in Figure 2. The HPC research team began by gathering and compiling basic information on each state's tobacco control programs. This step identified potential resources for tobacco control expenditures in each state. Following this task, the HPC researchers obtained information on the funding history of each state's tobacco control program, the program's focus and structure, the program's current funding sources, and each state's use of its MSA funds. This secondary task complimented the BTG/ImpacTeen project's State Tobacco Control Policy Surveillance System, which had been tracking state tobacco control funding through allocations/appropriations. The major sources of state tobacco control allocation/appropriation of STCPSS were the Campaign for Tobacco Free Kids' State Tobacco Control Funding database and the American Lung Association's State Legislated Actions on Tobacco Issues (SLATI) reports. In their annual SLATI reports, the American Lung Association reports state allocations/appropriations to state tobacco control programs by tracking state tobacco control legislations. Tobacco Free Kids collects similar data through their state and/or regional staffs who, in most cases, obtain such data from state tobacco control programs. In addition to state allocations/appropriations, STCPSS tracks federal funding, non-governmental funding that goes to state tobacco control activities through direct contact with federal government agencies (such as the CDC Office on Smoking and Health), and non-governmental organizations (such as the American Legacy Foundation and the Robert Wood Johnson Foundation).

Figure 2. STCESS Data Collection Process



In the initial stage of STCED, the HPC researchers used online search engines to identify key tobacco control program websites for each state and then compiled a list of their URLs. The researchers then read through these websites to extract all relevant documents about state tobacco control expenditures. Researchers also used the websites to locate the contact information of key personnel in each state for tobacco control expenditures. Minimally, two individuals were identified from each state in the event that an individual did not respond to a researcher's phone call or email.

In addition to information on tobacco control spending, our researchers also used tobacco control program websites to collect information on states' tobacco control activities, program structure and history, funding sources, and states' use of MSA funds when such information was available. Information relevant to each state tobacco control program was also extracted from various Campaign for Tobacco Free Kids reports, American Lung Association's State Legislated Actions on Tobacco Issues reports, and other online sources using online search engines.

To compile information relevant to state spending on tobacco control and prevention activities, HPC researchers searched through any available online electronic documents from state tobacco control agencies' websites. Researchers also utilized other publicly available electronic documents, including state audit and budget reports, those from state health departments, and those from other state agencies or organizations involved in state tobacco control and prevention efforts. Once all relevant information was obtained, our researchers initiated contact with the key personnel in each state. Typically, the first personal contacted was the director or head of the tobacco control division in a state's public health department.

The initial contact generally began with an email which explained who our researchers were, detailed the data for which they were looking, and inquired about the possibility of obtaining such data. If after a week our researchers did not receive a reply, they would follow up with a phone call to the same recipient of the email. Commonly, our research team would hear back from the contacted person within a week and be informed if he/she could provide them with the requested data. The vast majority of those contacted did not have expenditure data readily available, or they did not track their expenditures according to the CDC's Best Practices categories. Our researchers would follow up with the contact person on a regular basis, typically once every two weeks. This constant communication reaffirmed both sides' commitment to the data collection and helped to clarify and answer any questions our contacts had. It also served to resolve any other issues related to our request. The process of the initial communication until the delivery of the data took three to four months on average. If possible, during the process of obtaining the spending data,, our researchers also would request that our contacts verify the accuracy of the allocation/appropriation funding data that STCPSS collected from the Campaign for Tobacco Free Kids and the SLATI reports.

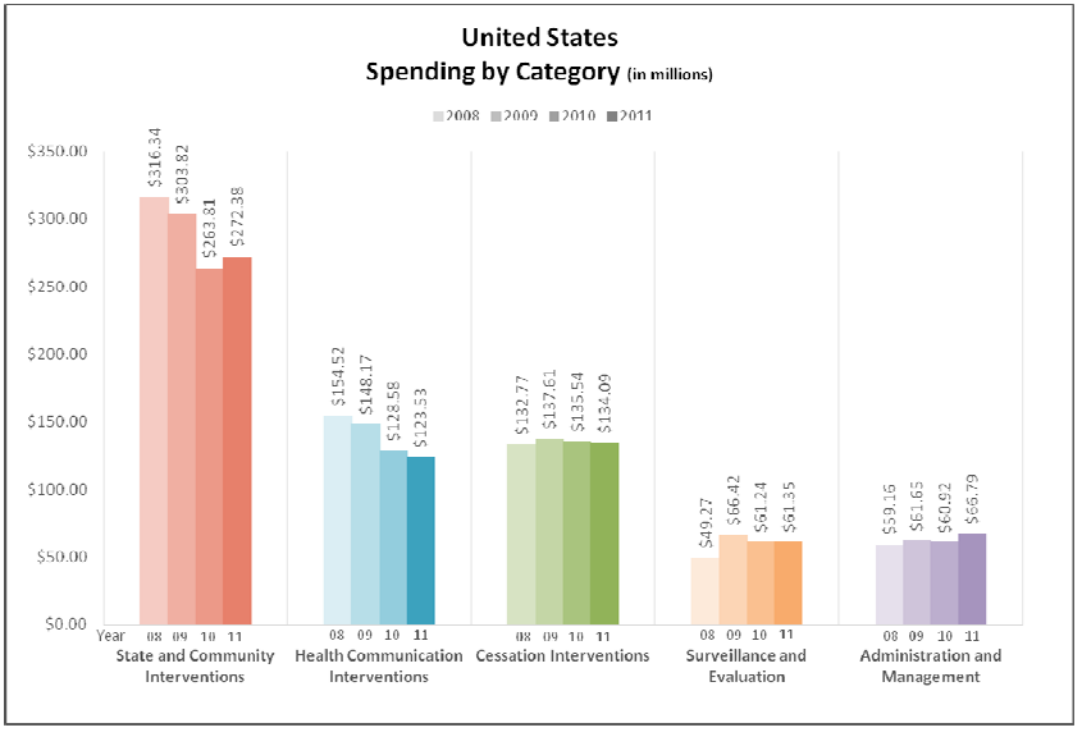
If our researchers did not receive a reply from the contacted person after repeated requests, they would contact the second person on the contact list and repeat the process detailed above. If any of the people contacted were unable to provide the requested information, our researchers would ask the contact if he/she knew of someone who would be able to provide the requested data. If a new contact was provided, our researchers would initiate communication and repeat the same process previously detailed. In many cases, and when multiple agencies were involved with

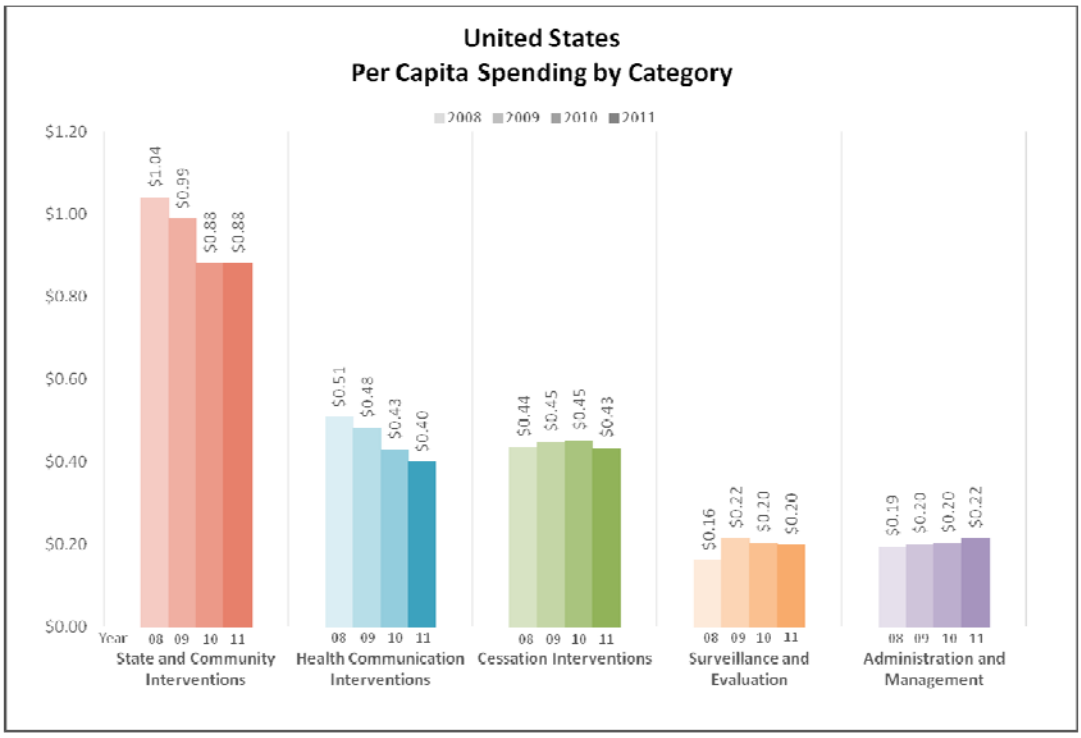
tobacco control initiatives, our researchers would contact each of those agencies (such as the state public health department, education department, and/or MSA funded foundations) in order to obtain the complete expenditure data. If none of the persons contacted responded or offered assistance after repeated requests, our researchers would file a formal Open Records Request in accordance to that particular state's law.

For the majority of the data collected, expenditures were provided to our researchers categorized according to the five program components of the CDC's Best Practices. In some cases, the provided expenditure data were not categorized. In these instances, if data had enough detail, our researchers would categorize the expenditures according to the criteria specified in the methodology section. If our researchers were unable to self-categorize the data, they would request the contact's assistance in sorting the data according to the CDC's Best Practices categories. At the end of our data collection, our researchers developed a data dictionary and documentations which described data sources, how spending data were constructed, and how the database was created.

In order to analyze the collected expenditure data, our researchers obtained data from the CDC's recommended annual per capita funding levels for state programs. For fiscal year 2007, the recommended annual per capita funding levels were taken from the CDC's 2007 Best Practices for Comprehensive Tobacco Control Programs. This report was found on the CDC's website. In calculating the recommended levels for fiscal years 2008 through 2011, our researchers needed to adjust per capita recommended spending levels in CDC's 2007 Best Practices. This adjustment was made according to the Appendix B guidelines found in the CDC's 2007 Best Practices report. The adjustment accounted for inflation in accordance with the U.S. Department of Labor Consumer Price Index, as well as accounting for population growth using U.S. Census Bureau population estimates.

3. Results


United States
Spending by Category (in millions)
2008 2009 2010 2011
$350.00
$300.00
$250.00
$200.00
$150.00
$100.00
$50.00
$0.00
$316.34
$303.82
$263.81
$272.38
$154.52
$148.17
$128.58
$123.53
$132.77
$137.61
$135.54
$134.09
$49.27
$66.42
$61.24
$61.35
$59.16
$61.65
$60.92
$66.79
Year 08 09 10 11
State and Community Interventions
Health Communication Interventions
Cessation Interventions
Surveillance and Evaluation
Administration and Management


United States
Per Capita Spending by Category
2008 2009 2010 2011
$1.20
$1.00
$0.80
$0.60
$0.40
$0.20
$0.00
$1.04
$0.99
$0.88
$0.88
$0.51
$0.48
$0.43
$0.40
$0.44
$0.45
$0.45
$0.43
$0.16
$0.22
$0.20
$0.20
$0.19
$0.20
$0.20
$0.22
Year 08 09 10 11
State and Community Interventions
Health Communication Interventions
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Surveillance and Evaluation
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States' spending in each of the CDC's Best Practices categories represented only a small fraction of the CDC recommended amount. Spending on state and community interventions, the largest program component by spending, represented only approximately 22% of the CDC's recommended spending levels between 2008 and 2011. Similarly, spending on health communication interventions and spending on surveillance and evaluation represented only about one fifth of the CDC's recommended spending levels. Spending on cessation interventions represented only 13% of the CDC's recommended spending levels. Spending on administration and management represented a little over one third of spending levels recommended by CDC.

Aggregated national tobacco control and prevention spending levels, while informative, mask the vast differences in spending across states and the differences in spending for each program component within a state. In the appendix, we present detailed tobacco control and prevention expenditure data for each state and the District of Columbia. These data reveal that tobacco control spending and individual component spending varied greatly across states, both in per capita terms and as a percentage of the CDC's recommended spending levels. Considerable variations also exist in spending levels on each program component across states and over time.

4. Summary and Discussion

Investing in comprehensive tobacco control programs and implementing evidence-based interventions have been shown to reduce youth initiation, tobacco-related disease and death, and tobacco-related health care costs and lost productivity. Moreover, if states allocate funding for tobacco control at CDC's Best Practices levels, they have the potential to achieve larger and more sustainable reductions in all forms of tobacco use and associated morbidity and mortality (CDC, 2014; DHHS, 2014).

The data presented in this report demonstrate a considerable gap between state investments in tobacco prevention and control and CDC's Best Practices recommendations. Although all states derive revenues from cigarette excise taxes, few states have a statutory requirement requiring that a portion of these revenues be dedicated to tobacco prevention and control (CDC, 2012). Instead, most cigarette tax revenues are used for general purposes. Additionally, although in recent years state cigarette excise taxes have nationally increased, these tax increases largely have come in response to shortfalls in state budgets, rather than as initiatives to increase tobacco control spending (CDC, 2007; CDC, 2014). Many state programs have experienced and are facing substantial state government cuts to tobacco control funding, resulting in the near-elimination of tobacco control programs in those states (CDC, 2014). In 2014, despite combined revenue of more than $25 billion from settlement payments and tobacco taxes for all states, states have appropriated only $481.2 million (1.9%) to comprehensive tobacco control programs (Tobacco Free Kids, 2015), an amount <15% of the CDC-recommended level of funding for all states combined (CDC, 2014). Only two states, Alaska and North Dakota, currently fund tobacco control programs at CDC-recommended levels (Tobacco Free Kids, 2015). Implementing comprehensive tobacco control programs at CDC-recommended levels could have a substantial impact: millions fewer persons in the United States would smoke and hundreds of thousands of premature tobacco-related deaths could be prevented; long-term investments could have even greater effects (CDC, 2014; DHHS, 2014).

The analyses in this report are subject to at least three limitations. First, some expenditure data might not have been captured because it was spent by agencies or organizations that were not tracked, which could result in underestimation. For example, direct service expenditures on cessation by private insurers were not captured, neither were the direct expenditures on cessation made by state Medicaid in most states. However, aggregated state tobacco control expenditures were comparable with state tobacco control funding data reported elsewhere (CDC, 2012). Second, expenditure data were self-reported. As a result, variations might exist with regard to expenditure classifications across states. Finally, private organizations or foundations using

private funds to conduct tobacco prevention and control activities were not included in the reported expenditures, which would lead to underestimation.

Each day in the United States, the tobacco industry spent nearly $24 million to advertise and promote cigarettes and smokeless tobacco (FTC, 2013). During the same period, more than 3,200 youth younger than 18 years of age smoked their first cigarette and another 2,100 youth and young adults who are occasional smokers progressed to become daily smokers (DHHS, 2014). If current rates continue, 5.6 million Americans younger than 18 years of age who are alive today are projected to die prematurely from smoking-related disease (DHHS, 2014). However, the tobacco-use epidemic can be markedly reduced by implementing interventions that are known to work. Full implementation of comprehensive tobacco control policies and evidence-based interventions at CDC-recommended funding levels could result in a substantial reduction in tobacco-related morbidity and mortality and billions of dollars in savings from averted medical costs and lost productivity in the United States (CDC, 2014; DHHS, 2014).

Table 1. National Tobacco Control and Prevention Expenditures: FY 2008 - FY 2011							
Category		State and Community Interventions	Health Communication Interventions	Cessation Interventions	Suveillance and Evaluation	Administration and Management	Total
FY 2008	Spending ($Million)	316.335	154.524	132.768	49.269	59.155	712.051
	Dollars ($) per Capita	1.04	0.51	0.44	0.16	0.19	2.34
	% of Total Spending	44%	22%	19%	7%	8%	100%
	Total CDC Recommended	1461.3	706.7	1046.2	321.4	161	3696.6
	% of CDC Recommendation	22%	22%	13%	15%	37%	19%
FY 2009	Spending ($Million)	303.821	148.167	137.609	66.421	61.646	717.664
	Dollars ($) per Capita	0.99	0.48	0.45	0.22	0.20	2.34
	% of Total Spending	42%	21%	19%	9%	9%	100%
	Total CDC Recommended	1461.3	706.7	1046.2	321.4	161	3696.6
	% of CDC Recommendation	21%	21%	13%	21%	38%	19%
FY 2010	Spending ($Million)	263.808	128.583	135.544	61.242	60.923	650.1
	Dollars ($) per Capita	0.88	0.43	0.45	0.20	0.20	2.17
	% of Total Spending	41%	20%	21%	9%	9%	100%
	Total CDC Recommended	1461.3	706.7	1046.2	321.4	161	3696.6
	% of CDC Recommendation	18%	18%	13%	19%	38%	18%
FY 2011	Spending ($Million)	272.384	123.531	134.092	61.351	66.788	658.146
	Dollars ($) per Capita	0.88	0.40	0.43	0.20	0.22	2.13
	% of Total Spending	41%	19%	20%	9%	10%	100%
	Total CDC Recommended	1461.3	706.7	1046.2	321.4	161	3696.6
	% of CDC Recommendation	19%	17%	13%	19%	41%	18%

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Appendix A: Tobacco Control and Prevention in FY 2008 - FY 2011: State by State Report

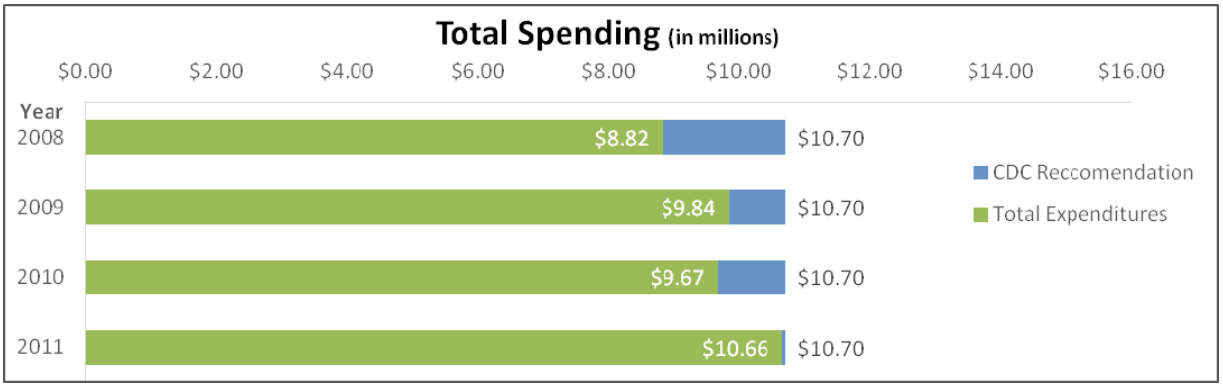
Alaska

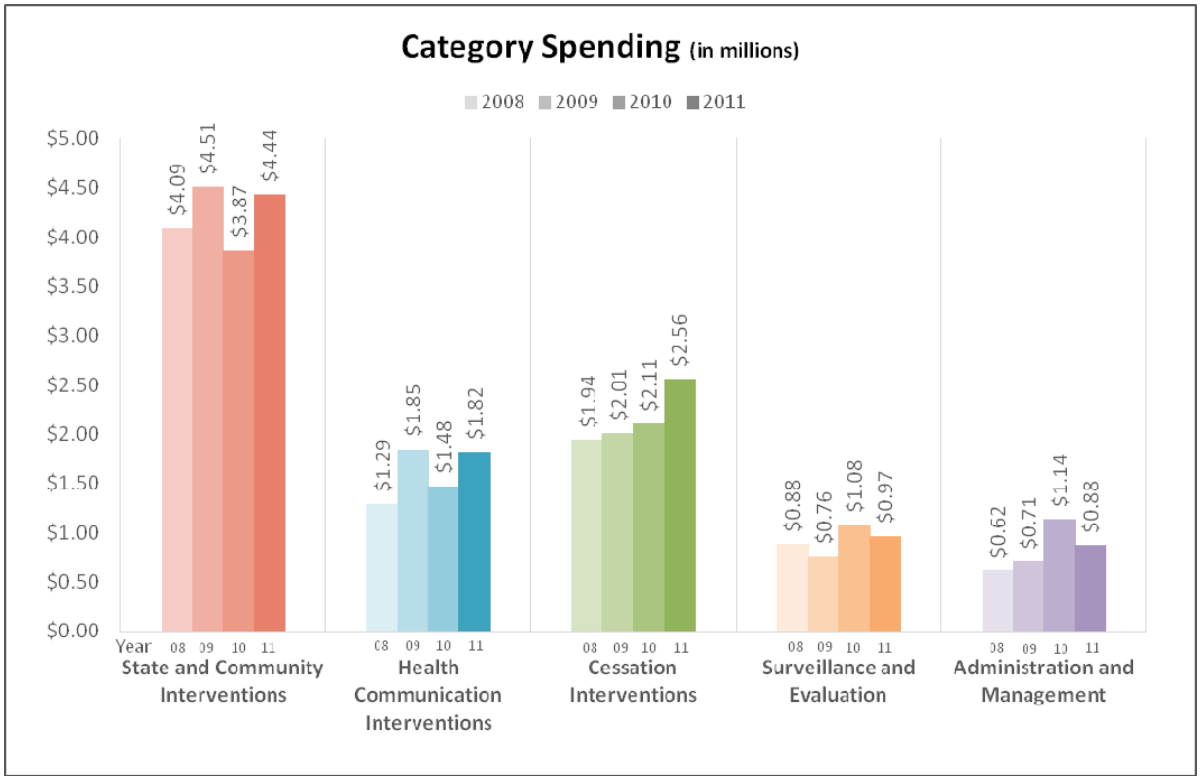
The creation of the Alaska Tobacco Control Alliance (ATCA) in 1992 marked the beginning of Alaska's comprehensive tobacco control efforts (ATCA, 2012). ATCA is a statewide organization that helps a network of health advocates develop, support, and sustain comprehensive tobacco control programs in Alaska. ATCA advises the State of Alaska's Division of Public Health regarding both its tobacco prevention and control needs and resources. Alaska's Tobacco Prevention and Control Program is housed under Alaska's Department of Health and Social Services Division of Public Health. It is funded primarily by the appropriations from its Master Settlement Agreement (MSA) payments through the Alaska Tobacco Use Education and Cessation Fund (ATCA, 2012). Since 1999, Alaska has been dedicating a portion of its MSA funds towards tobacco control measures. Between 2000 and 2001, Alaska sold 80% of its rights to annual cash flows from its MSA payments to the Alaska Housing Finance Corporation for a one-time payment. This one-time payment was used to finance numerous construction projects. The remaining 20% of the annual cash flows went into the Alaska Tobacco Use Education and Cessation Fund. Alaska does have a cigarette tax, which was raised in 2007 from $1.80 to $2.00 per pack of cigarettes. In 2005, for every pack of cigarettes sold in Alaska, $0.76 of the cigarette excise tax revenue was deposited into the "School Fund" for constructing and repairing the state's school facilities. The rest of the cigarette tax revenues went to the state general fund, a small portion of which was then deposited into the Alaska Tobacco Use Education and Cessation fund that supports Alaska's state tobacco control programs (ALA, 2012) .

Alaska spent $8.82 million on tobacco control expenditures during the 2008 fiscal year, reaching 82% of the CDC's recommended level. Of these expenditures, 46% was spent on state and community interventions, 15% on health communications, 22% on cessation interventions, 10% on surveillance and evaluation, and 7% on administration and management. In fiscal year 2009, Alaska invested at 92% of the CDC's recommendation for tobacco control, or $9.84 million. In this fiscal year, approximately 46% of tobacco control expenditures was used for state and community interventions, 19% was used for health communications, 20% was used for cessation interventions, 8% was used for surveillance and evaluation, and 7% was used for administration and management. The following fiscal year, Alaska invested $9.67 million, 90% of the CDC's recommended spending level. Of this investment on tobacco control, 40% was for state and community interventions, 15% was for health communications, 22% was for cessation interventions, 11% was for surveillance and evaluation, and 12% was for administration and management. In the following fiscal year, 2011, Alaska invested $10.66 million, reaching 100% of the CDC's recommended investment level on tobacco control. Of the $10.66 million, Alaska invested 42% in state and community interventions, 17% in health communications, 24% in

cessation interventions, 9% in surveillance and evaluation, and 8% in administration and management.

Alaska								
Tobacco Control Spending Profile FY2008 - FY2011								
	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$4,090,000	$1,290,000	$1,940,000	$880,000	$620,000	$8,820,000	$12.9	82%
FY2009	$4,510,000	$1,850,000	$2,010,000	$760,000	$710,000	$9,840,000	$14.1	92%
FY2010	$3,868,000	$1,475,000	$2,110,000	$1,079,000	$1,138,000	$9,670,000	$13.8	90%
FY2011	$4,436,000	$1,820,000	$2,558,000	$966,000	$875,000	$10,655,000	$14.9	100%





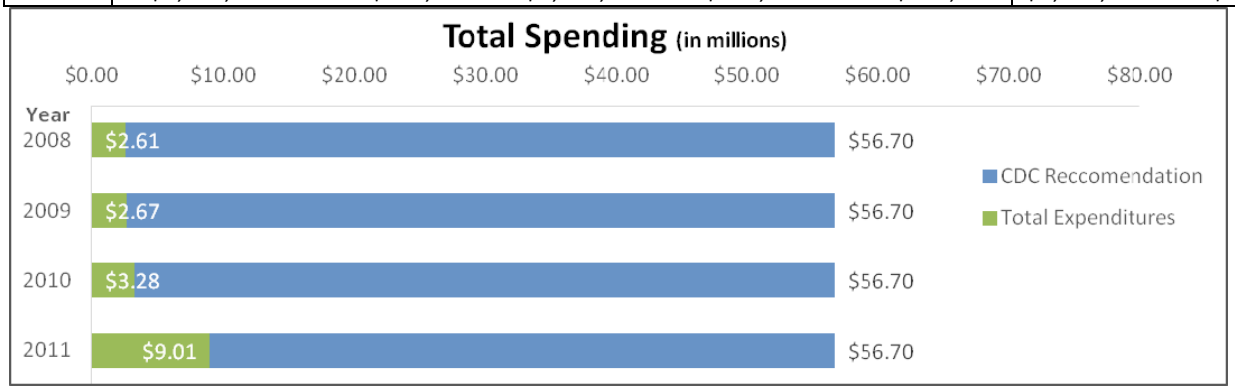
Alabama

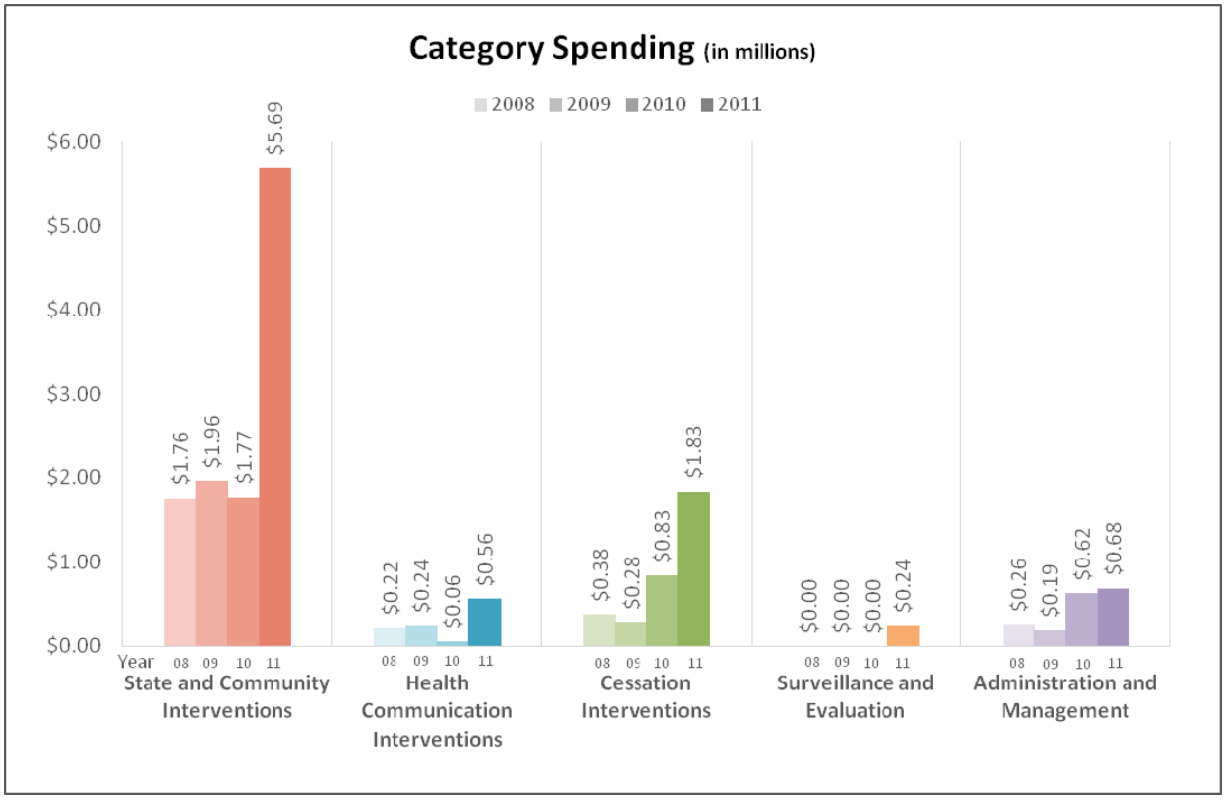
Alabama's Tobacco Prevention and Control program is nested within the Bureau of Chronic Disease Prevention under Alabama's Department of Public Health. It was created with funds from the Centers for Disease Control and Prevention in 1993 (ADPH, 2014). Additional funding for Alabama's Tobacco Control and Prevention program comes from Alabama's Children's First Trust Fund (CFTF), which was established in 1999 with Alabama's Master Settlement Agreement payments. It is overseen by the Alabama Children's Policy Council (ALA, 2012). The legislature appropriates any withdrawn or expended money from the fund. With the money allocated to the Children's First Trust Fund, up to $225,000 can be used for the trust fund's administration, 10% goes to the Department of Public Health (for the Children's Health Insurance Program, youth tobacco control programs, and the Alabama Qualified Health Center Grant Program); 22% goes to the State Board of Education; 20% goes to the Alabama Department of Human Resources, 5% to the Children's Trust Fund; 5% to the State Multiple Needs Children's Fund; 5% to the Department of Mental Health and Mental Retardation; 10% to the Juvenile Probation Services Fund; 17% to the Department of Youth Services; 3.5 % to the Medicaid Agency; and 1% to the Alcoholic Beverage Control Board (to enforce youth tobacco purchase laws). About half of the MSA money in Alabama was directed to the Children's First Trust Fund, which channels the funds to the above-listed purposes. Alabama does have a cigarette tax, which increased in 2004 from $0.165 per pack to $0.425 per pack. Tax revenues from cigarette and other tobacco products are not used for tobacco control or tobacco prevention. The majority of the tax revenue from tobacco is used for Medicaid and other health programs, and payments of state debts (ALA, 2012).

Alabama reached 5% of the CDC's recommended level in the 2008 fiscal year, spending $2.61 million on tobacco control expenditures. State and community interventions received the most money, taking 67% of the state's investment dollars, while 8% went to health communications, 15% went to cessation interventions, 0% went to surveillance and evaluation, and 10% went to administration and management. In fiscal year 2009, Alabama invested $2.67 million, or 5% of the CDC's recommendation for tobacco control. Again, state and community interventions received the most money, taking 73% of the state's investment dollars. For the remaining four categories, 9% of tobacco control expenditures was used for health communications, 11% was used for cessation interventions, 0% was used for surveillance and evaluation, and 7% was used for administration and management. The following fiscal year, Alabama supported its tobacco control programs with $3.28 million, attaining 6% of the CDC's recommended spending level. Of this $3.28 million, 54% was for state and community interventions, 2% was for health communications, 25% was for cessation interventions, 0% was for surveillance and evaluation, and 19% was for administration and management. In the following fiscal year, 2011, Alabama increased its investment in tobacco control to $9.01 million, meaning the state invested at 16% of the CDC's recommended investment level on tobacco control. Of the $9.01 million, Alabama

spent 63% in state and community interventions, 6% in health communications, 20% in cessation interventions, 3% in surveillance and evaluation, and 8% in administration and management.

Alabama								
Tobacco Control Spending Profile FY2008 - FY2011								
	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$1,757,000	$219,000	$377,000	$0	$256,000	$2,609,000	$0.6	5%
FY2009	$1,957,000	$236,000	$282,000	$0	$191,000	$2,666,000	$0.6	5%
FY2010	$1,769,000	$55,000	$833,000	$0	$620,000	$3,277,000	$0.7	6%
FY2011	$5,689,000	$559,000	$1,834,000	$244,000	$683,000	$9,009,000	$1.9	16%





Arizona

The Arizona Department of Health Services (ADHS) Bureau of Tobacco and Chronic Disease (BTCD) runs a comprehensive tobacco control program in Arizona known as Tobacco Free Arizona. Arizona's annual Master Settlement Agreement payments are deposited into the Arizona Tobacco Litigation Settlement Fund and are administered by the director of the Arizona Health Care Cost Containment System. Most of these funds are used for certain Medicaid program benefits. Arizona's tobacco control program began with the Tobacco Tax and Health Care Act (Proposition 200). This was passed in 1994 by Arizona voters and increased cigarette tax by $0.40 per pack. It allocated a portion of that increase for tobacco control and prevention efforts (ALA, 2012). Since then, Arizona's tobacco control and prevention programs have been funded exclusively through cigarette tax revenue. In 2002, Arizona voters approved Proposition 303, increasing the cigarette tax again and reaffirming the earmarking of the $0.23 from the 1994 cigarette tax increase to tobacco control programs. As part of Proposition 303, the Tobacco, Revenue, Use, Spending, and Tracking Commission (TRUST) was created to serve as an advisory board to the Arizona Department of Health Services (ADHS) on tobacco control issues (ADHS, 2013). An increase in cigarette tax of $0.82 was also passed in 2006. Of these cigarette tax revenues, $0.02 is deposited into the Smoke-Free Arizona Fund to enforce the smoke-free air law. After enforcement obligations are met, any remaining monies are transferred to Arizona's Tobacco Education and Prevention Program. The remaining $0.80 of the cigarette tax is distributed to the Early Childhood Development and Education Fund. Of the tax passed in 2002, $0.60 goes to the Tobacco Products Tax Fund, of which each $1.00 in the fund is split as described: $0.42 to the Protection Account, $0.05 to the Health Research Fund, $0.27 to the Medically Needy Account, $0.20 for the Emergency Health Services Account, $0.04 to the health care adjustment account, and $0.02 to the Health Education Account for tobacco prevention programs. Of the tax passed in 1994, $0.40 is deposited into the Tobacco Tax and Health Care Fund, of which each $1.00 is split as described: $0.23 goes into a Health Education Account for tobacco control and prevention programs, $0.05 to Health Research Account for research on the prevention and treatment of tobacco-related disease and addiction, $0.70 to the Medically Needy Account, and $0.02 into an adjustment account (ALA, 2012).

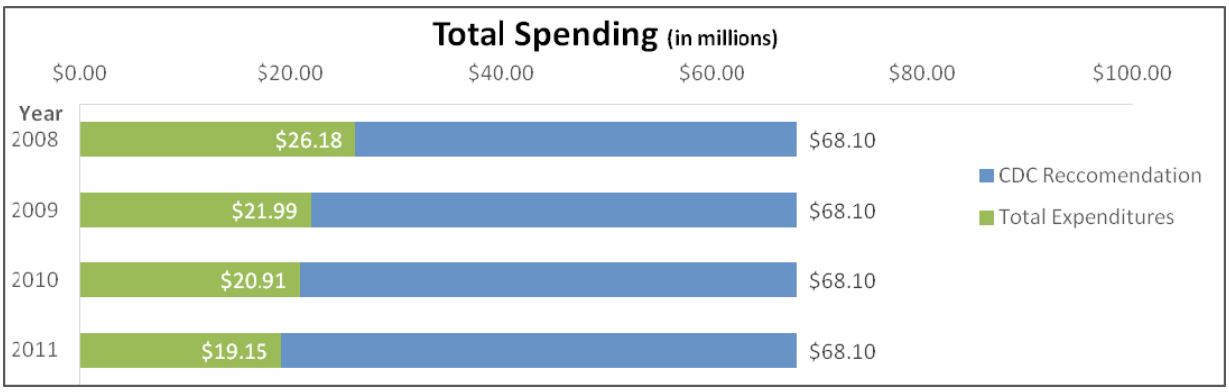
For the 2008 fiscal year, Arizona spent $26.18 million on tobacco control expenditures. This investment allowed the state to reach 38% of the CDC's recommendation for spending. Of these expenditures, 52% was spent on state and community interventions, 20% on health communications, 11% on cessation interventions, 9% on surveillance and evaluation, and 8% on administration and management. Arizona invested $21.99 million, or 32% of the CDC's recommendation for tobacco control, in fiscal year 2009. In this fiscal year, investment in state and community interventions dropped to 47%, health communications dropped to 17%, cessation interventions increased to 18%, surveillance and evaluation dropped to 7%, administration and management increased to 11%. The following fiscal year, Arizona invested 31% of the CDC's recommended spending level, or $20.91 million. Of this fiscal year's expenditure on tobacco

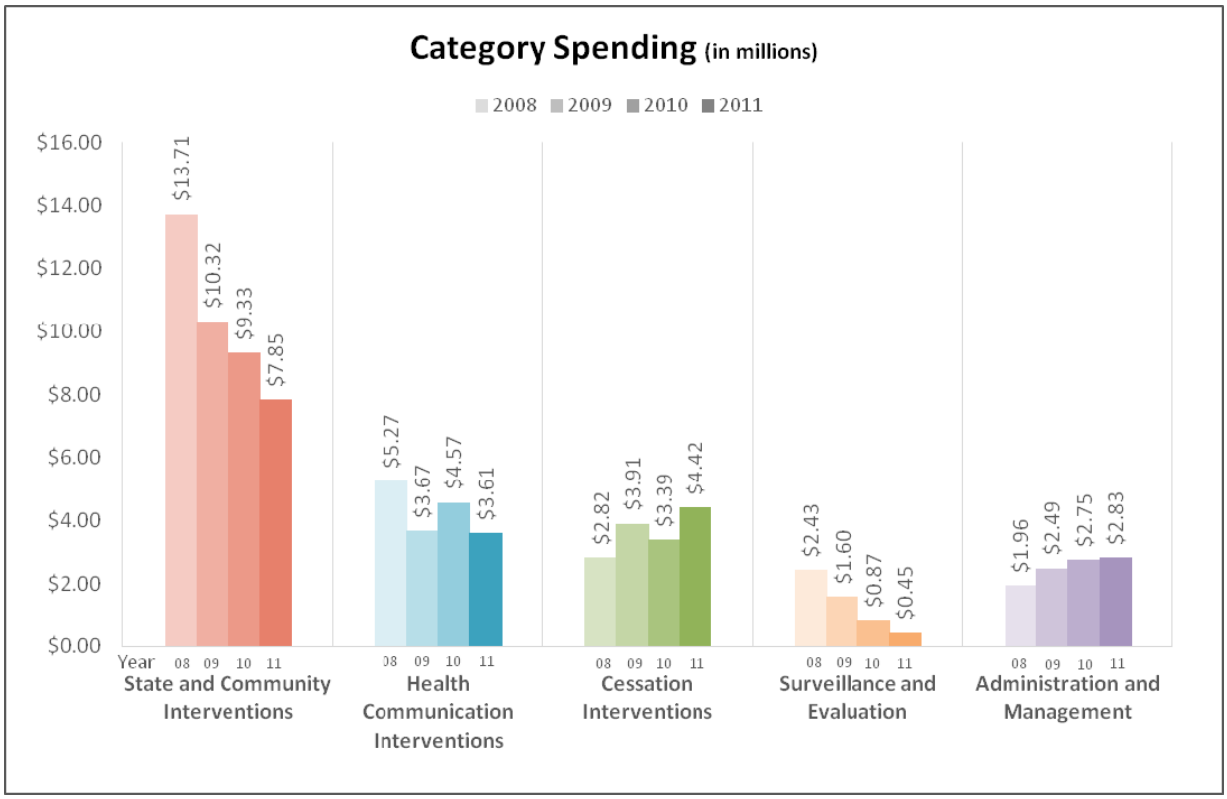
control, 45% was for state and community interventions, 22% was for health communications, 16% was for cessation interventions, 4% was for surveillance and evaluation, and 13% was for administration and management. For the final fiscal year, 2011, Arizona invested $19.15 million, obtaining 28% of the CDC's recommended investment level on tobacco control. Of the $19.15 million, Arizona supported state and community interventions with 41%, health communications with 19%, cessation interventions with 23%, surveillance and evaluation with 2%, and administration and management with 15%.

Arizona

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$13,706,000	$5,274,000	$2,817,000	$2,428,000	$1,956,000	$26,181,000	$4.0	38%
FY2009	$10,317,000	$3,672,000	$3,905,000	$1,604,000	$2,491,000	$21,989,000	$3.3	32%
FY2010	$9,333,000	$4,573,000	$3,385,000	$865,000	$2,752,000	$20,908,000	$3.3	31%
FY2011	$7,846,000	$3,605,000	$4,416,000	$454,000	$2,828,000	$19,149,000	$3.0	28%





Arkansas

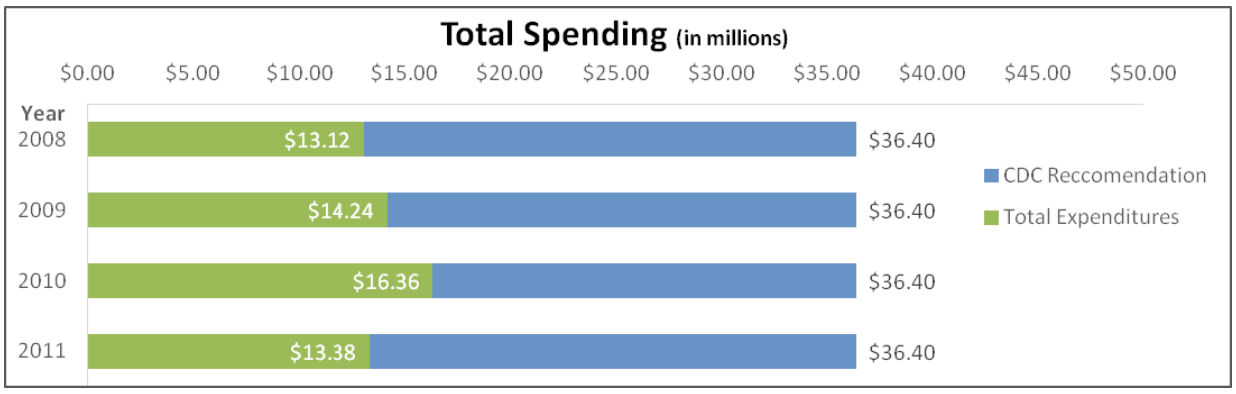
Arkansas' Tobacco Prevention and Cessation Program (TPCP) was created in 2001 (ADH, 2014). It is operated by the Arkansas Department of Health and funded by the state MSA payments. The MSA funding was governed through a ballot initiative approved by voters in 2000 which allocated 31.6% of the state's tobacco settlement funds to tobacco control and prevention programs (ALA, 2012). TPCP implements comprehensive tobacco prevention and control programs recommended by the CDC. Arkansas Tobacco Settlement Commission (ATSC) evaluates and monitors TPCP programs in a biannual report to the Governor and the state General Assembly. Payments from the MSA are deposited into the Tobacco Settlement Cash Holding Fund. The first $5 million of the MSA payments are, by law, distributed towards the Tobacco Settlement Debt Service Funds; the remaining money is deposited into the Tobacco Settlement Program Fund. The Tobacco Settlement Program Fund is split among the following programs: 31.6% go to the Tobacco Prevention and Cessation Program, 15.8% to the Targeted State Needs account, 29.8% to the Medicaid Expansion program, and 22.8% to Arkansas Biosciences Institute. Arkansas' cigarette tax was raised from $0.59 to $1.15 per cigarette pack in 2009. All monies earned from cigarette tax in Arkansas are considered general revenue (ALA, 2012).

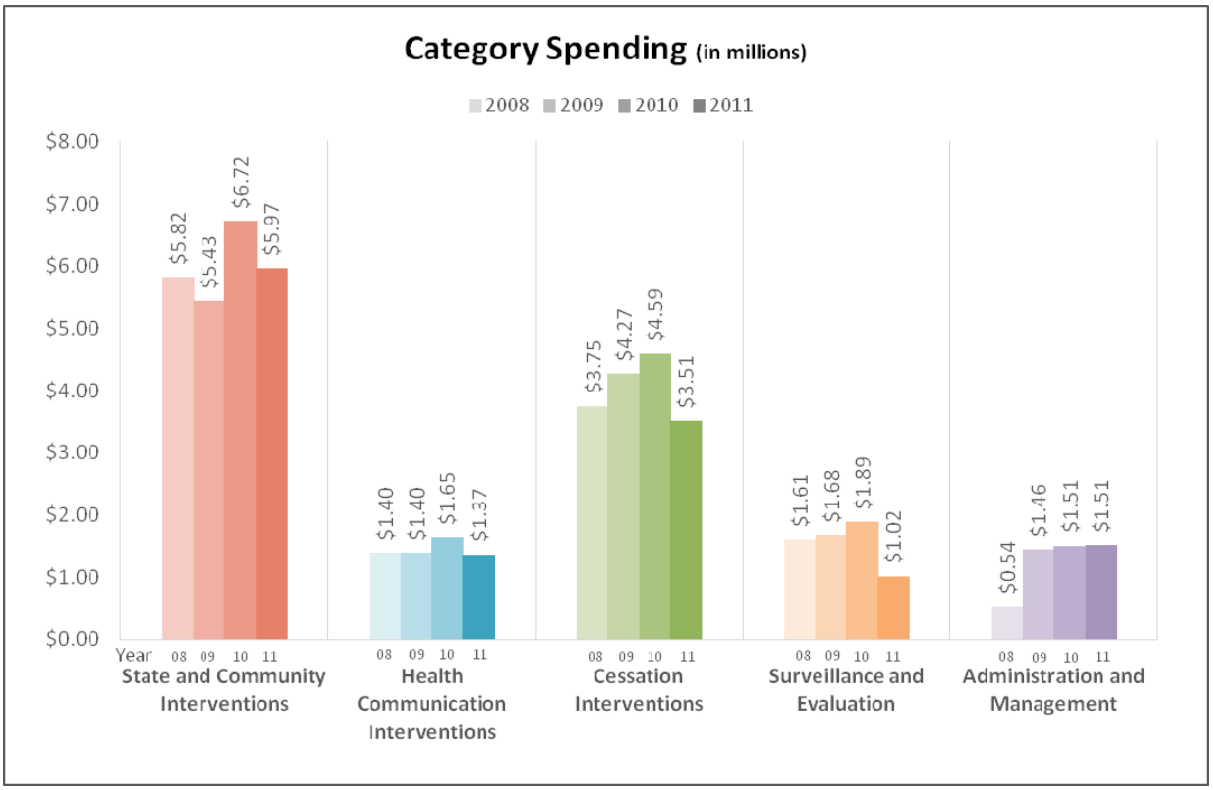
By spending $13.12 million on tobacco control expenditures in fiscal year 2008, Arkansas reached 36% of the CDC's recommended level. As common with many states, the largest proportion of this investment was in state and community interventions. Of the $13.12 million, 44% was spent on state and community interventions, 11% on health communications, 29% on cessation interventions, 12% on surveillance and evaluation, and 4% on administration and management. Arkansas increased its spending in the 2009 fiscal year to $14.24 million, thus fulfilling 39% of the CDC's recommendation for tobacco control. In this fiscal year, approximately 38% of tobacco control expenditures was used for state and community interventions, 10% was used for health communications, 30% was used for cessation interventions, 12% was used for surveillance and evaluation, and 10% was used for administration and management. In the 2010 fiscal year, Arkansas increased its support of tobacco control programs to $16.36 million, 45% of the CDC's recommended spending level. Of this investment on tobacco control, 41% was for state and community interventions, 10% was for health communications, 28% was for cessation interventions, 12% was for surveillance and evaluation, and 9% was for administration and management. For the final fiscal year of this study, 2011, Arkansas delegated $13.38 million to its tobacco control programs, thus reaching 37% of the CDC's recommended investment level on tobacco control. Of the $13.38 million, Arkansas invested 45% in state and community interventions, 10% in health communications, 26% in cessation interventions, 8% in surveillance and evaluation, and 11% in administration and management.

Arkansas

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$5,819,000	$1,395,000	$3,754,000	$1,609,000	$540,000	$13,117,000	$4.6	36%
FY2009	$5,431,000	$1,396,000	$4,272,000	$1,682,000	$1,456,000	$14,237,000	$4.9	39%
FY2010	$6,722,000	$1,648,000	$4,586,000	$1,891,000	$1,513,000	$16,360,000	$5.7	45%
FY2011	$5,967,000	$1,372,000	$3,508,000	$1,018,000	$1,514,000	$13,379,000	$4.6	37%





California

The California Tobacco Control Program is one of the longest running tobacco control programs in the country. It started in 1990 when California voters passed Proposition 99. Proposition 99 increased state cigarette tax by $0.25 and allocated 20% of the tax revenue for tobacco control and prevention purposes (ALA, 2013). California's tobacco control program consists of 3 state entities: The California Tobacco Control Program of the California Department of Public Health (CDPH/CTCP), which administers comprehensive tobacco control programs; the Coordinated School of Health and Safety Office of the California Department of Education (CDE/CSHSO), which is administers the Tobacco-Use Prevention Education (TUPE) program focusing on reducing youth smoking; and the University of California's Tobacco Related Disease Research Program (TRDRP) which supports researches on tobacco use, prevention, cessation, and tobacco related economic costs to the state (TEROC, 2012). The Tobacco Education and Research Oversight Committee (TEROC) evaluates the progress made by these programs on an ongoing basis. It also provides budget and policy recommendations to the state legislature. State funding for tobacco control in California comes from its tobacco tax revenues (ALA, 2012). At the time of report, cigarette excise tax rate in California is $0.87 per pack. The tax revenue is distributed as follows: $0.10 is allocated to state general funds for state budget purposes; $0.02 to the Breast Cancer Fund for cancer research, prevention, and screening programs; $0.50 to the California Children and Families First Trust Fund for promoting, supporting, and improving early child development programs; and the remaining $0.25 to the programs funded under Proposition 99. About a quarter of the revenues are allocated to various tobacco control and prevention programs, and most of the remaining revenues go towards medical care programs, including uncompensated health care for the medically indigent and environmental resource programs. California's rights to the Master Settlement Agreement annual payments were sold to the California Infrastructure and Economic Development Bank for a lump sum payment. The Bank is allowed to sell any portion from the MSA to a special purpose trust. Revenue from the sale is deposited into the general fund, with the exception of residual interest sales; these are deposited in the Tobacco Asset Sale Revenue Fund to be used as specified (ALA, 2012).

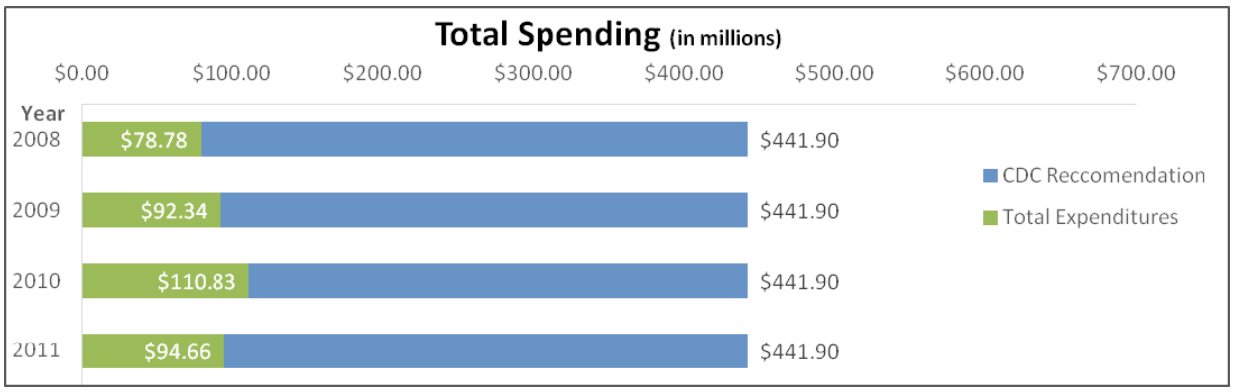
California spent $78.78 million on tobacco control expenditures in the 2008 fiscal year, investing at 18% of the CDC's level of recommendation. The greater majority of this fiscal year's money- 63%- went towards state and community interventions. The remaining amount of the $78.78 million was dispersed as follows: 20% for health communications, 5% for cessation interventions, 5% for surveillance and evaluation, and 7% for administration and management. California increased its spending to 21% of the CDC's recommendation for tobacco control in fiscal year 2009, allocating $92.34 million to this cause. In this fiscal year, the state used approximately 46% of tobacco control expenditures for state and community interventions, 17% for health communications, 5% for cessation interventions, 24% for surveillance and evaluation, and 8% for administration and management. The following fiscal year, California funded tobacco control programs with $110.83 million, reaching 25% of the CDC's recommended

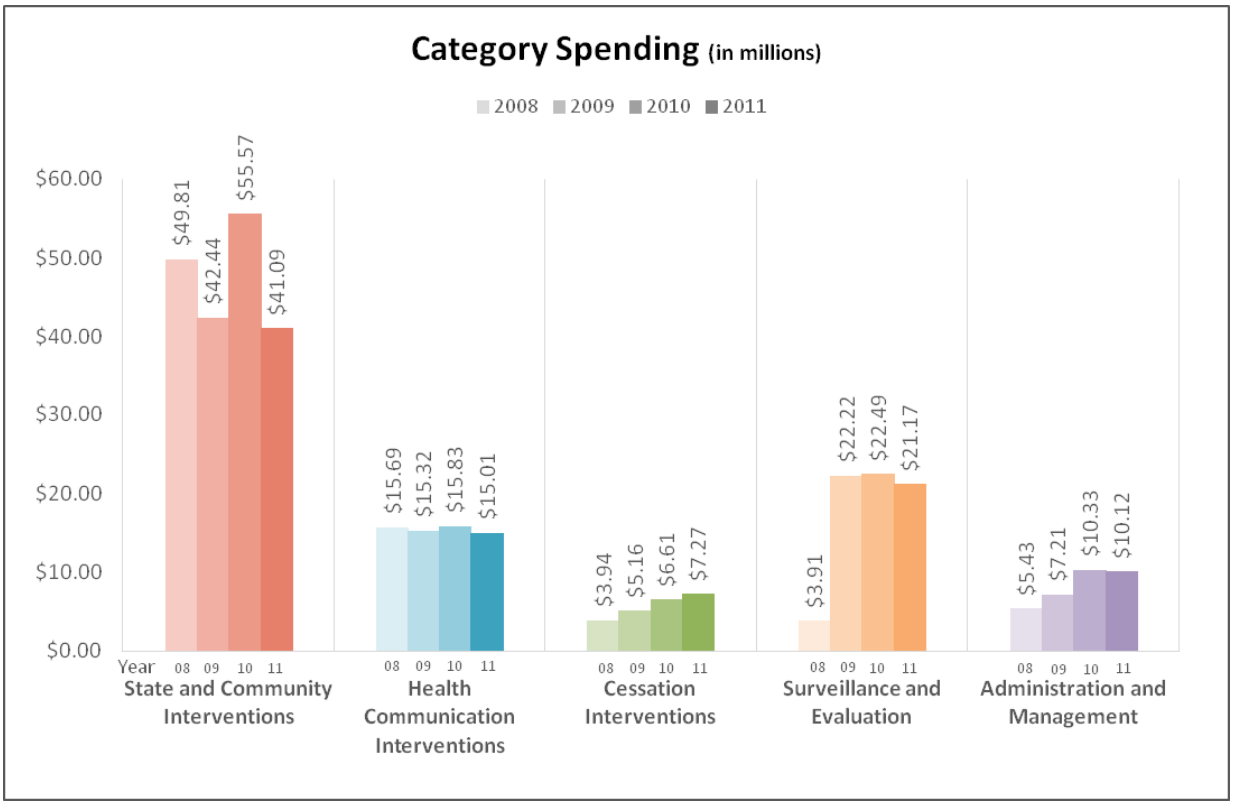
spending level. From this increased investment, 50% was for state and community interventions, 14% was for health communications, 6% was for cessation interventions, 20% was for surveillance and evaluation, and 10% was for administration and management. In the following fiscal year, 2011, California decreased its investment $94.66 million, and met 21% of the CDC's recommended investment level on tobacco control. The $94.66 million was divided as follows: 43% in state and community interventions, 16% in health communications, 8% in cessation interventions, 22% in surveillance and evaluation, and 11% in administration and management.

California

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$49,810,000	$15,690,000	$3,940,000	$3,910,000	$5,430,000	$78,780,000	$2.1	18%
FY2009	$42,438,000	$15,320,000	$5,157,000	$22,216,000	$7,213,000	$92,344,000	$2.5	21%
FY2010	$55,568,000	$15,832,000	$6,607,000	$22,490,000	$10,332,000	$110,829,000	$3.0	25%
FY2011	$41,089,000	$15,014,000	$7,267,000	$21,167,000	$10,121,000	$94,658,000	$2.5	21%





Colorado

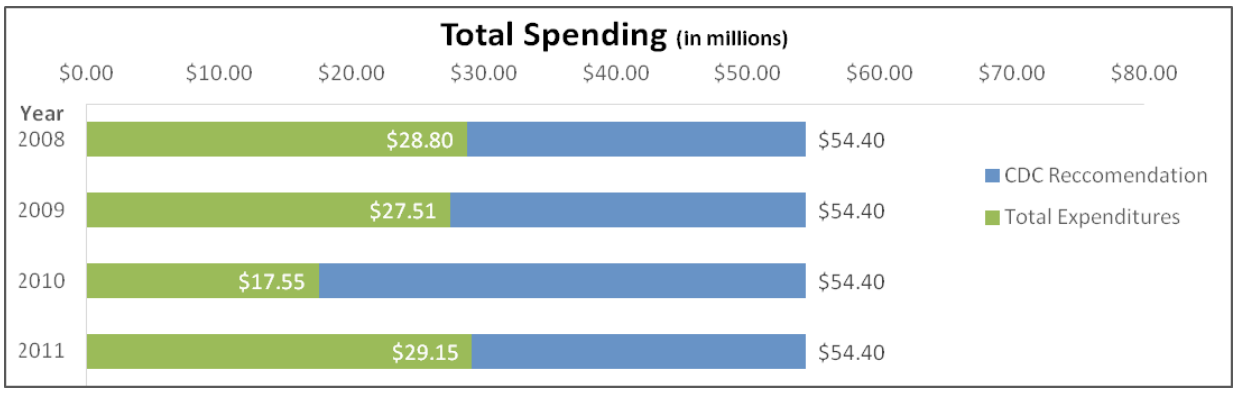
The Tobacco Review Committee in Colorado oversees Colorado's Department of Public Health and Environment (CDPHE). The CDPHE administers Colorado's Tobacco Education, Prevention, and Cessation Grant Program, which provides funding for statewide tobacco control programs. In 2005, Colorado raised its cigarette excise tax and started to fund its tobacco control program through cigarette taxes. Current tax is at $0.84, of which $0.64 is distributed to the Tobacco Tax Cash Fund and from there distributed to specific programs. Additionally, $0.20 goes towards the state general fund and old age pension fund. Within the Tobacco Tax Cash Fund, 46% goes to the Health Care Expansion Fund; 19% goes to the Primary Care Fund; 16% goes to the Tobacco Education Programs Fund; and 16% goes to the Prevention, Early Detection and Treatment Fund, except for fiscal years 2009-2012 (ALA, 2012). In these fiscal years, interest and income from the Tobacco Tax Cash Fund are deposited into the general state fund. Master Settlement Agreement money are deposited into the Tobacco Litigation Settlement Cash Fund and then distributed to a variety of funds and programs for health, litigation, education, social services, budget shortfalls, or to meet other need in the general fund (ALA, 2012).

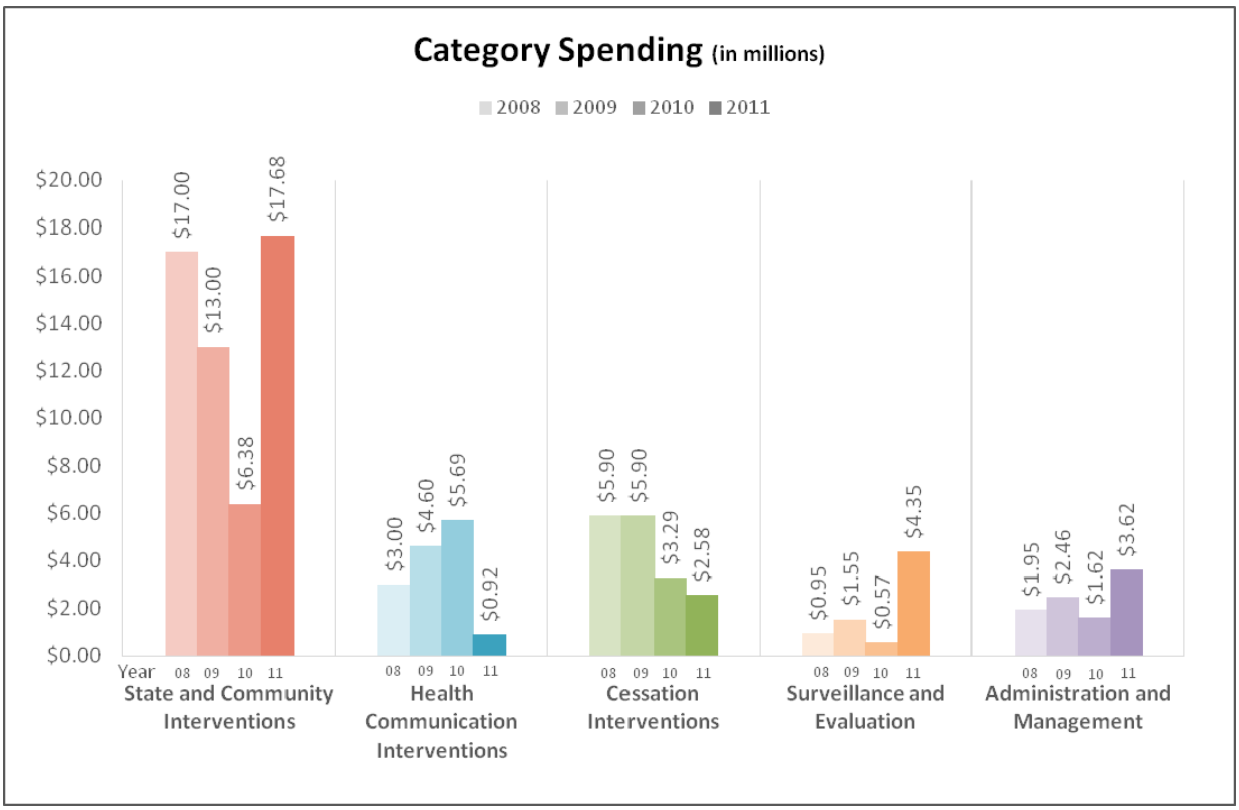
Colorado invested $28.8 million on tobacco control expenditures in the 2008 fiscal year, fulfilling 53% of the CDC's recommended investment level. With these investments, the state allocated 59% tostate and community interventions, 10% to health communications, 21% to cessation interventions, 3% to surveillance and evaluation, and 7% to administration and management. Colorado reached 51% of the CDC's recommendation for tobacco control in the 2009 fiscal year, by funding tobacco control programs with $27.51 million. The state used approximately 47% of tobacco control expenditures for state and community interventions, 17% for health communications, 21% for cessation interventions, 6% for surveillance and evaluation, and 9% for administration and management. The following fiscal year, Colorado decreased its investment to $17.55 million, meeting 32% of the CDC's recommended spending level. Of this money provided for tobacco control, 36% went to state and community interventions, 33% went to health communications, 19% went to cessation interventions, 3% went to surveillance and evaluation, and 9% went to administration and management. In the following fiscal year, 2011, Colorado increased its investment markedly with $29.15 million provided to tobacco control programs, and the state was able to obtain 54% of the CDC's recommended investment level for tobacco control. Of the $29.15 million, Colorado invested 61% in state and community interventions, 3% in health communications, 9% in cessation interventions, 15% in surveillance and evaluation, and 12% in administration and management.

Colorado

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$17,000,000	$3,000,000	$5,900,000	$950,000	$1,950,000	$28,800,000	$5.8	53%
FY2009	$13,000,000	$4,600,000	$5,900,000	$1,550,000	$2,460,000	$27,510,000	$5.5	51%
FY2010	$6,377,000	$5,686,000	$3,292,000	$574,000	$1,622,000	$17,551,000	$3.5	32%
FY2011	$17,675,000	$924,000	$2,582,000	$4,354,000	$3,618,000	$29,153,000	$5.8	54%





Connecticut

Connecticut's funding for tobacco control programs is taken from its annual Master Settlement Agreement payments (ALA, 2012). With the MSA money, Connecticut created the Tobacco and Health Trust Fund (THTF) to implement its tobacco control programs. The Tobacco and Health Trust Fund does not directly run its tobacco control programs, rather it makes recommendations to the state legislature concerning the appropriations for state tobacco control activities/programs. The Connecticut Department of Public Health (DPH) and the Department of Mental Health and Addiction Services (DMHAS) are the general the recipients of these appropriate funds. The money is then used to carry out tobacco control activities. Nearly all tobacco control activities executed by the DPH and the DMHAS are performed in collaboration with other state agencies and community partners. Until 2008, the board of trustees who administered the funds at the Tobacco and Health Trust Fund were allowed to allocate half of the earnings and interest from the trust fund for tobacco control programs. In 2008, half of the annual principal paid into the account and all of the earnings could be allocated towards tobacco control purposes. In 2009, the state legislature changed the rules on how monies from the THTF could be spent, allowing the Trust Fund's Board to spend up to 50% of the amount added by the legislature to the principal balance of the Fund (TFK, 2012). Starting in fiscal year 2002 and following every year after, MSA payments have been allocated for the following purposes: $12 million for the Tobacco and Health Trust Fund, $4 million for the Biomedical Research Trust Fund, an unspecified amount for the general fund, and the remainder for the Tobacco and Health Trust Fund. Starting in fiscal year 2005 and following every year after, $100,000 is allocated to the Department of Revenue Services and $25,000 is allocated to the Attorney General. Between fiscal years 2005 and 2015, $10 million will be allocated to the Stem Cell Research Fund. Revenues from cigarette tax, which increased from $3.00 to $3.40 in 2011, are allocated to the state general fund and from there are appropriated by the legislature (ALA, 2012).

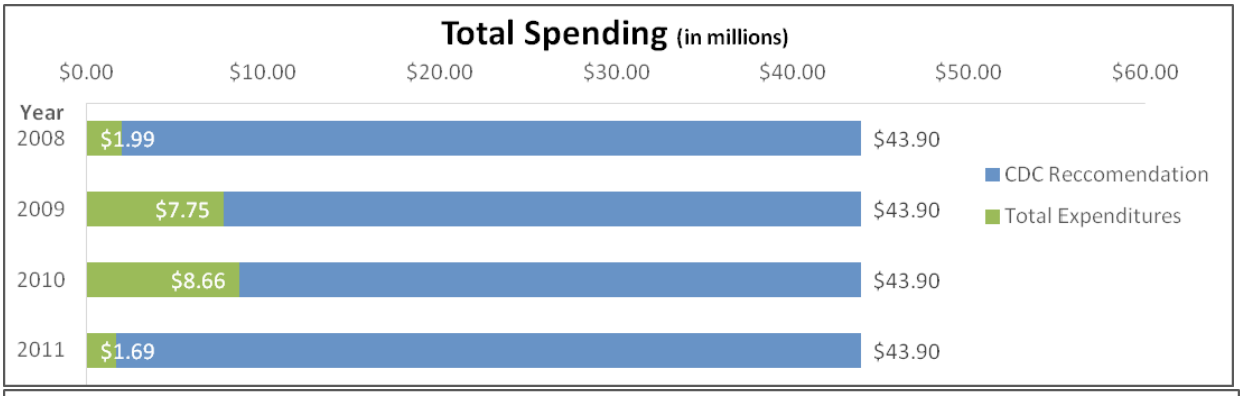
For the 2008 fiscal year, Connecticut met 5% of the CDC's suggested spending level, financing tobacco control programs with $1.99 million. Of this total amount, Colorado assigned 24% to state and community interventions, 13% to health communications, 55% to cessation interventions, 5% to surveillance and evaluation, and 3% to administration and management. Connecticut increased its tobacco control investment in the 2009 fiscal year. By spending $7.75 million, Connecticut invested at 18% of the CDC's recommendation for tobacco control. State and community's funding decreased to 14%, health communications increased to 28%, cessation interventions decreased to 50%, surveillance and evaluation increased to 7%, and administration and management decreased to 1%. The following fiscal year, Connecticut again increased its investment with $8.66 million allocated to tobacco control programs. This allocation reached 20% of the CDC's recommended spending level. Of these monies provided to tobacco control, 21% was for state and community interventions, 25% was for health communications, 44% was for cessation interventions, 8% was for surveillance and evaluation, and 2% was for administration and management. In the following fiscal year, 2011, Connecticut's funding for

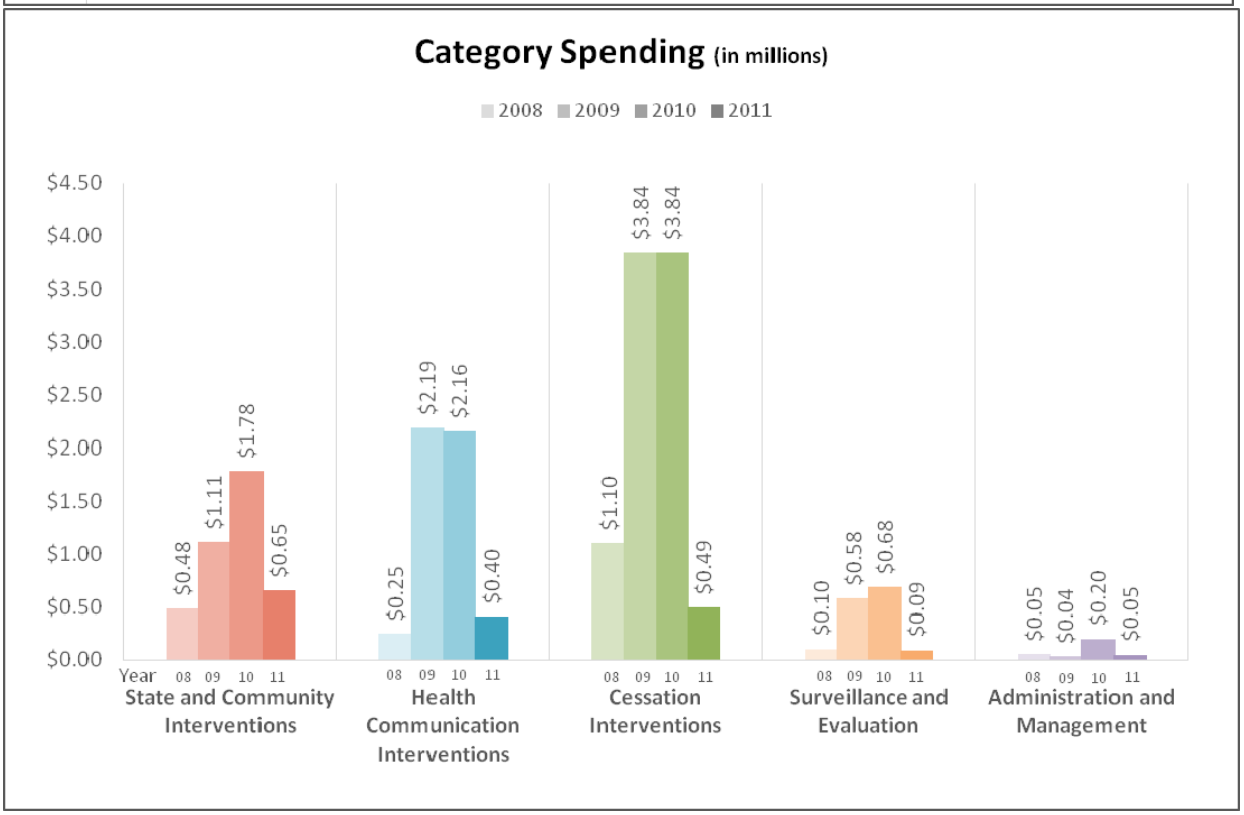
tobacco control decreased significantly to $1.69 million, reaching 4% of the CDC's recommended investment level on tobacco control. Connecticut assigned 38% of the $1.69 million to state and community interventions, 24% to health communications, 29% to cessation interventions, 6% to surveillance and evaluation, and 3% to administration and management.

Connecticut

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$483,000	$249,000	$1,104,000	$103,000	$52,000	$1,991,000	$0.6	5%
FY2009	$1,110,000	$2,186,000	$3,839,000	$577,000	$38,000	$7,750,000	$2.2	18%
FY2010	$1,783,000	$2,155,000	$3,842,000	$683,000	$200,000	$8,663,000	$2.4	20%
FY2011	$650,000	$404,000	$493,000	$93,000	$49,000	$1,689,000	$0.5	4%





Delaware

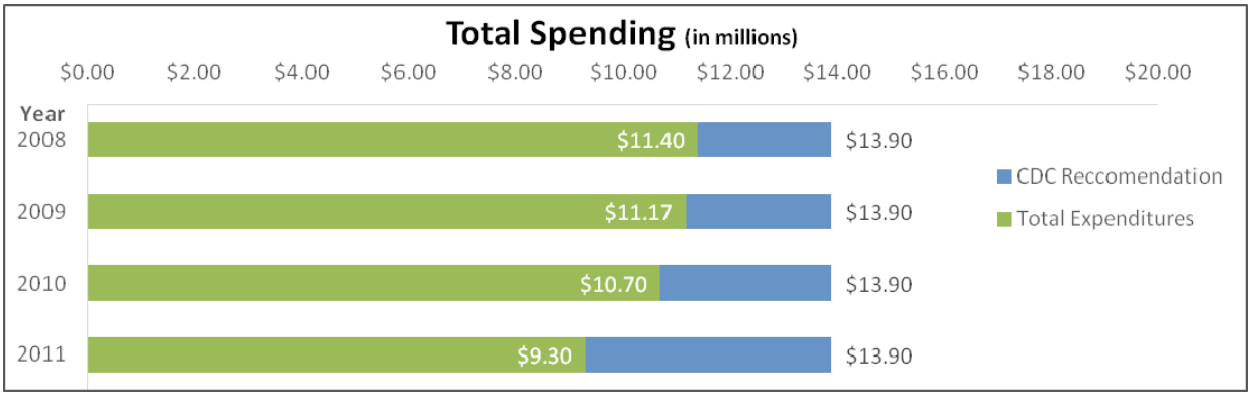
The Delaware Department of Health and Social Services (DHSS) manages Delaware's Tobacco Prevention and Control Program. CDC grants and Delaware's Master Settlement Agreement payments allocated to the Delaware Health Fund support the DHSS (DHSS, 2011). The Delaware Health Fund Advisory Committee oversees the fund and sends its recommendations as to how the money should be spent to the state legislature for approval. These recommendations and approval occur during the state's annual budget process. Other state agencies, such as the Department of Education and the Department of Safety and Homeland Security, also receive money for tobacco control related activities. Delaware's Tobacco Prevention and Control Program collaborates with the Delaware Tobacco Prevention Coalition, health care organizations, youth and community groups, educational organizations, grassroot networks, and other state agencies to carry out tobacco control activities throughout the state. Delaware's Tobacco Control Program focuses on cessation programs, anti-tobacco media campaigns, and youth-led anti-tobacco campaigns. Since 2002, approximately 75% of the funds from the Delaware Health Fund were spent on state health programs, the remaining 25% was divided between tobacco control programs (about 15%) and social services/education programs (about 10%). Funding for fiscal year 2012 did not come from the Health Fund, but rather from a blend of one-time, special appropriations to the General Fund (TFK, 2012). Delaware has as cigarette tax of $1.60, which was increased from $1.15 in 2009.

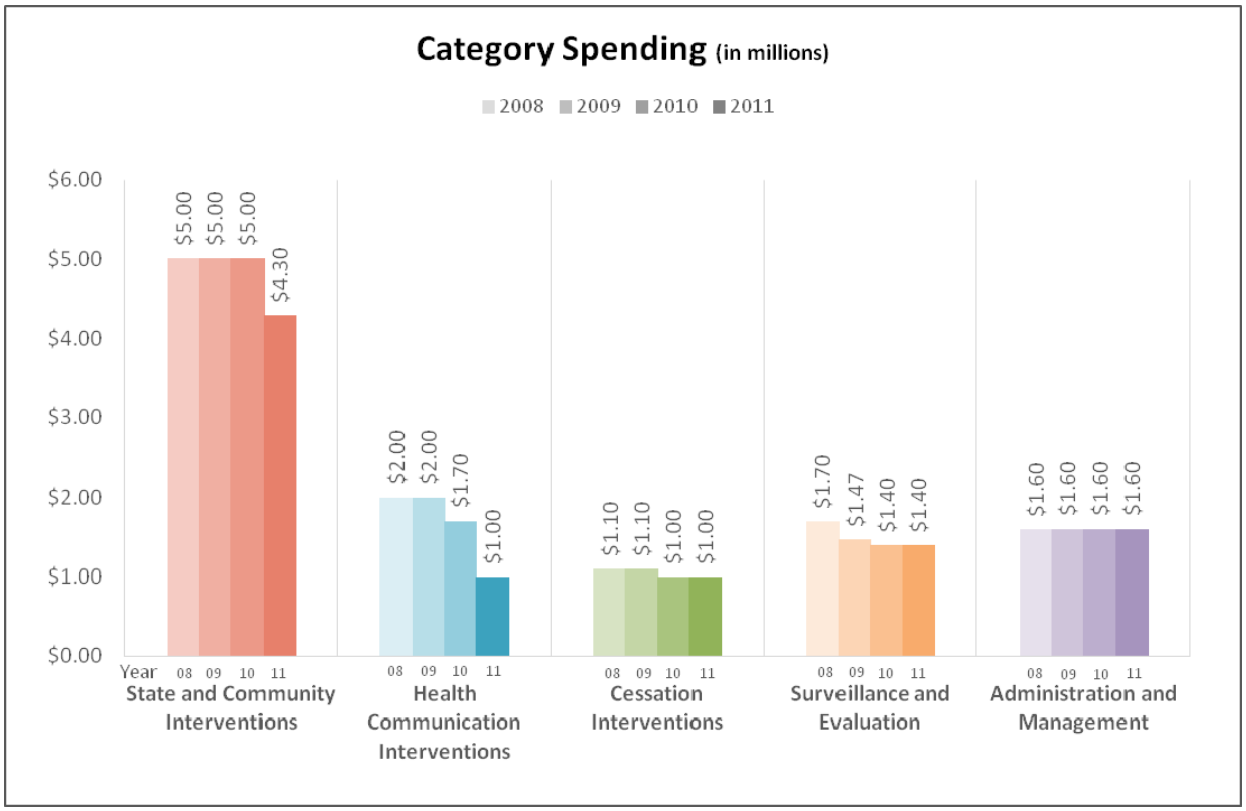
By appointing $11.4 million to tobacco control expenditures in the 2008 fiscal year, Delaware obtained 82% of the CDC's recommended level. On trend with most other states, the majority of this amount, 44%, was spent on state and community interventions. Of the remaining amount, 17% was appointed to health communications, 10% to cessation interventions, 15% to surveillance and evaluation, and 14% to administration and management. In fiscal year 2009, Delaware continued to invest at a high percentage of the CDC's recommendations, reaching 80% of its suggested total. With the $11.17 million provided to tobacco control programs, the state used approximately 45% for state and community interventions, 18% for health communications, 10% for cessation interventions, 13% for surveillance and evaluation, and 14% for administration and management. The following fiscal year, 2010, Delaware authorized $10.7 million, or 77% of the CDC's recommended spending level, to be spent on tobacco control and prevention. With this total, Delaware delegated 47% towards state and community interventions, 16% towards health communications, 9% towards cessation interventions, 13% towards surveillance and evaluation, and 15% towards administration and management. Delaware continued to decrease its allocations for tobacco control in 2011 as well,investing $9.3 million, reaching 67% of the CDC's suggested investment level for tobacco control. Delaware supported state and community interventions with 46% of the $9.3 million and continued to support the remaining categories in the following ways: 11% to health communications, 11% to cessation interventions, 15% to surveillance and evaluation, and 17% to administration and management.

Delaware

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$5,000,000	$2,000,000	$1,100,000	$1,700,000	$1,600,000	$11,400,000	$13.1	82%
FY2009	$5,000,000	$2,000,000	$1,100,000	$1,470,000	$1,600,000	$11,170,000	$12.6	80%
FY2010	$5,000,000	$1,700,000	$1,000,000	$1,400,000	$1,600,000	$10,700,000	$12.0	77%
FY2011	$4,300,000	$1,000,000	$1,000,000	$1,400,000	$1,600,000	$9,300,000	$10.3	67%





District of Columbia

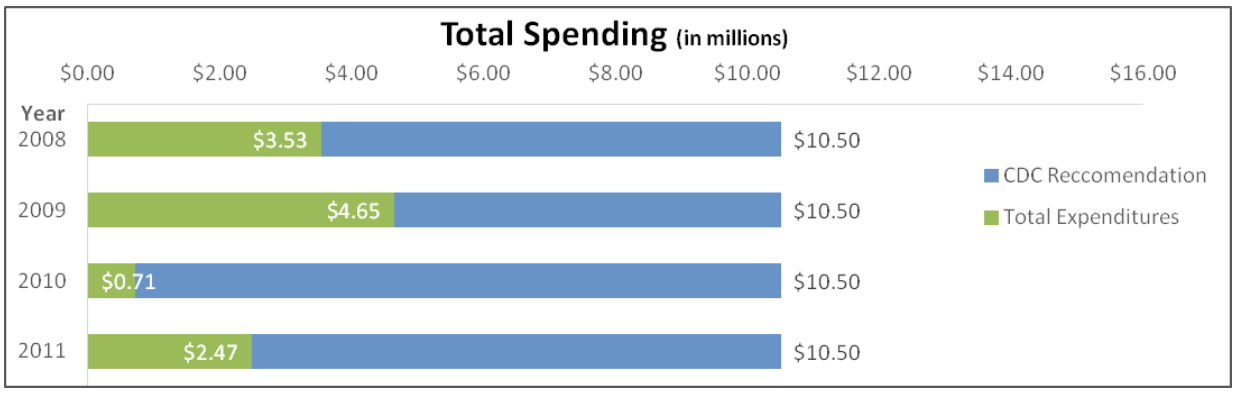
The District of Columbia's Department of Health has been involved in tobacco prevention and cessation measures through its tobacco control program since 1993 (DMH, 2010). To receive a lump sum, the District of Columbia sold the majority of its rights from the MSA annual funds to a Tobacco Settlement Financing Corporation. The money received from the sale was used to cover its debts (ALA, 2012). A portion of money was taken from the lump sum and was then used to establish a Community Health Care Financing Fund in 2006. The money transferred from the 2006 securitization of MSA cash flows was deposited in this fund. The majority of the money in the fund is allocated for health care promotion and delivery of health care services. Between 2007 and 2009, the District of Columbia used funds from the American Lung Association and spent $10 million on the DC Tobacco-Free Families Campaign. The campaign focused on tobacco prevention and cessation. The funds, however, were not re-appropriated for the 2010 fiscal year (TFK, 2012). Tobacco control programs are currently funded through the city's general fund. The District of Columbia does have a cigarette tax of $2.50, increased from $2.00 in 2009.

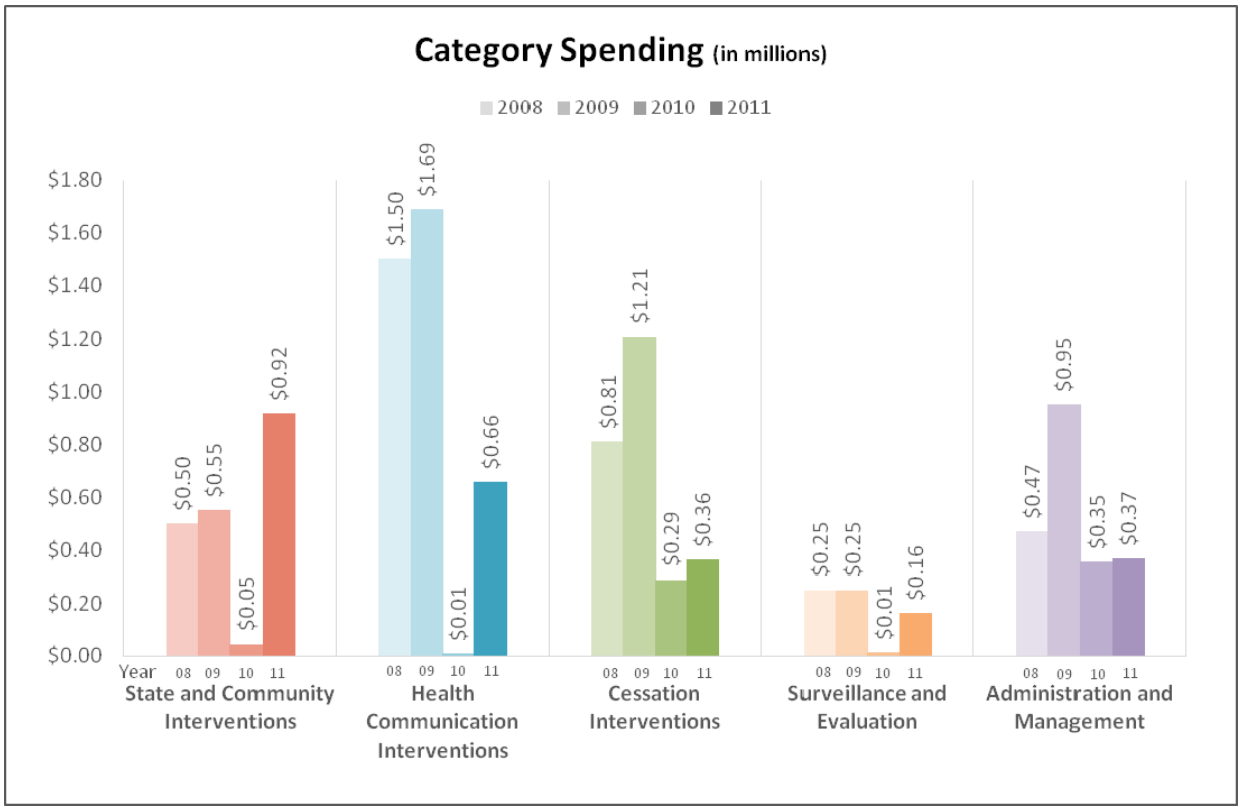
To reach 34% of the CDC's recommended tobacco control spending level, the District of Columbia spent $3.53 million on tobacco control programs in 2008. Of these expenditures, state and community interventions received 14%, health communications received 43%, cessation interventions received 23%, surveillance and evaluation received 7%, and administration and management received 13%. In fiscal year 2009, the District of Columbia invested $4.65 million, or 44% of the CDC's level of recommendation for tobacco control expenditures. In this fiscal year, approximately 12% of tobacco control expenditures was issued to state and community interventions, 36% was issued to health communications, 26% was issued to cessation interventions, 5% was issued to surveillance and evaluation, and 21% was issued to administration and management. The following fiscal year, the District of Columbia invested less money- $0.713 million- reaching 7% of the CDC's recommended spending level for the area. With this amount, 6% went towards enforcing state and community interventions, 1% went towards implementing health communications, 41% went towards cessation interventions, 2% went towards conducting surveillance and evaluation, and 50% went towards administration and management. In the following fiscal year, 2011, the District of Columbia's investment increased significantly, and the District allocated $2.47 million towards tobacco control programs. With this amount, the District of Columbia was able to meet 24% of the CDC's recommended investment level for tobacco control. Of the $2.47 million, the District invested 37% in state and community interventions, 26% in health communications, 15% in cessation interventions, 7% in surveillance and evaluation, and 15% in administration and management.

District of Columbia

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$500,000	$1,500,000	$810,000	$250,000	$470,000	$3,530,000	$6.0	34%
FY2009	$550,000	$1,690,000	$1,210,000	$250,000	$950,000	$4,650,000	$7.8	44%
FY2010	$46,000	$10,000	$289,000	$14,000	$354,000	$713,000	$1.2	7%
FY2011	$919,000	$658,000	$364,000	$164,000	$369,000	$2,474,000	$4.1	24%





Florida

Florida's tobacco control and prevention efforts date back to 1989 when its Department of Health and Rehabilitative Services began receiving federal funding to engage in tobacco prevention and control activities. Florida is one of the four states which settled with tobacco companies prior to the Master Settlement Agreement (ALA, 2012). The settlement funds are deposited into the Department of Financial Services Tobacco Settlement Clearing Trust Fund and then subjected allocation by the state legislature. From there, monies are transferred to a number of trust funds. For the first five years after settlement payments began, Florida provided substantial funding to the Department of Health to support tobacco control programs. As part of the settlement agreement, Florida launched the Tobacco Pilot Program which targeted tobacco use among underage youth in 1999. In 2003, however, the funding for the tobacco program was reduced to $1.0 million, which forced the program to discontinue several key components of its youth tobacco program. Components such as school-based tobacco education, youth development, and counter-marketing efforts were terminated. Since 2007, the Florida Department of Health's Bureau of Tobacco Prevention Program (BTPP) administers a comprehensive statewide tobacco education and prevention program. Current funds for Florida's tobacco control programs are secured by a ballot initiative passed in 2006. Its implementation began in fiscal year 2008. This legislative action directs 15% of tobacco settlement money towards tobacco prevention programs (ALA, 2012). In addition to the settlement payments, Florida receives a significant amount of revenues from its cigarette excise tax, currently at $1.339 per pack. Of the cigarette excise tax, $1.00 is deposited into the Health Care Trust Fund within the Agency for Health Care Administration and the remaining $0.339 is distributed to varying funds and programs. Most of Florida's settlement money was used for a variety of purposes, including financing state health care programs (TFK, 2012).

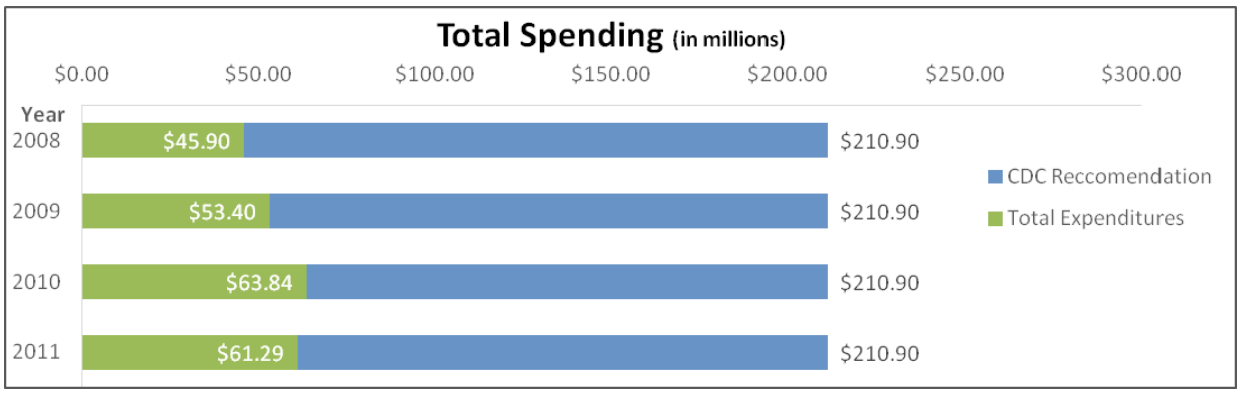
Florida spent $45.9 million on tobacco control expenditures throughout the 2008 fiscal year, reaching 22% of the CDC's recommended level. Of these expenditures the state spent, 27% on state and community interventions, 42% on health communications, 20% on cessation interventions, 2% on surveillance and evaluation, and 9% on administration and management. In fiscal year 2009, Florida invested at 25% of the CDC's recommendation for tobacco control, or $53.4 million. In this fiscal year, Florida used approximately 32% of tobacco control expenditures for state and community interventions, 37% for health communications, 16% for cessation interventions, 10% for surveillance and evaluation, and 5% for administration and management. The following fiscal year, Florida invested $63.84 million, 30% of the CDC's recommended spending level. Of this investment on tobacco control, the state expended 27% for state and community interventions, 32% for health communications, 28% for cessation interventions, 8% for surveillance and evaluation, and 5% for administration and management. In the following fiscal year, 2011, Florida invested $61.29 million, reaching 29% of the CDC's recommended investment level on tobacco control. Of the $61.29 million, Florida invested 27%

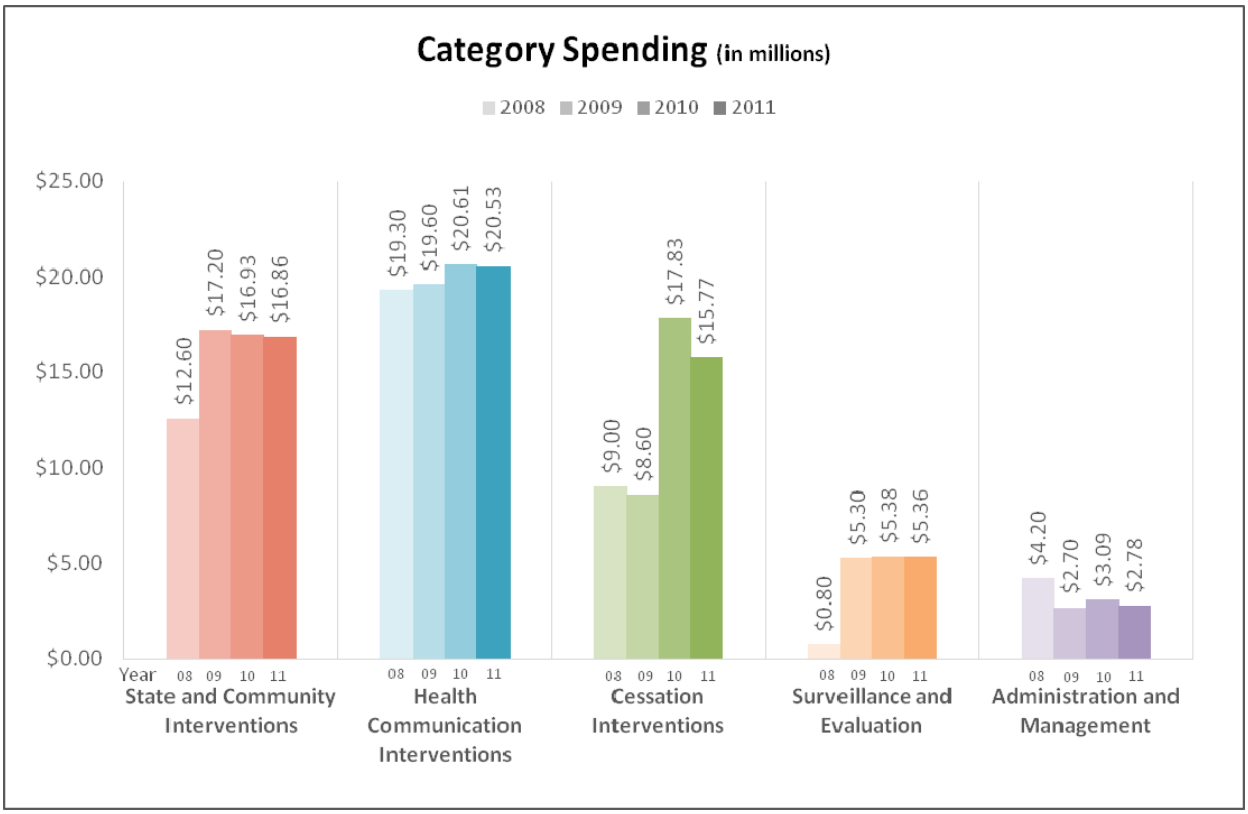
in state and community interventions, 33% in health communications, 26% in cessation interventions, 9% in surveillance and evaluation, and 5% in administration and management.

Florida

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$12,600,000	$19,300,000	$9,000,000	$800,000	$4,200,000	$45,900,000	$2.5	22%
FY2009	$17,200,000	$19,600,000	$8,600,000	$5,300,000	$2,700,000	$53,400,000	$2.9	25%
FY2010	$16,928,000	$20,614,000	$17,832,000	$5,376,000	$3,092,000	$63,842,000	$3.4	30%
FY2011	$16,861,000	$20,532,000	$15,769,000	$5,355,000	$2,777,000	$61,294,000	$3.3	29%





Georgia

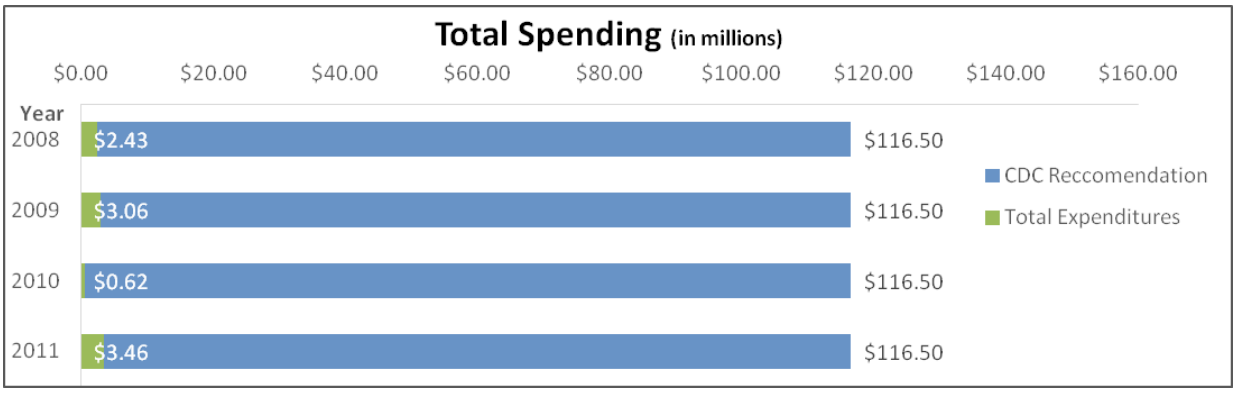
Georgia's Department of Public Health (DPH) has been engaging in tobacco use prevention and control activities since 1990. The Tobacco Use Prevention Program (TUPP) within the Georgia Division of Public Health coordinates the state's tobacco control strategies (Georgia Tobacco Task Force, 2008). The receipt of MSA funds in 2001 allowed the expansion of TUPP to include comprehensive and statewide initiatives in all health districts. Initially, the tobacco control funding was close to $20 million per year; however, funding was cut in fiscal year 2004 to $2 million per year. Money obtained from the MSA is annually distributed through an appropriations process. Of these MSA payments, the One-Georgia Fund receives 33%, and the remaining 66% goes into the state's general budget process. A portion of the money in the One-Georgia Fund is invested in the Economic Development, Growth, and Expansion Fund (EDGE), which helps Georgia communities compete with localities in other states for business. A portion also goes into the Equity Fund, which is used for a variety of projects, including tourism, recreation, aquaculture, and technical colleges (TFK, 2012). Georgia has a tobacco tax of $0.37 per pack, and all revenue goes to the state general fund.

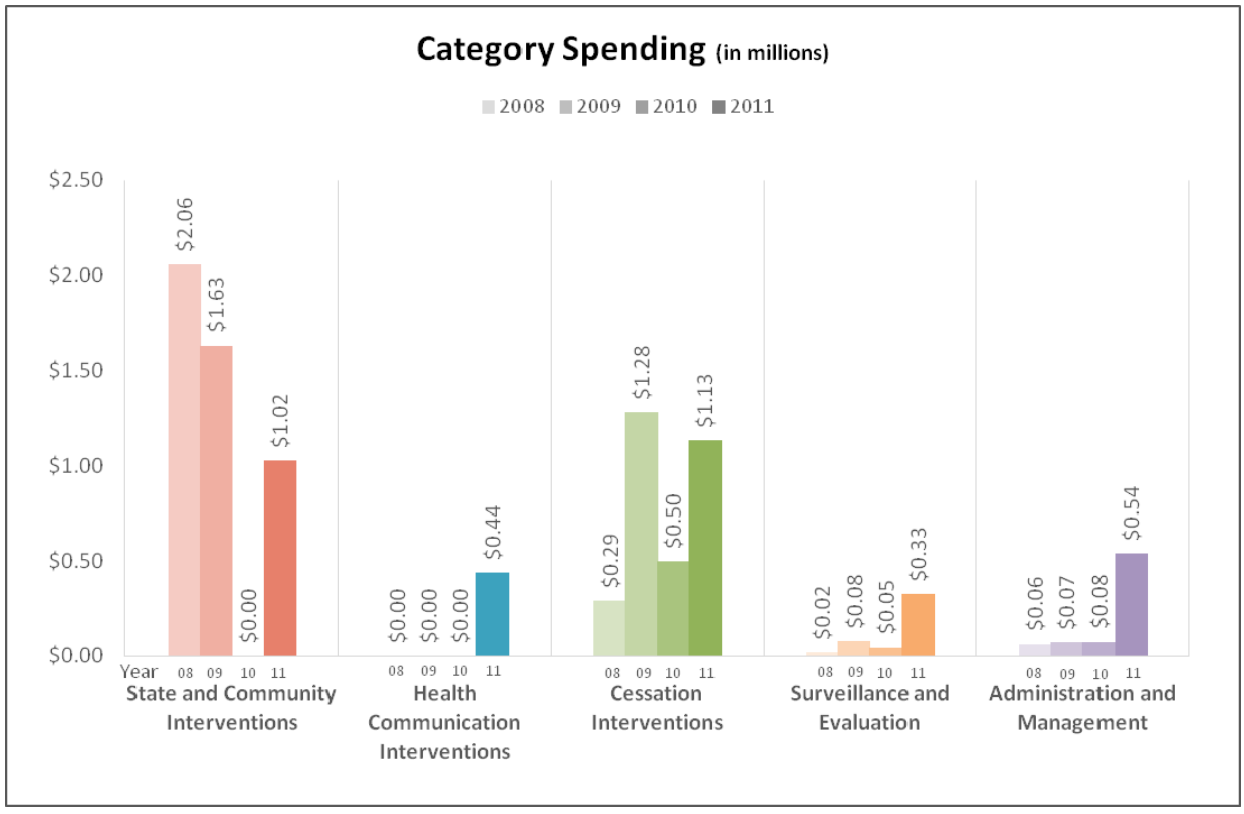
Throughout the 2008 fiscal year, Georgia spent $2.43 million on tobacco control, meaning Georgia spent 2% of the CDC's recommended level. The $2.43 million was split amongst the five CDC categories in the following manner: 85% delegated to state and community interventions, 0% delegated to health communications, 12% delegated to cessation interventions, 1% delegated to surveillance and evaluation, and 2% delegated to administration and management. In the proceeding fiscal year, Georgia increased its expenditures, attaining 3% of the CDC's recommendation for tobacco control and investing $3.06 million. In this fiscal year, state and community interventions spent approximately 53% of the tobacco control expenditures, health communications spent 0%, cessation interventions spent 42% of the total, surveillance and evaluation spent 3%, and administration and management spent 2% of the $3.06 million. The following fiscal year, Georgia experienced a decrease in tobacco control allocation, providing $0.621 million, or 1%, of the total that the CDC's recommends.. State and community interventions and health communications received nothing from this amount, cessation interventions received the majority of the monies at 81%, surveillance and evaluation and administration and management split the remaining 19%, with 7% for surveillance and evaluation and 12% administration and management. For the final fiscal year, 2011, Georgia returned to meeting 3% of the CDC's recommended investment level by providing $3.46 million to tobacco control programs. Of the $3.46 million, Georgia invested 29% in state and community interventions, 13% in health communications, 33% in cessation interventions, 9% in surveillance and evaluation, and 16% in administration and management.

Georgia

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$2,055,000	$0	$290,000	$19,000	$63,000	$2,427,000	$0.3	2%
FY2009	$1,633,000	$0	$1,280,000	$78,000	$71,000	$3,062,000	$0.3	3%
FY2010	$0	$0	$500,000	$46,000	$75,000	$621,000	$0.1	1%
FY2011	$1,024,000	$438,000	$1,131,000	$326,000	$542,000	$3,461,000	$0.4	3%





Hawai'i

In 2000, Hawai'i established its tobacco control program with funds appropriated from its Master Settlement Agreement payments. These funds were deposited into the Hawai'i Tobacco Prevention and Control Trust Fund to implement tobacco control and prevention measures in the state. The Tobacco Prevention and Control Trust Fund also engages in tobacco control through community grants. It maintains an advisory board which helps to develop strategic plans for tobacco control programs in Hawai'i (The Finance Project, 2011). The Hawai'i State Department of Health also contributes to Hawaii's tobacco control efforts through a variety of ways, including the Tobacco Prevention and Education Program (TPEP), the Healthy Hawai'i Initiative (TSP/HHI), and the Alcohol and Drug Abuse Division (ADAD). TPEP is the official state government program that addresses tobacco control in Hawai'i. Funding for the programs comes mainly from the CDC's National Tobacco Control Program. The primary focus of TPEP's work includes state and local tobacco control collaboration, as well as education and training, program oversight, and technical assistance. The Healthy Hawai'i Initiative covers health promotion and disease prevention programs. The ADAD conducts wurveillance and enforcement of youth tobacco access laws (Hawai'i State Department of Health, 2012). By law, the first $350,000 of the monies goes towards the Tobacco Enforcement Special Fund. The remaining monies are further split among the following programs: 15% to the Emergency and Budget Reserve Fund, 25% to the Department of Health for health promotion and disease prevention programs, 6.5% to the Tobacco Prevention and Control Trust Fund, 28% to a University Revenue Undertakings Fund, and 25.5% to the state general fund. Hawaii's current cigarette tax is $3.20 per pack. Of this tax, $0.80 is deposited into several funds focusing on cancer research, the state trauma system, community health centers, and emergency medical services. The remaining portion of the tax is placed in the state's general fund (ALA, 2012).

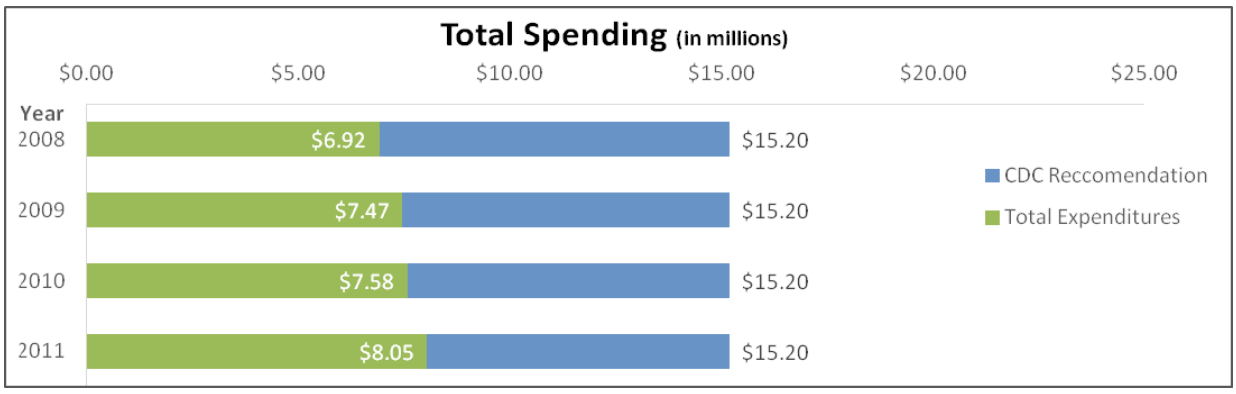
For tobacco control expenditures in the 2008 fiscal year, Hawai'i spent $6.92 million. Hawaii's expenditures reached 46% of the CDC's suggested spending total. In this fiscal year, Hawai'i invested 28% in state and community interventions, 17% in health communications, 36% in cessation interventions, 7% in surveillance and evaluation, and 12% in administration and management. Hawai'i increased its investment the following fiscal year and satisfied 49% of the CDC's recommendation for tobacco control, or $7.47 million. In 2009, state and community interventions received 29% of the states tobacco control funds, health and communications received 18% of funds , cessation interventions received 31% of funds, surveillance and evaluation received 9% of funds, and administration and management received 13% of funds. Again, Hawai'i increased its tobacco control investments the following fiscal year, and provided $7.58 million, or 50% of CDC's recommended spending level, to tobacco control programs. The largest percentage of this budget, 35%, went to state and community interventions. From there, 21% went to health communications, 19% went to cessation interventions, 10% went to surveillance and evaluation, and 15% went to administration and management. Hawai'i continued to increase its spending on tobacco control for the 2011 fiscal year. Hawai'i reached

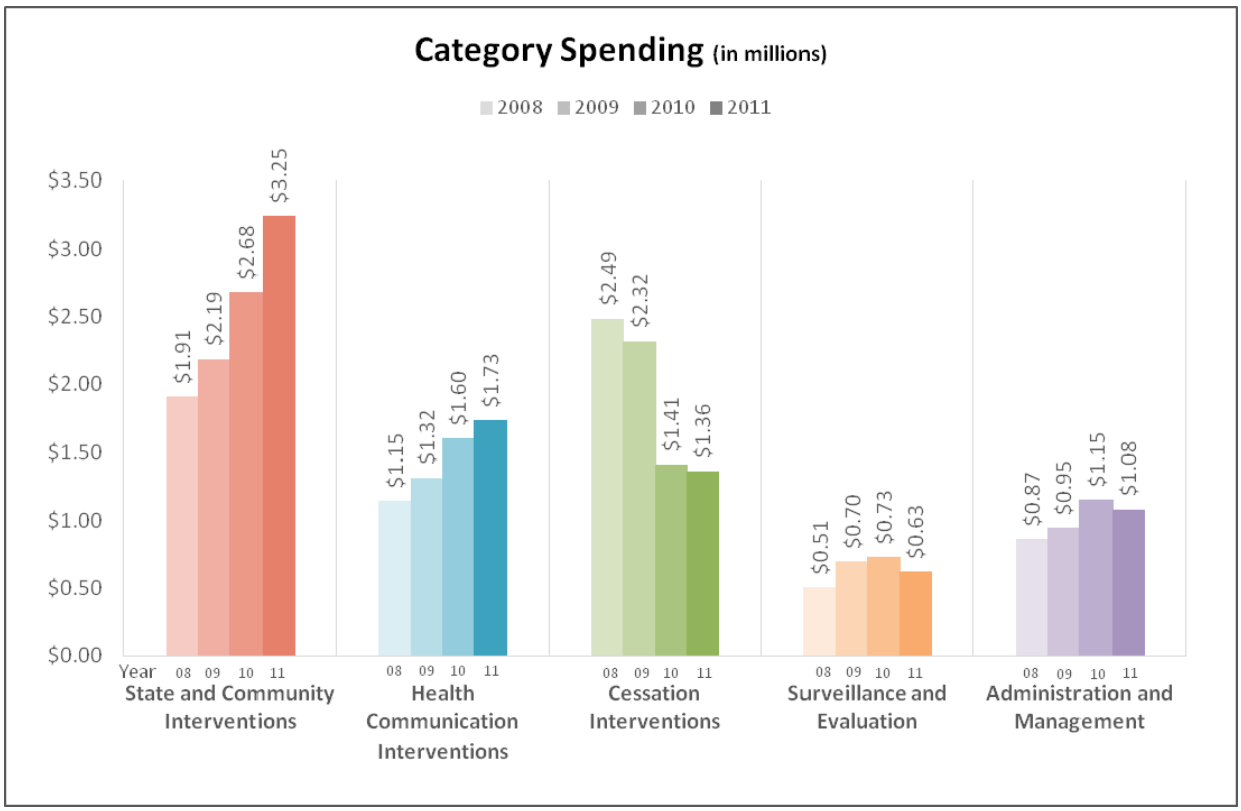
53% of the CDC's recommended investment level for tobacco control by investing $8.05 million. Of the $8.05 million, Hawai'i invested 40% in state and community interventions, 22% in health communications, 17% in cessation interventions, 8% in surveillance and evaluation, and 13% in administration and management.

Hawai'i

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$1,911,000	$1,147,000	$2,485,000	$510,000	$866,000	$6,919,000	$5.4	46%
FY2009	$2,187,000	$1,316,000	$2,318,000	$699,000	$947,000	$7,467,000	$5.8	49%
FY2010	$2,681,000	$1,599,000	$1,412,000	$731,000	$1,152,000	$7,575,000	$5.6	50%
FY2011	$3,245,000	$1,732,000	$1,359,000	$625,000	$1,084,000	$8,045,000	$5.9	53%





Idaho

Idaho receives more than $20 million annually from its MSA payments. Initially, those funds were deposited into the Idaho Millennium Fund. In 2007, the state began distributing 80% of its MSA money to the Millennium Permanent Endowment Fund, and 20% was distributed to the Millennium Fund. The state treasury invests and administers these funds; it also transfers 5% of the fund's fair market value to the Idaho Millennium Income Fund (TFK, 2012). The money in the Idaho Millennium Income Fund is subject to legislative appropriation with restricted use for three health purposes- tobacco control, substance abuse, and chronic disease prevention related to tobacco or substance abuse. This fund, along with money from the CDC, helps to fund Idaho's current tobacco and prevention program, Project Filter. The primary focus of this program is to provide cessation services and to promote quitting among Idaho's smokers. Collaboration with local health districts and health institutions ensures these services are provided to the states' constituents (Idaho Department of Health and Welfare, 2009). Idaho's tax on cigarettes is $0.57 per pack. Revenue from cigarette excise tax is, by law, distributed as follows- $0.051746 goes to the public school income fund which provides substance abuse programs in the state's public schools, $0.051746 goes to the Department of Juvenile Corrections for county juvenile probation services, and an unspecified amount is distributed to the state refund account to pay current refund claims. After that, 17.3% of the remaining tax revenue is distributed to a permanent building fund; 0.4% is distributed to the central tumor registry account; 1% is distributed to the cancer control account; an amount equal to the annual general fund appropriation for bond levy equalization is distributed annually to the state general fund; and all remaining revenues go to a permanent building fund to be used to repair, remodel, and restore the state capitol building. Once that project has been certified as completed, remaining revenues go to an economic recovery reserve fund. Half of the tax revenues from other tobacco products are, by law, distributed to the public school income fund to pay for substance abuse programs in the public schools; the other half of revenues from other tobacco products go to the Department of Juvenile Corrections for county juvenile probation services (ALA, 2012).

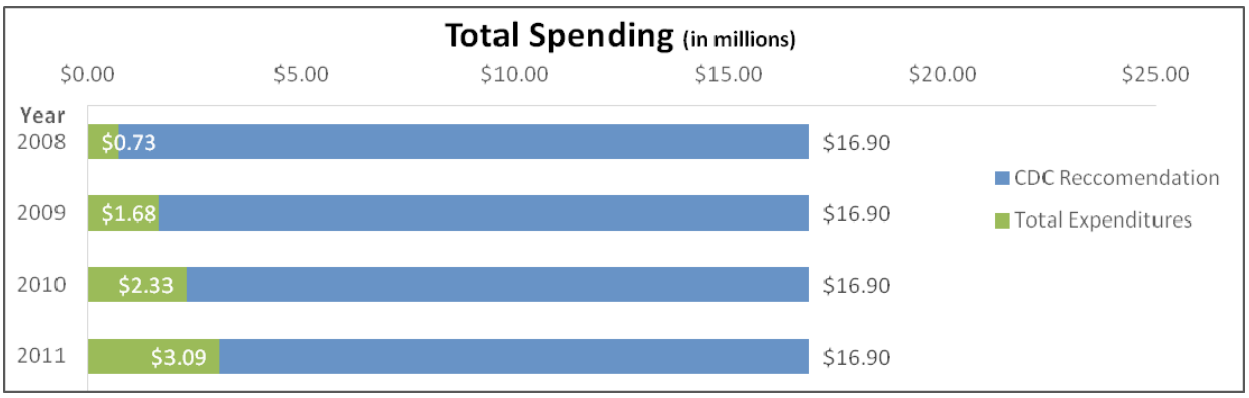
By spending $2.76 million on tobacco control expenditures in the 2008 fiscal year, Idaho reached 4% of the CDC's recommendation for tobacco control expenditures. With this amount, 14% was spent on state and community interventions, 66% on health communications, 9% on cessation interventions, 10% on surveillance and evaluation, and 1% on administration and management. In the 2009 fiscal year, the state provided more money for tobacco control, $1.68 million, and reached 10% of the CDC's recommended level. For 2009, a lower portion of the money was used for both state and community interventions (6%) and health communications (16%). However, a significant increase went towards cessation interventions (74%). Surveillance decreased (3%), and administration and management remained constant (1%). For the 2010 fiscal year, Idaho appropriated $2.33 million, or 14% of the CDC's recommended spending level, to tobacco control. Of this appropriated amount, 18% went to state and community interventions, 19% went to health communications, 39% went to cessation interventions, 8%

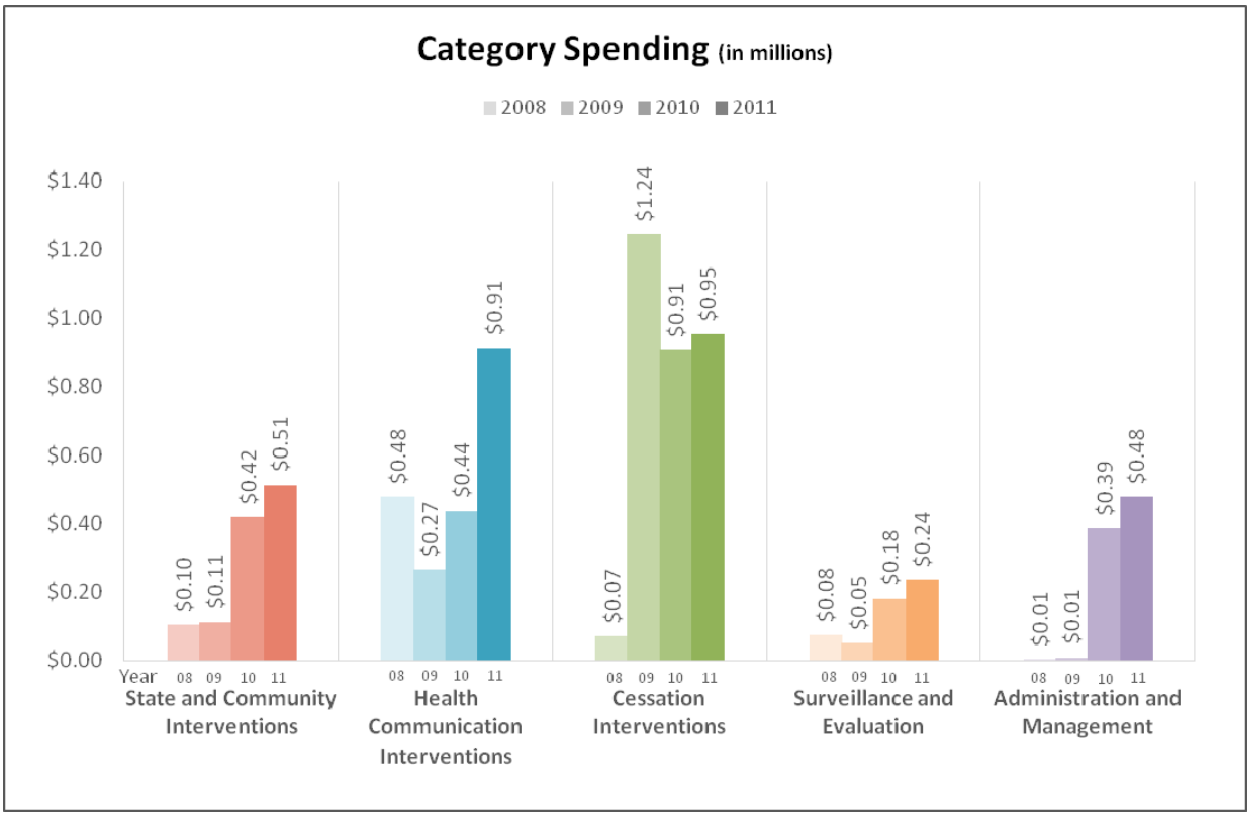
went to surveillance and evaluation, and 16% went to administration and management. In the following fiscal year, 2011, Idaho continued its upward trend in investment, and supplied $3.1 million to tobacco control, reaching 18% of the CDC's suggested investment level. Of the $3.1 million, Idaho invested 17% in state and community interventions, 29% in health communications, 31% in cessation interventions, 8% in surveillance and evaluation, and 15% in administration and management.

Idaho

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$103,000	$478,000	$69,000	$75,000	$5,000	$730,000	$0.5	4%
FY2009	$112,000	$266,000	$1,243,000	$50,000	$9,000	$1,680,000	$1.1	10%
FY2010	$419,000	$437,000	$905,000	$181,000	$385,000	$2,327,000	$1.5	14%
FY2011	$513,000	$911,000	$953,000	$235,000	$477,000	$3,089,000	$2.0	18%





Illinois

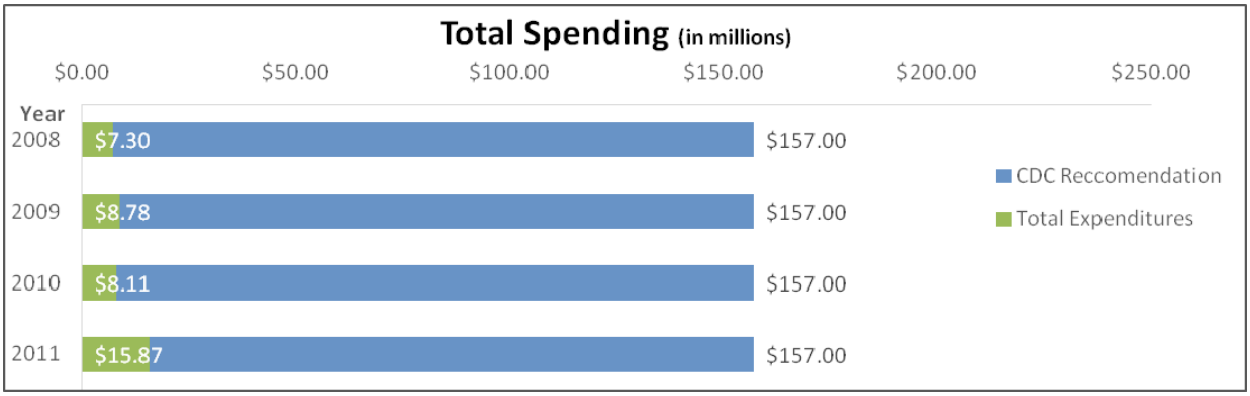
Illinois does not pursue one single comprehensive statewide tobacco control program; it distributes its state funds for tobacco control to the Illinois Department of Public Health (IDPH), local health departments, and the state quitline. Initially, in 2000 and 2001, Illinois allocated about $80 million for several tobacco prevention and control programs using its Master Settlement Agreement payments, but the programs were phased out as the state allocated less money toward tobacco control every year. Budget shortfallsmade it difficult to secure stable funds for implementing a comprehensive tobacco control and prevention program. In 2010, Illinois sold 55% of its MSA payments to the Railsplitter Tobacco Settlement Authority for an up-front lump sum payment. The lump sum was placed into several accounts under the Tobacco Recovery Fund and the Attorney General Account Fund. The remaining portion of the annual MSA payments is also deposited there. Under the Tobacco Settlement Recovery Fund, three accounts exist: the General Account, the Tobacco Settlement Bonds Proceeds Account, and the Tobacco Settlement Residual Account. No less than $2.5 million is deposited into the Attorney General Tobacco Fund, and the Illinois legislature allocates the remaining monies in the other accounts. Tobacco tax in Illinois, currently at $1.98 per pack, is dedicated to its School Common Fund, the School Infrastructure Fund, the Long Term Care Provider Fund, and the state General Revenue Fund (ALA, 2012).

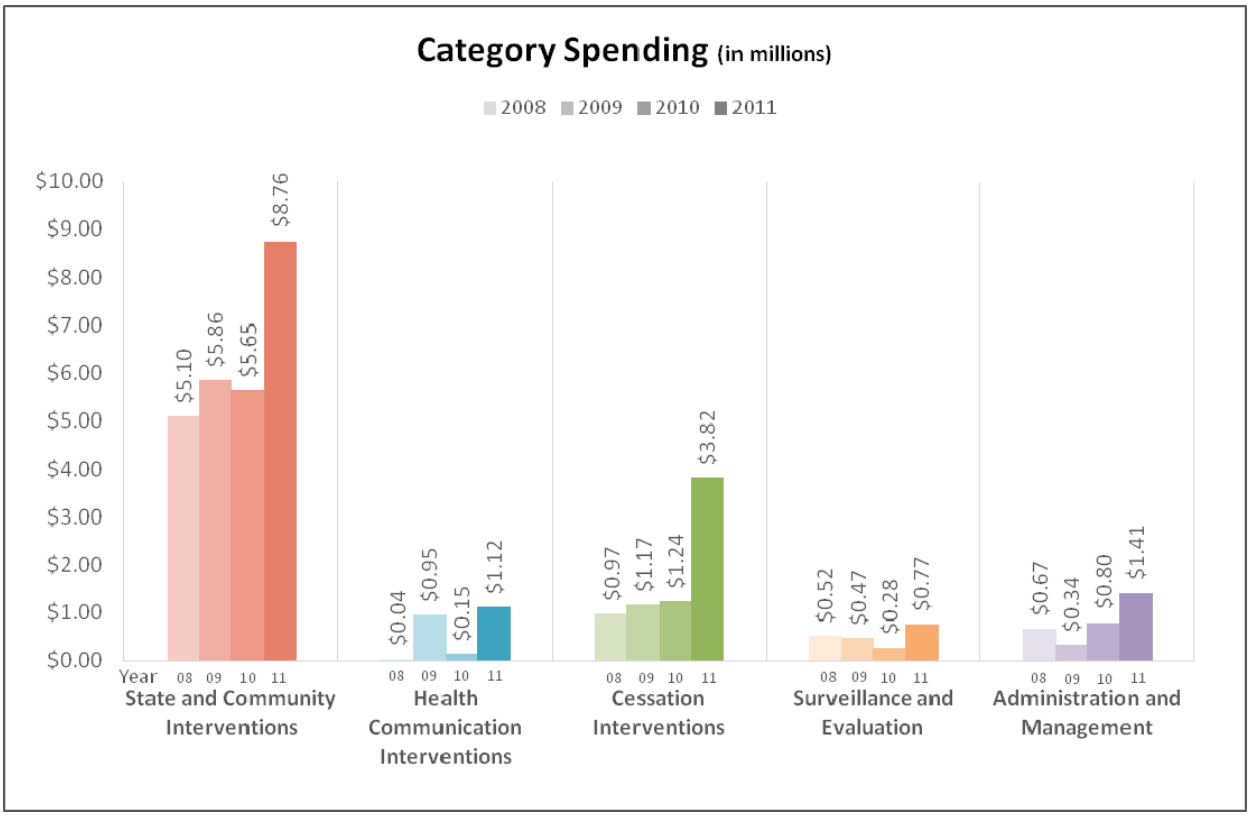
Illinois' expenditures for the 2008 fiscal year reached $7.3 million, or 5% of the CDC's recommended level for tobacco control and prevention. Of these expenditures, the state spent the majority, 70%, on state and community interventions. Of the portion of money remaining, the state spent 1% on health communications, 13% on cessation interventions, 7% on surveillance and evaluation, and 9% on administration and management. In fiscal year 2009, Illinois increased its spending dollars and satisfied 6% of the CDC's recommendation for tobacco control by supplying $8.78 million for programs and prevention. As in the preceding fiscal year, state and community interventions spent 67%, or the largest percentage of the budget. The remaining portion of the $8.78 million was divided amongst the four other CDC categories in the following way: 11% for health communications, 13% for cessation interventions, 5% for surveillance and evaluation, and 4% for administration and management. The following fiscal year, Illinois decreased its investment in tobacco control to $8.11 million, 5% of the CDC's recommended spending level. Of this investment on tobacco control, 70% provided funding for state and community interventions, 2% provided funding for health communications, 15% provided funding for cessation interventions, 3% provided funding for surveillance and evaluation, and 10% provided funding for administration and management. In the following fiscal year, 2011, Illinois increased its expenditures to $15.87 million, reaching 10% of the CDC's recommended investment level on tobacco control. Of the $15.87 million, Illinois supplied 55% to state and community interventions, 7% to health communications, 24% to cessation interventions, 5% to surveillance and evaluation, and 9% to administration and management.

Illinois

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$5,098,000	$41,000	$970,000	$518,000	$669,000	$7,296,000	$0.6	5%
FY2009	$5,855,000	$945,000	$1,169,000	$470,000	$338,000	$8,777,000	$0.7	6%
FY2010	$5,651,000	$146,000	$1,244,000	$276,000	$796,000	$8,113,000	$0.6	5%
FY2011	$8,756,000	$1,117,000	$3,822,000	$766,000	$1,412,000	$15,873,000	$1.2	10%





Indiana

Beginning in 2005, Indiana divided its MSA payments in a variety of ways. Of the payments, Indiana used 50% for state health programs, about 25% for economic development and to provide assistance to tobacco farmers, approximately 16% for state social and education programs, and 6% fortobacco control (The Finance Project, 2011). In addition to MSA funds, the Healthy Indiana Plan (HIP) legislation passed in 2007, providing additional tobacco cessation funds in 2008 and 2009 from the increase on cigarette excise tax (TFK, 2010). MSA payments also financed the Indiana Tobacco Use Prevention and Cessation Trust Fund. The state's comprehensive tobacco control program, Indiana Tobacco Prevention and Cessation Program (ITPC), is then financed with the trust fund. By law, the ITPC was required to spend 75% of its total funds on local community programs and cessation programs (ITPC, 2009). In 2011, the ITPC became the Tobacco Prevention and Cessation Commission under the State Health Department. Currently, Indiana's MSA payments are deposited into the Tobacco Master Settlement Agreement Fund. These funds are appropriated through a regular biennial budgeting process for various state programs that include allocations for the Tobacco Use Prevention and Cessation Trust Fund. The current tax revenue of $0.995 per pack of cigarettes is distributed to a variety of programs, with over half (53.68%) going to the state general fund and 27.05% going to the Indiana check-up plan trust fund. Smaller portions go to a variety of departments, divisions, and funds, including 4.22% to the Department of Natural Resources and the Clean Water Indiana Fund; 0.6% to the Division of Mental Health and Addiction; 5.43% to the Pension Relief Fund; 2.46% to the appropriations for Medicaid Current Obligations; 4.1% toany appropriations for a health initiative; and 2.46% to the reimbursement of the state general fund for a specified tax credit (ALA, 2012).

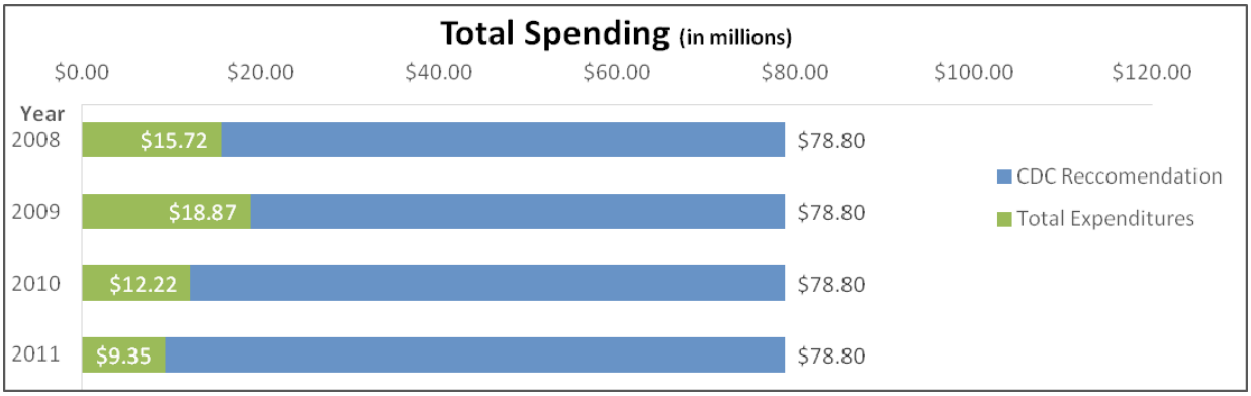
Indiana spent $15.72 million on tobacco control expenditures in the 2008 fiscal year, reaching 20% of the CDC's recommended level. When categorized according to the CDC's Best Practices components, the state spent 66% of the money on state and community interventions, 16% on health communications, 6% on cessation interventions, 4% on surveillance and evaluation, and 8% on administration and management. In fiscal year 2009, Indiana increased the amount of money dedicated to tobacco control and met 24% of the CDC's suggest amount; it provided programs with $18.87 million. In this fiscal year, approximately 61% of tobacco control expenditures funded state and community interventions, 11% funded health communications, 17% funded cessation interventions, 5% funded surveillance and evaluation, and 6% funded administration and management. The following fiscal year, the total for tobacco control programs decreased to $12.23 million, or 16% of the CDC's recommended spending level. Of this quantity allocated for tobacco control, the state invested 59% in state and community interventions, 9% in health communications, 21% in cessation interventions, 2% in surveillance and evaluation, and 9% in administration and management. Expenditures for the following fiscal year, 2011, remained consistent with the 2010 fiscal year. Indiana provided $12.22 million, again fulfilling 16% of the CDC's recommended investment level for tobacco control and prevention.

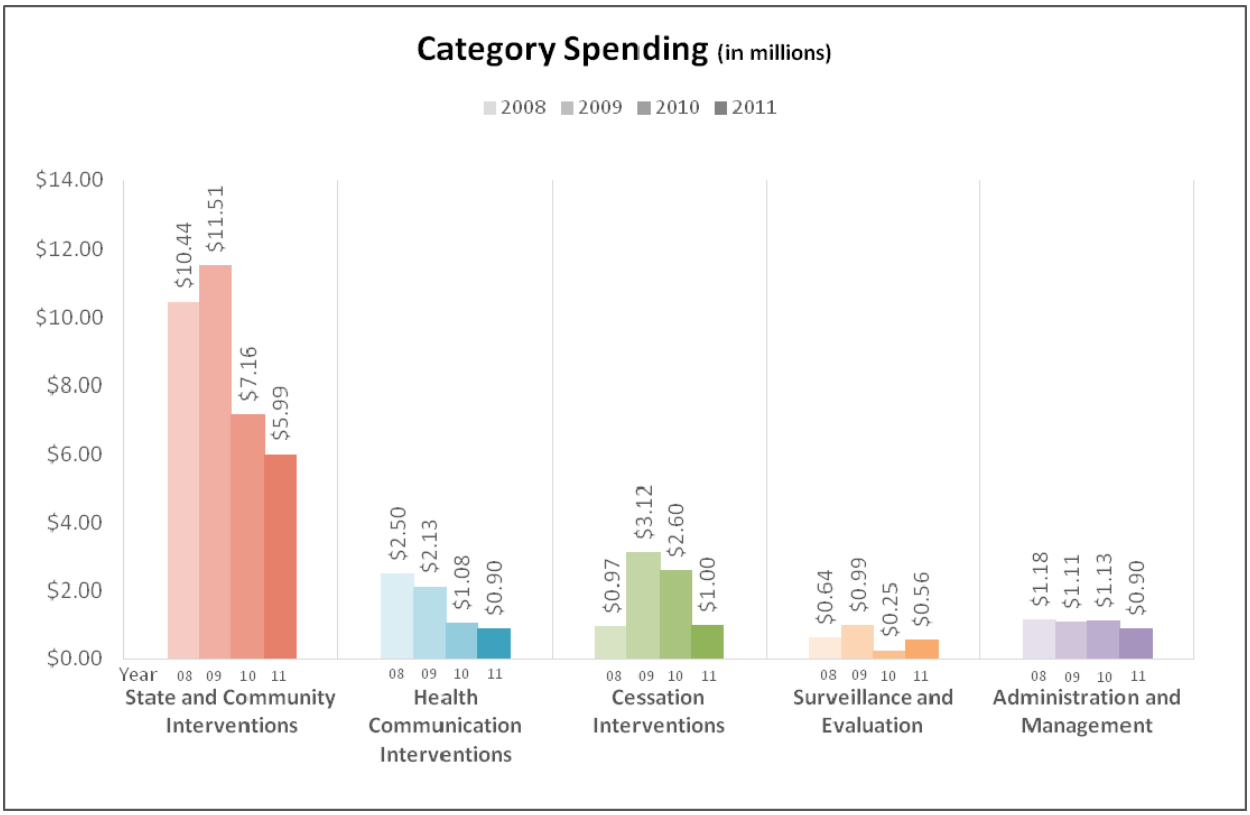
Of the $12.22 million, Indiana invested 64% in state and community interventions, 10% in health communications, 11% in cessation interventions, 6% in surveillance and evaluation, and 9% in administration and management.

Indiana

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$10,442,000	$2,495,000	$968,000	$638,000	$1,178,000	$15,721,000	$2.5	20%
FY2009	$11,513,000	$2,131,000	$3,119,000	$994,000	$1,110,000	$18,867,000	$2.9	24%
FY2010	$7,161,000	$1,079,000	$2,598,000	$252,000	$1,127,000	$12,217,000	$1.9	16%
FY2011	$5,990,000	$900,000	$1,000,000	$560,000	$900,000	$9,350,000	$1.4	12%





Iowa

The tobacco control programs in Iowa are maintained by the Iowa Department of Public Health's Division of Tobacco Use Prevention and Control. The tobacco control programs currently administered by the division include quitlines; Just Eliminate Lies, a youth tobacco use prevention program; Priority Population Networks, a service for Iowa's diverse communities; enforcement of Iowa's Smoke-free Air Act and laws prohibiting tobacco sales to minors; and Community Partnerships, local tobacco control programs that support tobacco prevention and cessation initiatives at the county level. In addition, the division conducts ongoing surveillance of youth and adult tobacco usage in Iowa. Iowa's tobacco control programs are funded through general appropriations from Iowa's MSA payments, tobacco tax revenue from the Health Care Trust Fund, and through federal stimulus money (Mapes, 2009). All funds from the Master Settlement Agreement go into the Tobacco Settlement Trust Fund. A portion of Iowa's MSA payments were securitized in 2001, and The Healthy Iowans Tobacco Trust Fund was created. Through subsequent selling of the remaining MSA funds, settlement payments in Iowa are wholly dedicated to debt service on the securitization of bonds. In 2009, tobacco control funding came from three sources: the Healthy Iowans Tobacco Trust Fund, the Health Care Trust Fund, and the general fund (TFK, 2009). A large portion of Iowa's MSA money was used in state health care programs, capital projects, and debt services. Funds currently come from the state's general fund. In 2007, a $1.00 tax increase on all packs of cigarettes was enacted, bringing the tax to $1.36 per pack. Most of the revenue from the cigarette tax in Iowa is deposited in the state's general fund. Beginning July 1, 2007, a large portion of the cigarette tax and other tobacco product taxes is appropriated annually to the Health Care Trust Fund, which is used for purposes related to health care; substance abuse treatment and prevention; and tobacco use prevention, cessation, and control (ALA, 2012).

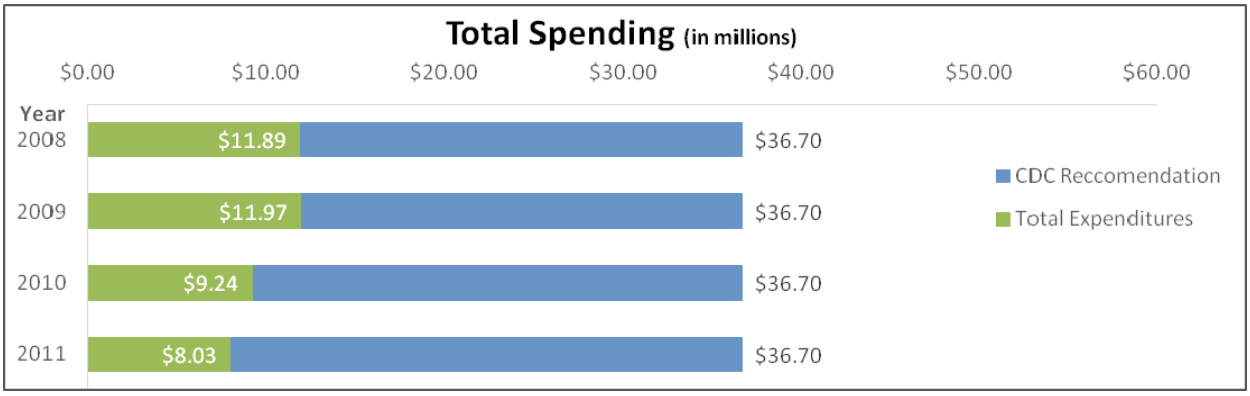
Iowa attained 32% ofthe CDC's recommended spending for tobacco control expenditures by assigning $11.89 million to tobacco control and prevention programs. Of these $11.89 million, 46% financed state and community interventions, 16% financed health communications, 26% financed cessation interventions, 2% financed surveillance and evaluation, and 10% financed administration and management. In fiscal year 2009, Iowa invested a slightly higher amount of money, $11.97 million, or 33% of the CDC's recommendation, for tobacco control. In this fiscal year, Iowa used approximately 39% of tobacco control expenditures for state and community interventions, 18% for health communications, 31% for cessation interventions, 3% for surveillance and evaluation, and 9% for administration and management. The following fiscal year, Iowa's expenditures on tobacco control decreased to $9.24 million, reaching 25% of the CDC's suggested spending level. With this money for tobacco control, Iowa used 49% for state and community interventions, 16% for health communications, 23% for cessation interventions, 3% for surveillance and evaluation, and 9% for administration and management. In the following fiscal year, 2011, Iowa decreased its contribution for tobacco control to $8.03 million, attaining 22% of the CDC's recommended tobacco control investment level. Of the $8.03 million, state

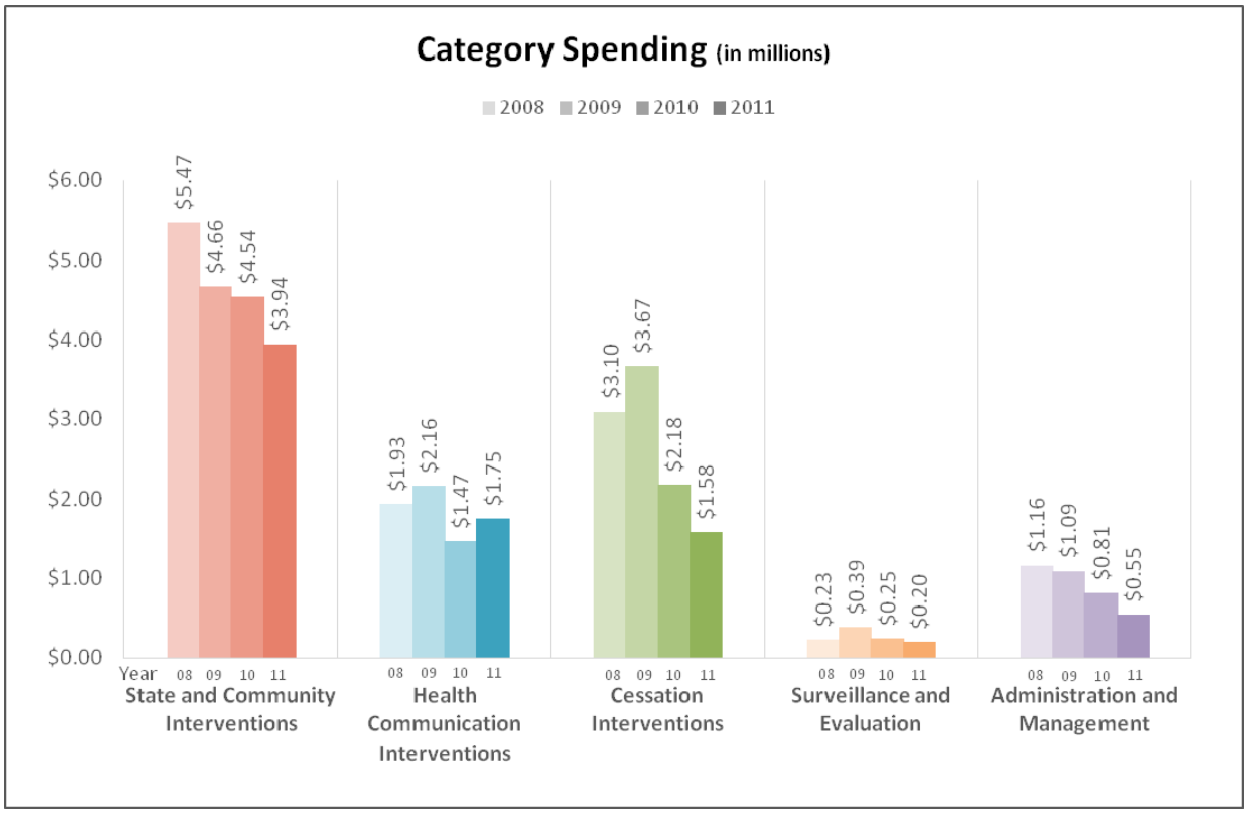
and community interventions expended 49%, health communications expended 22%, cessation interventions expended 20%, surveillance and evaluation expended 2%, and administration and management expended 7%.

Iowa

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$5,472,000	$1,931,000	$3,095,000	$226,000	$1,161,000	$11,885,000	$4.0	32%
FY2009	$4,660,000	$2,164,000	$3,670,000	$389,000	$1,091,000	$11,974,000	$4.0	33%
FY2010	$4,537,000	$1,468,000	$2,177,000	$245,000	$814,000	$9,241,000	$3.1	25%
FY2011	$3,941,000	$1,754,000	$1,582,000	$204,000	$548,000	$8,029,000	$2.6	22%





Kansas

Since the year 2000, Kansas Tobacco Use Prevention Program (TUPP) has been managed by the Kansas Department of Health and Environment (KDHE) using the funds appropriated from its Master Settlement Agreement and federal grants. Currently, Kansas' comprehensive tobacco control funding comes from MSA payments and state general funding. Due to limited funding, TUPP does not implement a statewide tobacco program; instead, it works at the county level to promote interventions. Kansas deposits MSA payments directly into the Kansas Endowment for Youth Fund in the state Treasury. Money in the fund is allocated to various programs which are controlled by the legislature through the normal appropriations process. Part of the money in the fund is transferred to the Children's Initiatives Fund to support programs, projects, improvements, and services beneficial to children's physical and mental health, welfare, safety, and overall well-being. The money within the Children's Initiative Fund may be used for tobacco control. In addition to MSA payments, Kansas taxes cigarettes at $0.79 per pack, and places all cigarette tax revenue into the state general fund (ALA, 2012).

Kansas spent $2.76 million on tobacco control expenditures in the 2008 fiscal year, achieving 9% of the CDC's recommended level. Of these expenditures, state and community interventions claimed 51%, health communications claimed 5%, cessation interventions claimed 7%, surveillance and evaluation claimed 20%, and administration and management claimed 17%. In fiscal year 2009, Kansas invested at 8% of the CDC's recommendation for tobacco control, or $2.53 million. In this fiscal year, 61% of tobacco control expenditures went towards state and community interventions, 6% went towards health communications, 4% went towards cessation interventions, 4% went towards surveillance and evaluation, and 25% went towards administration and management. In the fiscal year of 2010, Kansas contributed $2.23 million, or 7% of the CDC's recommended spending level, to tobacco control and prevention. Of this contribution, the state spent 56% on state and community interventions, 4% on health communications, 6% on cessation interventions, 1% on surveillance and evaluation, and 33% on administration and management. In the final fiscal year, 2011, Kansas totaled $2.64 million in tobacco control expenditures, meeting 8% of the CDC's recommended investment level on tobacco control. Of the $2.64 million, Kansas totaled 64% in state and community interventions, 3% in health communications, 7% in cessation interventions, 3% in surveillance and evaluation, and 23% in administration and management.

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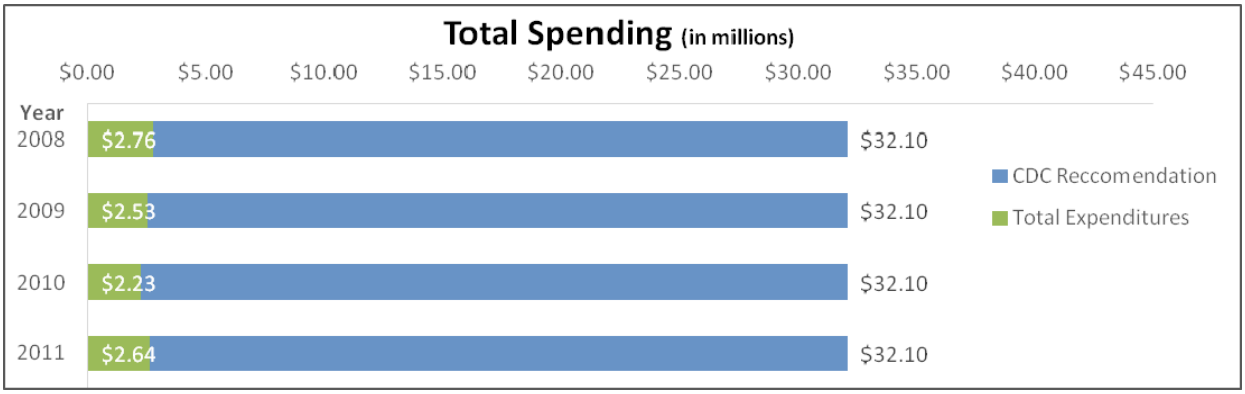
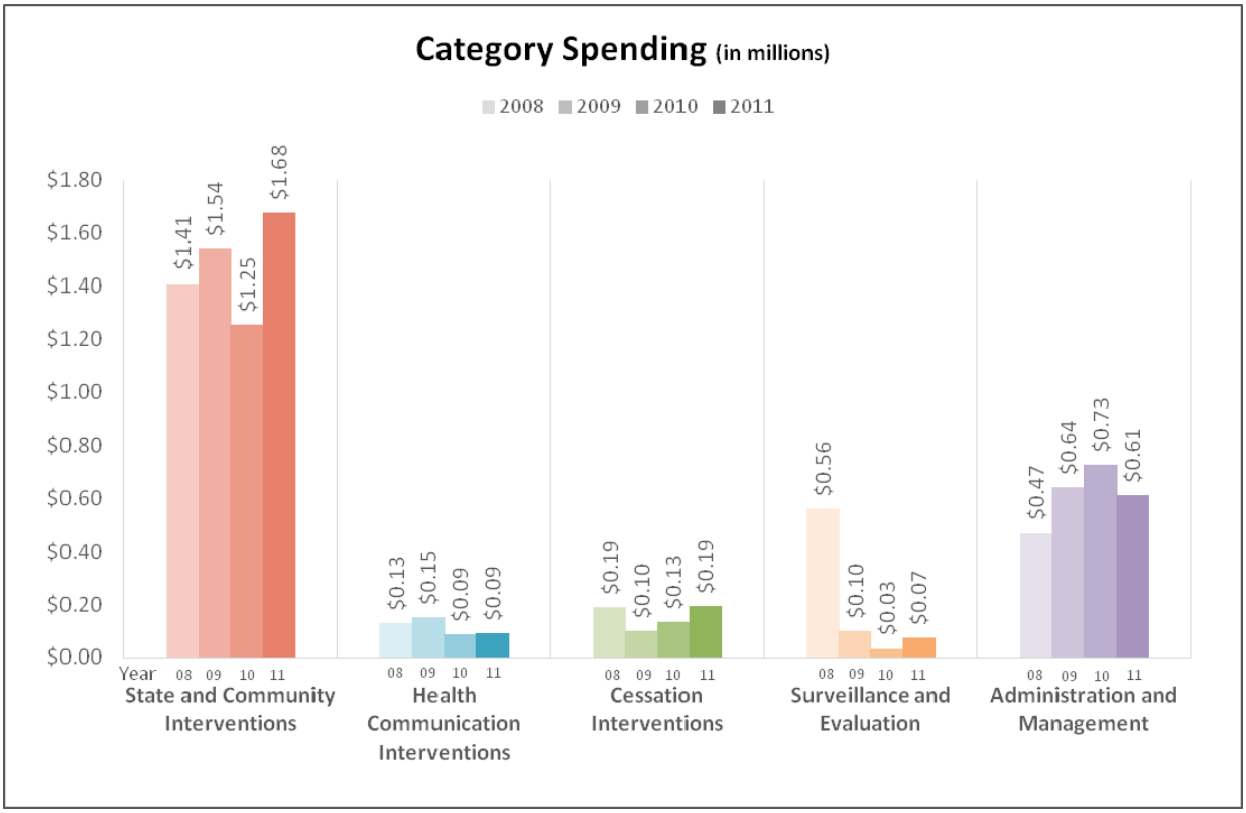
Kansas

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$1,410,000	$130,000	$190,000	$560,000	$470,000	$2,760,000	$1.0	9%
FY2009	$1,540,000	$150,000	$100,000	$100,000	$640,000	$2,530,000	$0.9	8%
FY2010	$1,254,000	$87,000	$134,000	$33,000	$726,000	$2,234,000	$0.8	7%
FY2011	$1,675,000	$90,000	$191,000	$74,000	$610,000	$2,640,000	$0.9	8%





Kentucky

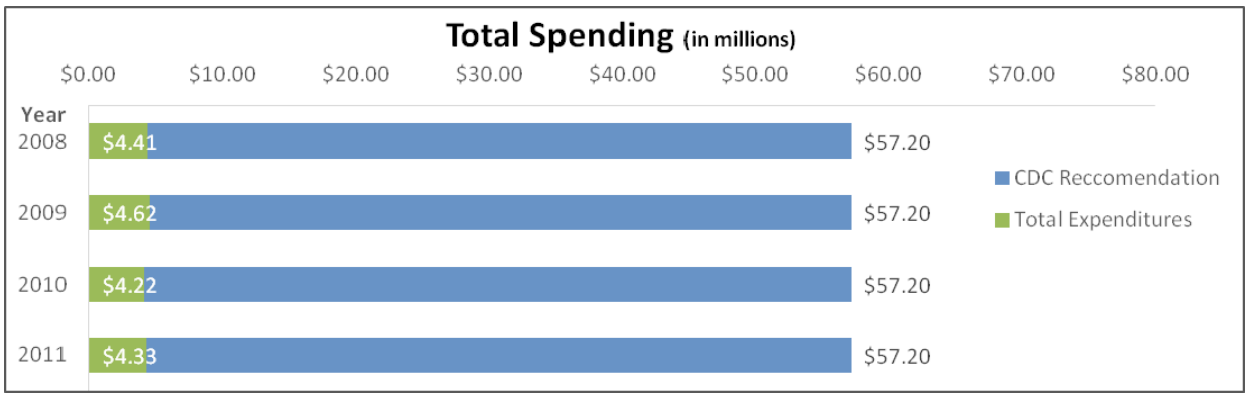
The Kentucky Department of Public Health runs Kentucky's Tobacco Prevention and Cessation Program. Kentucky's tobacco prevention and cessation program works with local health departments to implement community and statewide initiatives to reduce youth smoking and promote quitting (KCHFS, 2014). Funding for the tobacco control programs comes from MSA payments and the state general fund. A law dictates that Kentucky's MSA money is distributed to three areas: 50% to the Rural Development Fund, 25% to the Early Childhood Development Fund, and 25% to the Kentucky Health Care Improvement Fund (ALA, 2012). The majority of Kentucky's tobacco control money comes from the Health Care Improvement Fund. From the 25% earmarked for the Health Care Improvement Fund, 10% goes to discourage the use of harmful substances by minors, including tobacco (these funds are split between the Kentucky Agency for Substance Abuse Policy and the Department of Public Health's Tobacco Prevention and Cessation Program); 70% goes to a new health insurance program for people with costly health conditions; and 20% goes to lung cancer research at the University of Louisville and the University of Kentucky (The Finance Project, 2011). In addition to MSA payments, Kentucky increased its cigarette tax to $0.60 per pack in 2009. The majority of its tax revenue goes to the state general fund. Additionally, $0.01 of the cigarette tax is deposited into the Cancer Research Institutions Matching Fund in the state Treasury. From there, the funds are split between the University of Kentucky and the University of Louisville for cancer research, while $0.005 is appropriated to the Tobacco Research and Development Center at the University of Kentucky (ALA, 2012).

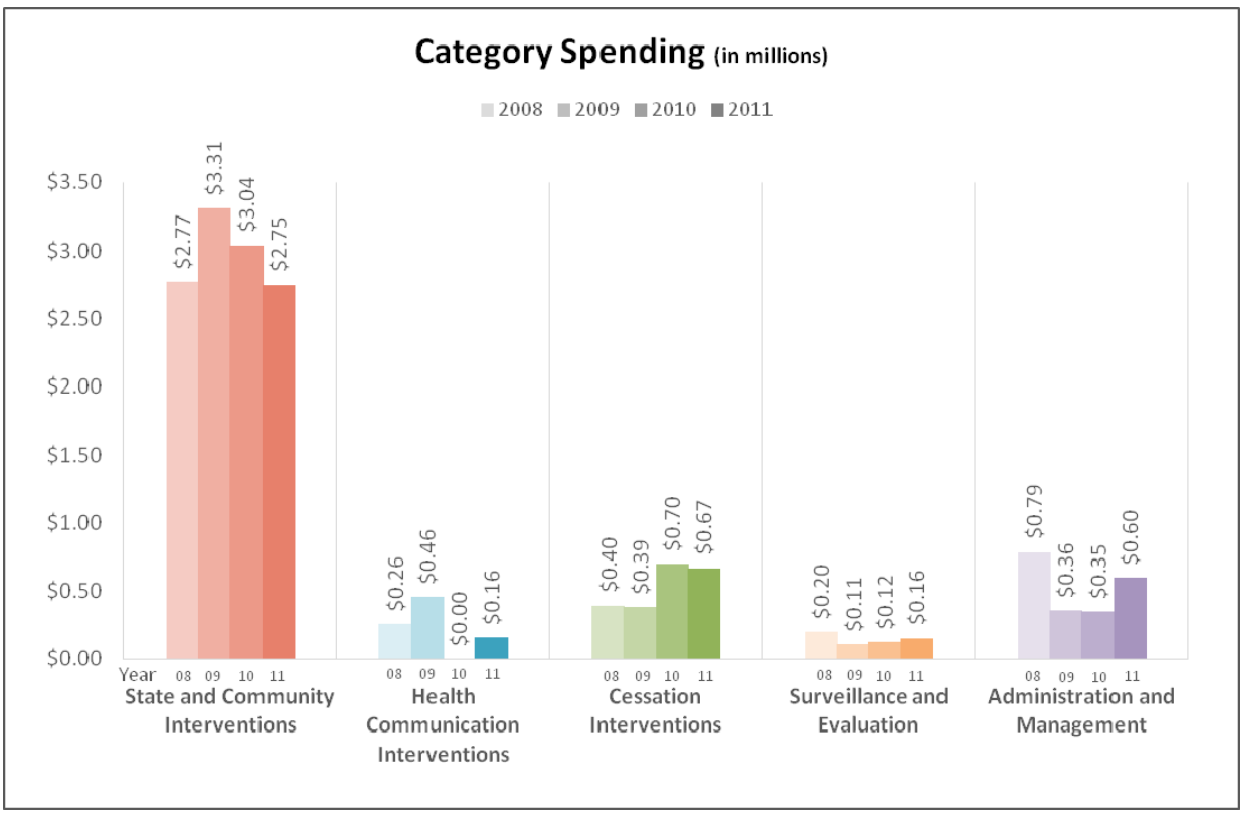
Kentucky reached 8% of the CDC's recommended level of spending on tobacco control by delegating $4.4 million to tobacco control expenditures in the 2008 fiscal year. The state delegated money to the five CDC categories in the following manner: 63% to state and community interventions, 6% to health communications, 9% to cessation interventions, 4% to surveillance and evaluation, and 18% to administration and management. In fiscal year 2009, Kentucky's tobacco control investment remained constant at 8% of the CDC's recommendation for tobacco control, or $4.62 million. In this fiscal year's tobacco control budget, approximately 72% of tobacco control expenditures supported state and community interventions, 10% supported health communications, 8% supported cessation interventions, 2% supported surveillance and evaluation, and 8% supported administration and management. The following fiscal year, 2010, Kentucky used $4.62 million, again reaching 8% of the CDC's recommended spending level.. Of this amount, Kentucky used 72% for state and community interventions, 0% for health communications, 17% for cessation interventions, 3% for surveillance and evaluation, and 8% for administration and management. In the 2011 fiscal year, Kentucky repeated a similar budget expenditure of $4.33 million for tobacco control, reaching 8% of the CDC's suggested investment level. Of the $4.33 million, Kentucky invested 63% in state and community interventions, 4% in health communications, 15% in cessation interventions, 4% in surveillance and evaluation, and 14% in administration and management.

Kentucky

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$2,769,000	$257,000	$395,000	$199,000	$785,000	$4,405,000	$1.0	8%
FY2009	$3,307,000	$458,000	$386,000	$109,000	$355,000	$4,615,000	$1.1	8%
FY2010	$3,040,000	$0	$701,000	$124,000	$352,000	$4,217,000	$1.0	7%
FY2011	$2,749,000	$158,000	$669,000	$155,000	$596,000	$4,327,000	$1.0	8%





Louisiana

The Louisiana Cancer Research Consortium established the Louisiana Campaign for Tobacco-Free Living (TFL) in 2002. In 2002, the state tobacco excise tax increase passed and as a direct result, TFL created a statewide tobacco control program. TFL provides statewide coordination of existing tobacco control initiatives, funds innovative community tobacco control programs, conducts a statewide media campaign, administers a state hospital system cessation program, and monitors and evaluates tobacco control program impacts and outcomes. The core staff of the Louisiana Public Health Institute coordinates all aspects of the statewide implementation and evaluation of TFL (LPHI, 2014). In addition, the Louisiana Tobacco Control Program (TCP), under the Louisiana Department of Health and Hospitals, has been engaging in tobacco control activities since 1993. Federal grants from the CDC help to fund the TCP. The two programs, TCP and TFL, collaborate together on many programs, such as implementing the Community Program Grants (LDHH, 2014). Louisiana's tobacco control programs are funded through MSA payments and cigarette tax revenue. The majority (60%) of future MSA payments have been sold for an up-front lump sum payment to the Tobacco Settlement Financing Corporation. The other 40% of the annual MSA payments are distributed to the Millennium Trust and Louisiana Fund. From here, the monies are directed towards several other funds. Each year, the Louisiana Department of Health and Hospitals receives $0.5 million for a tobacco prevention and cessation program. Beginning in 2003 and continuing every year forward, after allocating money to the Bond and Security and Redemption Fund, 75% of the proceeds (from dividend and interest income and capital gains on investment) from the MSA that were not sold to the Tobacco Settlement Financing Corporation are allocated to the Millennium Trust. With the start of the 2012 fiscal year, these monies are allocated to the TOPS Fund and investment earnings are split as follows: 33% to the Education Excellence Fund, 33% to the Health Excellence Fund, and 33% to the TOPS Fund. Louisiana's cigarette tax was increased in 2002 from $0.24 to $0.36 per pack. From this tax, $0.12 is dedicated to the Tobacco Tax Health Care Fund, of which $0.07 is used as follows: 29.2% for funding preventions, 42.8% for the Louisiana Cancer Research Center of Louisiana State University Health Sciences Center in New Orleans/Tulane Health Sciences Center, and the remaining 28% for the Cancer Center of Louisiana State University Health Sciences Center. The remaining $0.05 is divided as follows: 20% for the Office of Addictive Disorders in the state Department of Health and Hospitals, 20% for the Louisiana State University Agricultural Center and the Southern University Agricultural Research and Extension Center, 20% for the Drug Abuse Resistance Programs, and 40% for the Office of State Police in the Department of Public Safety and Corrections (ALA, 2012).

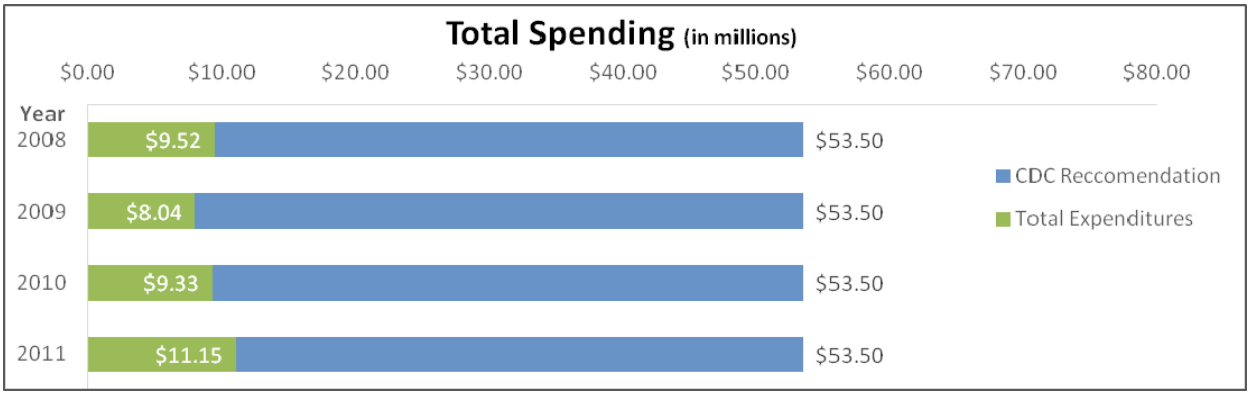
Louisiana's tobacco control programs spent a total of $9.52 million, or 18% of the CDC's suggested amount, in the 2008 fiscal year. With this $8.01 million, the state allocated 34% to state and community interventions, 31% to health communications, 18% to cessation interventions, 8% to surveillance and evaluation, and 9% to administration and management. In fiscal year 2009, Louisiana's investment decreased to $8.01 million, meeting 15% of the CDC's

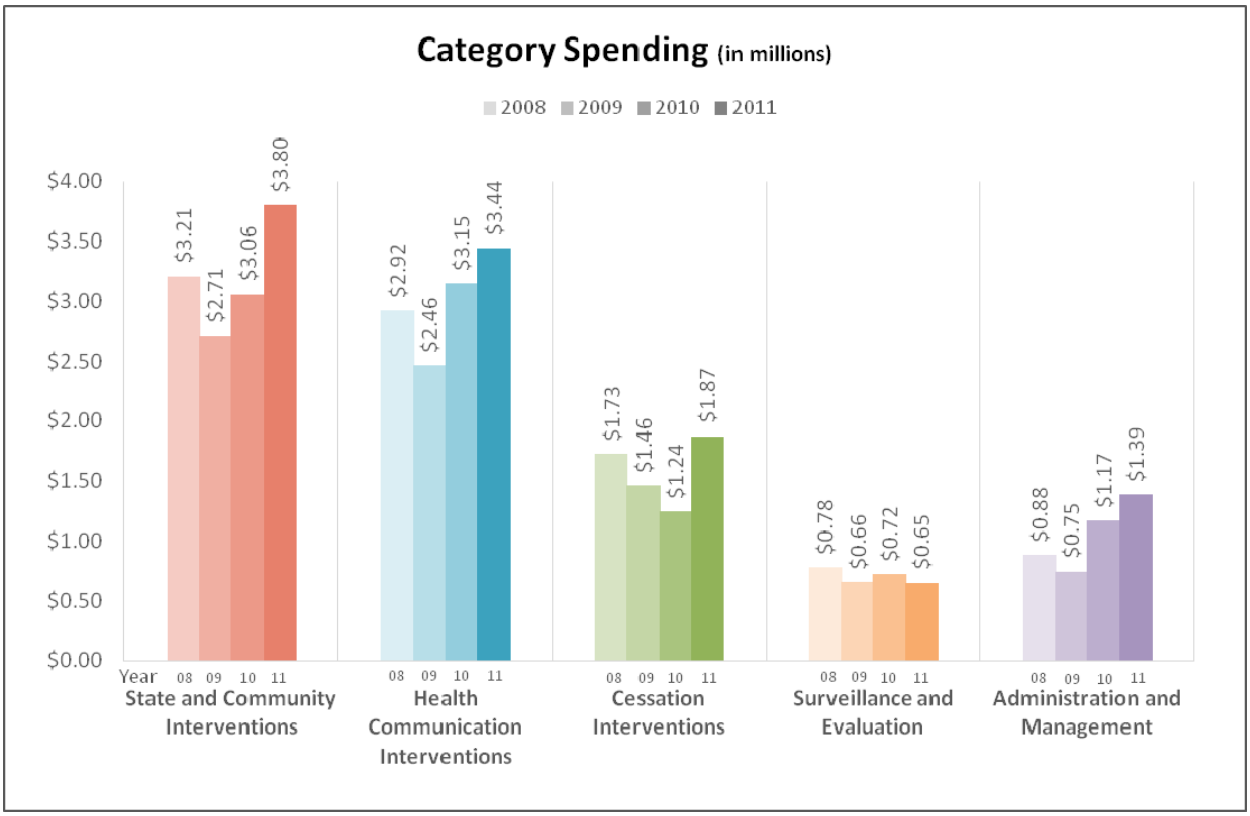
recommendation for tobacco control. In this fiscal year, Louisiana used approximately 34% of tobacco control expenditures for state and community interventions, 31% for health communications, 18% for cessation interventions, 8% for surveillance and evaluation, and 9% for administration and management. The following fiscal year, Louisiana invested $9.33 million, 17% of the CDC's recommended spending level. Of this investment on tobacco control, the state provided 33% of the total to state and community interventions, 34% to health communications, 13% to cessation interventions, 8% to surveillance and evaluation, and 12% to administration and management. The 2011 fiscal year brought $9.33 million to Louisiana's tobacco control programs. This amount allowed the state to again attain 17% of the CDC's recommended level for tobacco control. Of the $9.33 million, Louisiana dedicated 34% to state and community interventions, 31% to health communications, 17% to cessation interventions, 6% to surveillance and evaluation, and 12% to administration and management.

Louisiana

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$3,209,000	$2,918,000	$1,728,000	$780,000	$883,000	$9,518,000	$2.2	18%
FY2009	$2,710,000	$2,464,000	$1,459,000	$659,000	$746,000	$8,038,000	$1.8	15%
FY2010	$3,058,000	$3,146,000	$1,240,000	$721,000	$1,165,000	$9,330,000	$2.1	17%
FY2011	$3,804,000	$3,439,000	$1,873,000	$651,000	$1,386,000	$11,153,000	$2.5	21%





Maine

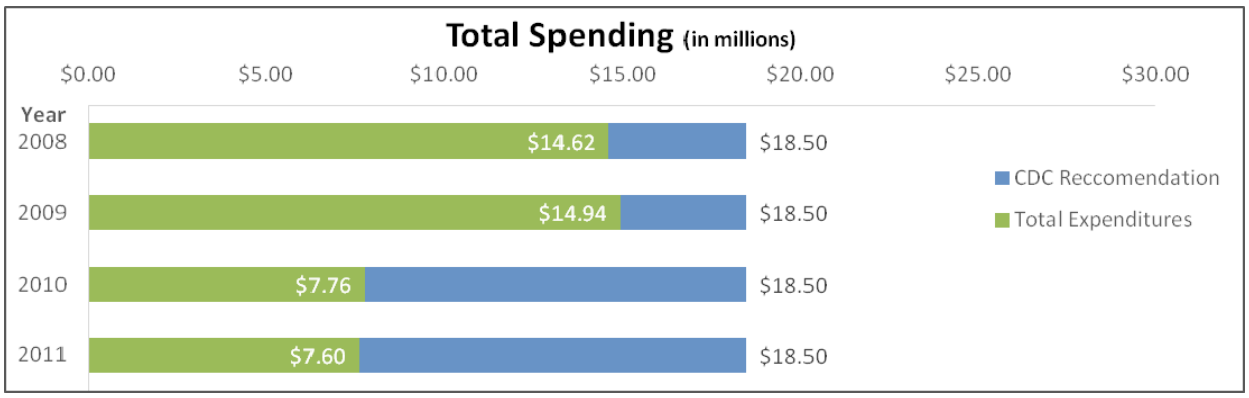
Maine's tobacco control program was established in 1993 through the National Cancer Institute's ASSIST (American Stop Smoking Intervention Study) program. As a result of the tobacco excise tax legislation, Maine established the Partnership for Tobacco-Free Maine (PTM). In 1998/1999, Maine's tobacco control funding from the tax revenue was replaced with its Master Settlement Agreement (MSA) payments (The Finance Project, 2011). Beginning in 1999, Maine's MSA payments were deposited into the Fund for a Healthy Maine and the Fund for a Healthy Maine Trust. In 2001, the Trust Fund was eliminated and the Fund for Healthy Maine was maintained. Several health related programs, including tobacco control, are maintained through the Fund for a Healthy Maine (ALA, 2012). PTM continues to perform its duties primarily through community and school tobacco control grants. Additionally, it maintains statewide cessation services and conducts media initiatives. Further, Maine differentiates between funding for tobacco control work and funding for other activities that target tobacco-related chronic disease. In 2005, Maine raised its cigarette tax from $1.00 to $2.00, and revenues from this tax are deposited into the state general fund. (ALA, 2012).

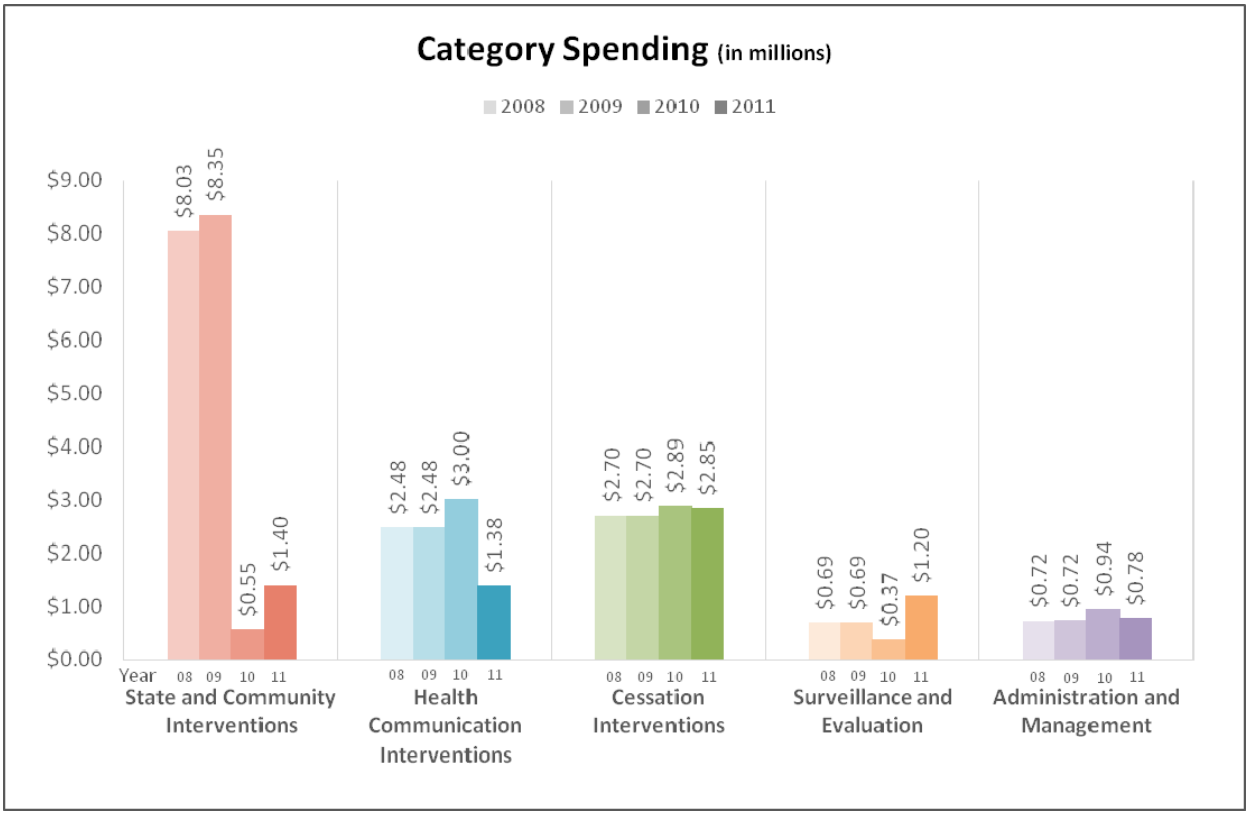
Maine authorized $14.62 million to be spent on tobacco control expenditures for the duration of the 2008 fiscal year, fulfilling 79% of the CDC's recommended level. Of these expenditures, 55% went to state and community interventions, 17% to health communications, 18% to cessation interventions, 5% to surveillance and evaluation, and 5% to administration and management. In fiscal year 2009, Maine increased expenditures to 81% of the CDC's recommendation for tobacco control, or $14.94 million. In this fiscal year, the state used approximately 56% of the $14.94 million for state and community interventions, 16% for health communications, 18% for cessation interventions, 5% for surveillance and evaluation, and 5% for administration and management. The following fiscal year, Maine decreased tobacco control spending to $7.76 million, or 42% of the CDC's recommended spending level. Of this investment on tobacco control, 7% went towards state and community interventions, 39% went towards health communications, 37% went towards cessation interventions, 5% went towards surveillance and evaluation, and 12% went towards administration and management. In the following fiscal year, 2011, Idaho totaled $7.6 million in tobacco control spending, reaching 41% of the CDC's suggested investment level. Of the money provided for tobacco control, the state allotted 18% for state and community interventions, 18% for health communications, 38% for cessation interventions, 16% for surveillance and evaluation, and 10% for administration and management.

Maine

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$8,033,000	$2,478,000	$2,700,000	$690,000	$717,000	$14,618,000	$11.1	79%
FY2009	$8,352,000	$2,478,000	$2,700,000	$690,000	$724,000	$14,944,000	$11.3	81%
FY2010	$552,000	$3,004,000	$2,890,000	$368,000	$942,000	$7,756,000	$5.8	42%
FY2011	$1,398,000	$1,382,000	$2,845,000	$1,202,000	$775,000	$7,602,000	$5.7	41%





Maryland

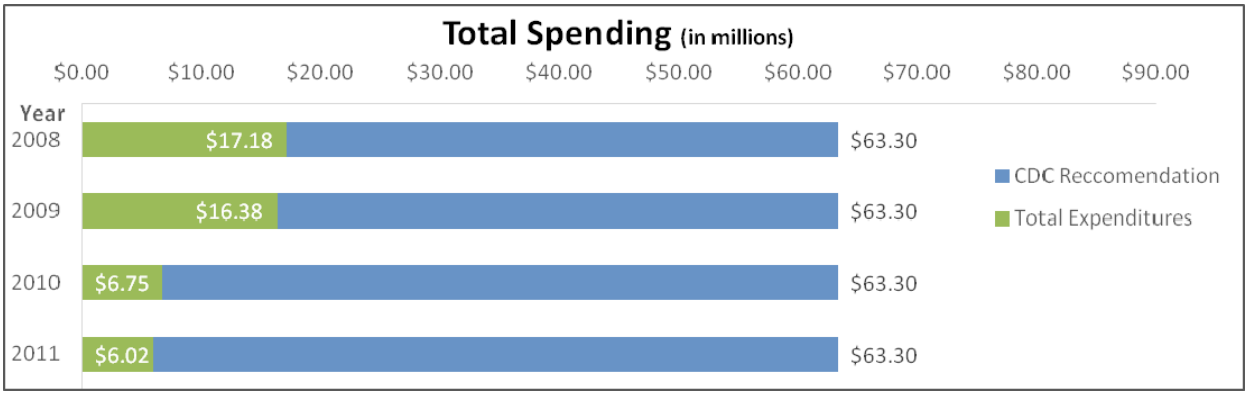
In 2000, substantial funds from Maryland's MSA payments were given to the Maryland Department of Mental Health and Hygiene (MDMHH) to implement a tobacco control program (ALA, 2000). MDMHH created the Tobacco Use Prevention and Cessation Unit. This unit provides oversight, technical assistance, and training to local health departments and tobacco control grant recipients to ensure that their efforts are coordinated with the statewide program goals and messages. Maryland deposits MSA payments into state's Cigarette Restitution Fund (CRF), which are subject to the legislative allocation and the appropriation process (ALA, 2012). At minimum, 50% of funds from the CRF are allocated to the Tobacco Use and Prevention and Cessation Program; the Cancer Prevention, Education, Screening, and Treatment Program; and other programs. Of the monies from the CRF, at least 30% is used for the Maryland Medical Assistance Program and 0.15% is used to enforce the MSA. Starting in fiscal year 2007, the governor of Maryland was required to allocate $21 million for tobacco reducing activities to the annual budget, but that amount was reduced for fiscal years 2010 through 2012 to address budget shortfalls (The Finance Project, 2011). Maryland's funding comes from its MSA payments and the state general fund. In 2008, Maryland's cigarette tax was increased from $1.00 to $2.00.

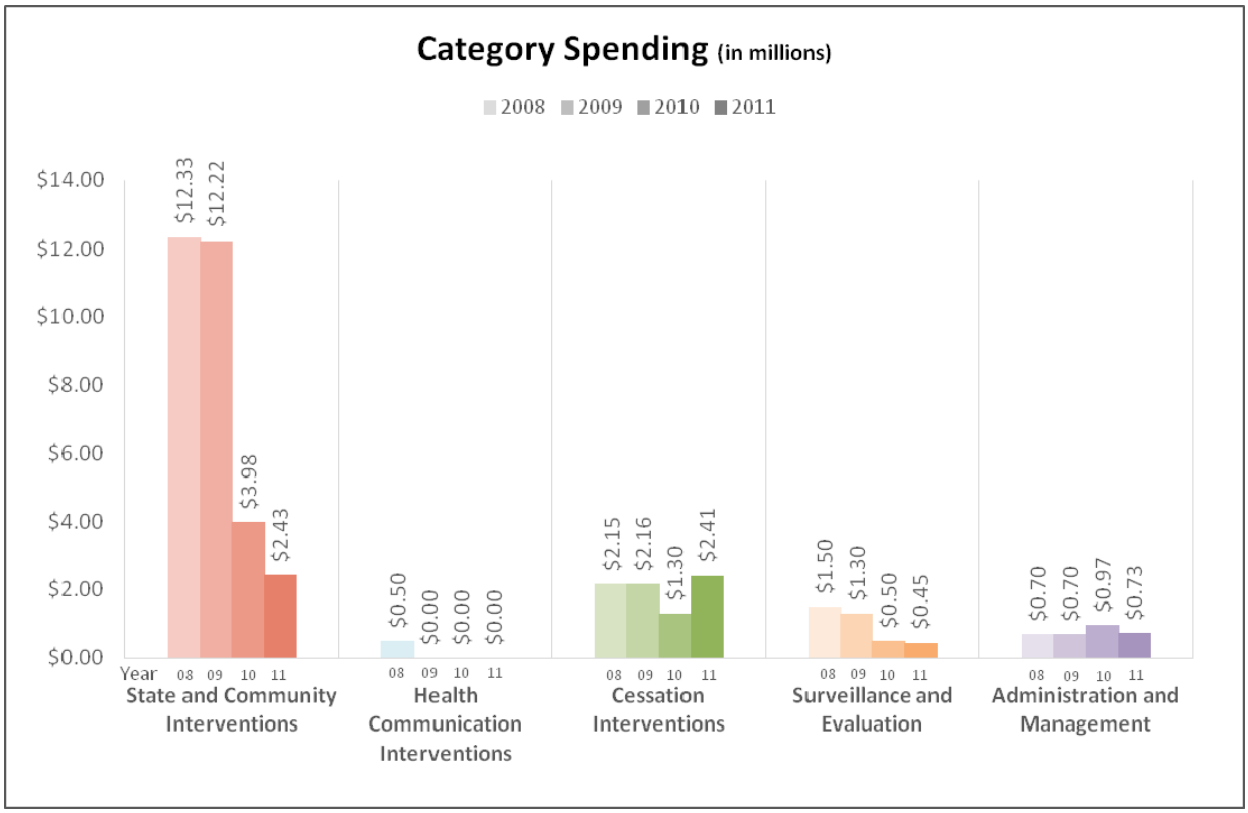
For the 2008 fiscal year, Maryland spent $17.18 million on tobacco control expenditures, reaching 27% of what the CDC suggests the state spends. Maine contributed 72% of this money to state and community interventions, 3% to health communications, 12% to cessation interventions, 9% to surveillance and evaluation, and 4% to administration and management. Maryland's investment decreased to 26% of the CDC's recommendation for tobacco control, or $16.38 million, for the 2009 fiscal year. Maryland funded state and community interventions with 75% of the $16.38 million, health communications with 0%, cessation interventions with 13%, surveillance and evaluation with 8%, and administration and management with 4%. The following fiscal year, Maryland decreased expenditures again to $6.75 million, or 11% of the CDC's recommended spending level. The state appropriated 59% for state and community interventions, 0% for health communications, 19% for cessation interventions, 8% for surveillance and evaluation, and 14% for administration and management. The budget spent throughout the 2011 fiscal year reached $6.02 million, totaling 10% of the CDC's recommended investment level on tobacco control. Of the $6.02 million, Maryland expended 40% on state and community interventions, 0% on health communications, 40% on cessation interventions, 8% on surveillance and evaluation, and 12% on administration and management.

Maryland

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$12,330,000	$500,000	$2,150,000	$1,500,000	$700,000	$17,180,000	$3.1	27%
FY2009	$12,220,000	$0	$2,160,000	$1,300,000	$700,000	$16,380,000	$2.9	26%
FY2010	$3,980,000	$0	$1,301,000	$500,000	$968,000	$6,749,000	$1.2	11%
FY2011	$2,425,000	$0	$2,410,000	$453,000	$732,000	$6,020,000	$1.0	10%





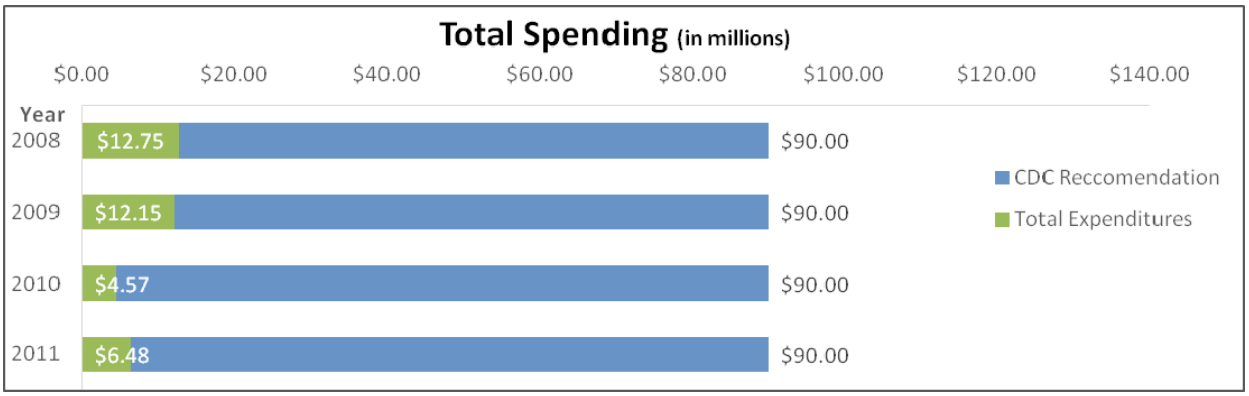
Massachusetts

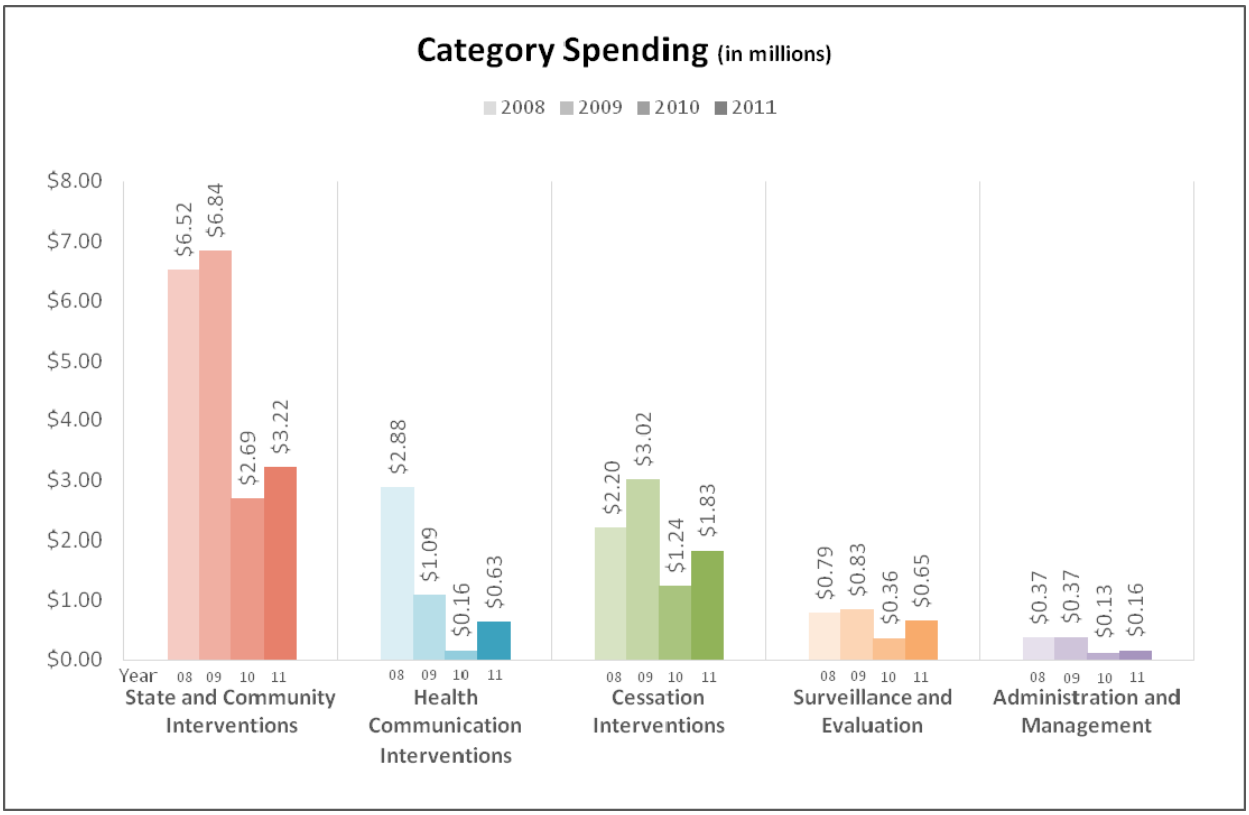
The Massachusetts Tobacco Cessation and Prevention Program (MTCP), under the Massachusetts Department of Public Health, began its operation in 1993 with the initial funding from Massachusetts' tobacco excise tax revenue. Funding for MTCP later changed in 1999 when Master Settlement Agreement money began supplementing the program (TFK, 2012). From 1995 to 1999, the funding for its tobacco control program ranged from $37 million to $31 million. Beginning in 1999, the CDC provided some additional funding. In 2000, with additional funding from the MSA, the MTCP's budget grew to $54 million. In fiscal year 2003, both funding sources (the tax revenue and MSA payments) were nearly eliminated due to budget shortfalls and legislative changes and MSA usage. Since 2003, MTCP received funds through general appropriation. Although funding for tobacco control did increase from 2007 to 2009, the budget was reduced in 2010 (TFK, 2009). Until 2012, all money from the MSA was deposited into the Health Care Security Trust, serving the purpose of improving the health statues of the state's citizens. Of the monies deposited into the fund, 30% of investment income for the year and 30% of the tobacco proceeds were transferred to the state general fund. In 2012, 100% of the MSA payment and the interest earned from it went into the state general fund. In 2013, 10% of MSA money was put into the State Retiree and Benefits Trust Fund and 90% went to the state general fund. Each year, the amount deposited into the State Retiree Benefits Trust Fund will increase by 10% until it reaches 100% of the MSA payments. Currently, funding for tobacco control is supported through the state's general fund. Massachusetts raised its cigarette tax in 2013 from $2.51 to $3.51 per pack, with money from the tax going to the Commonwealth Care Trust Fund, the Children's and Senior's Health Care Assistance Fund, the Local Aid Fund and the state General Fund (ALA, 2012).

Massachusetts expenditures on tobacco control amounted to $12.75 million in the 2008 fiscal year, fulfilling 14% of the CDC's recommended level. Of this amount, state and community interventions received 51%, health communications received 23%, cessation interventions received 17%, surveillance and evaluation received 6%, and administration and management received 3%. In fiscal year 2009, Massachusetts again fulfilled 14% of the CDC's recommendation for tobacco control at $12.15 million. In this fiscal year, the state used approximately 56% of tobacco control expenditures for state and community interventions, 9% for health communications, 25% for cessation interventions, 7% for surveillance and evaluation, and 3% for administration and management. Massachusetts' contribution to tobacco control in 2010 was $4.57 million, 5% of the CDC's suggestion for spending. Of this contribution to tobacco control, 58% went towards state and community interventions, 4% went towards health communications, 27% went towards cessation interventions, 8% went towards surveillance and evaluation, and 3% went towards administration and management. In the final fiscal year, 2011, Massachusetts provided $6.48 million for its tobacco control programs, reaching 7% of what the CDC suggests. Of the $6.48 million, the state provided 50% to state and community

interventions, 10% to health communications, 28% to cessation interventions, 10% to surveillance and evaluation, and 2% to administration and management.

Massachusetts								
Tobacco Control Spending Profile FY2008 - FY2011								
	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$6,521,000	$2,880,000	$2,197,000	$785,000	$367,000	$12,750,000	$2.0	14%
FY2009	$6,839,000	$1,089,000	$3,019,000	$830,000	$374,000	$12,151,000	$1.8	14%
FY2010	$2,693,000	$162,000	$1,237,000	$355,000	$127,000	$4,574,000	$0.7	5%
FY2011	$3,221,000	$631,000	$1,827,000	$645,000	$158,000	$6,482,000	$1.0	7%





Michigan

Michigan's tobacco control program is managed by the Michigan Department of Community Health. Funds are annually allocated by the state legislature from its tobacco tax revenues. Michigan has never dedicated Master Settlement Agreement money toward tobacco prevention, therefore all funding currently comes from the cigarette tax revenue. With insufficient funds to implement statewide, comprehensive tobacco control programs, non-profit charity organizations, such as Tobacco Free Michigan (TFM), advocate the anti-tobacco media campaigns and put pressure on the state legislative body for additional tobacco control funds (TFM, 2014). Beginning in 1999, MSA revenue was placed into two funds, The Michigan Merit Award Trust Fund and the Tobacco Settlement Trust Fund. In 2005,The Tobacco Settlement Trust Fund was eliminated. For an up-front, one lump sum payment, Michigan sold a portion of its MSA payments to the Michigan Tobacco Settlement Authority. The remaining money is allocated to the 21st Century Jobs Trust Fund, the Michigan Merit Award Trust Fund, and/or the general fund of Michigan. The Michigan Finance Authority holds the right to issue securities backed by MSA payments according to the state's budget needs. Michigan established the 21st Century Job Trust Fund within the Department of Treasury to receive proceeds from the securitization of MSA money.. Interest and earnings from the fund are transferred to the state general fund. Additionally, the Michigan Merit Award Trust Fund uses remaining MSA money to fund education programs. Michigan has a cigarette excise tax of $2.00, which increased in 2004 from $1.25 per pack. Monies from this excise tax goes to the Healthy Michigan Fund, the Health and Safety Fund, the general fund, the State School Aid Fund, counties with a population of more than two million to be used only for indigent health care, and the Medicaid Benefits (ALA, 2012).

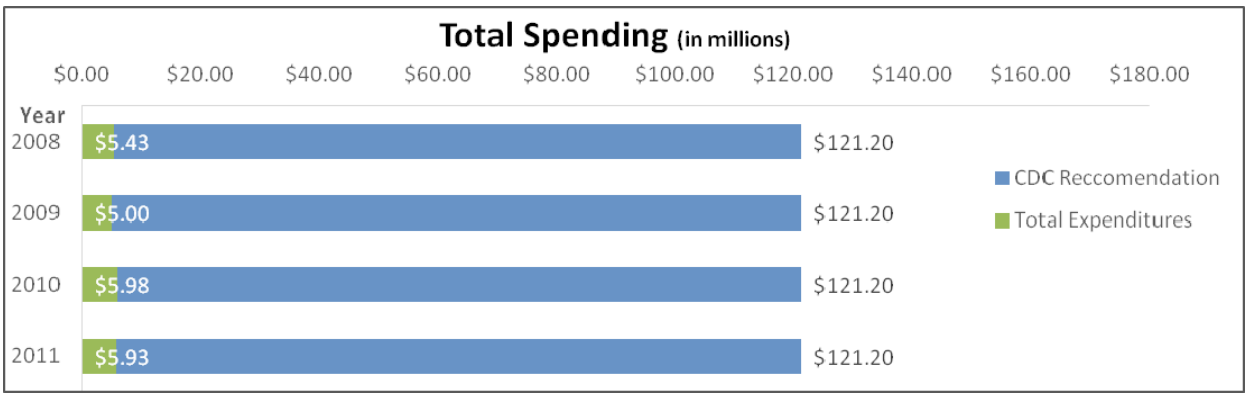
Michigan spent $5.43 million on tobacco control expenditures in the 2008 fiscal year, reaching 5% of the CDC's recommended level. Of these expenditures, the state spent 35% on state and community interventions, 8% on health communications, 26% on cessation interventions, 7% on surveillance and evaluation, and 24% on administration and management. Michigan's money for tobacco control decreased in fiscal year 2009, meeting 4% of the CDC's recommendation for tobacco control, thus providing $5 million for programs. In this fiscal year, Michigan used 40% of tobacco control expenditures for state and community interventions, 4% for health communications, 28% for cessation interventions, 4% for surveillance and evaluation, and 24% for administration and management. The following fiscal year, 2010, Michigan invested $5.98 million, 5% of the CDC's recommended spending level. Of this investment on tobacco control, the state set aside 44% for state and community interventions, 7% for health communications, 21% for cessation interventions, 4% for surveillance and evaluation, and 24% for administration and management. Spending remained consistent for the 2010 and 2011 fiscal year, again meeting 5% of the CDC's recommended investment level on tobacco control, totaling $5.93 million in expenditures. Of the $5.93 million, Michigan expended 48% in state and community

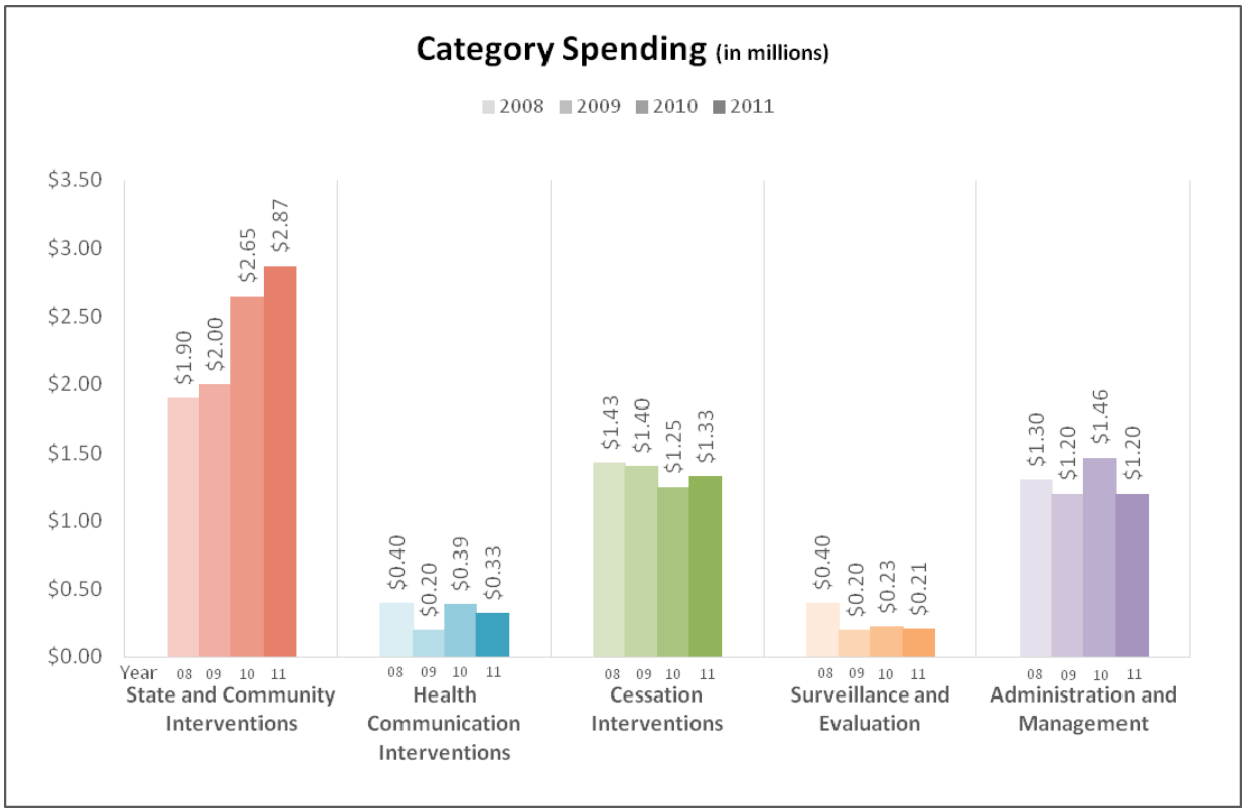
interventions, 6% in health communications, 22% in cessation interventions, 4% in surveillance and evaluation, and 20% in administration and management.

Michigan

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$1,900,000	$400,000	$1,430,000	$400,000	$1,300,000	$5,430,000	$0.5	5%
FY2009	$2,000,000	$200,000	$1,400,000	$200,000	$1,200,000	$5,000,000	$0.5	4%
FY2010	$2,650,000	$393,000	$1,249,000	$225,000	$1,464,000	$5,981,000	$0.6	5%
FY2011	$2,872,000	$325,000	$1,325,000	$208,000	$1,200,000	$5,930,000	$0.6	5%





Minnesota

Minnesota is one of four states which settled individually with the major cigarette manufacturers before the Master Settlement Agreement (TFK, 2012). The state of Minnesota settled for an estimated $6.13 billion; the co-plaintiff, Blue Cross and Blue Shield of Minnesota, settled for $241 million (ALA, 2012). Annual payments from the settlement (76% of the total) are deposited into the state's general funds, whereas the one time initial payouts from the settlement were split among four sources: $202 million (3% of total) for ClearWay Minnesota, $451 million (9%) for the Tobacco Use Prevention and Local Public Health Endowment Fund, $289 million (6%) for the Medical Education Endowment, and $203 million (6%) for the Academic Health Center Account (MDH, 2003). As a result of the tobacco settlement agreement, tobacco control and prevention is primarily run by ClearWay Minnesota (formerly known as the Partnership for Action against Tobacco). ClearWay is an independent, nonprofit foundation overseen by the Ramsey County District Court. Since 1998, guaranteed funding provided by the tobacco settlement agreement has allowed ClearWay to establish statewide tobacco control and prevention programs. In addition to finding supplemental support for research grants, the foundation focuses on cessation interventions through quitline services, media campaigns, and diverse community interventions (Clearway Minnesota, 2012). ClearWay is not Minnesota's only tobacco control program. The Minnesota Department of Health (MDH) houses a tobacco control program that is currently funded through state appropriations and the CDC. With these funds, MDH administers local grant programs focused on reducing youth tobacco use and addressing the high prevalence of tobacco use in tribal communities (MDH, 2014). Starting in 2006, a third party, Blue Cross/ Blue Shield of Minnesota, launched a long-term initiative using a portion of its $241 million settlement to improve the overall health of Minnesotans. One of its main foci is to improve the health of Minnesotans through reducing tobacco use (TFK, 2012). Minnesota does have a cigarette tax, raised from $1.23 per pack of cigarettes to $2.38 per pack of cigarettes in 2013, with the revenue from $0.48 of the tax being distributed to the Academic Health Center Special Revenue Fund, Medical Education and Research Costs Account, and the state general fund (ALA, 2012).

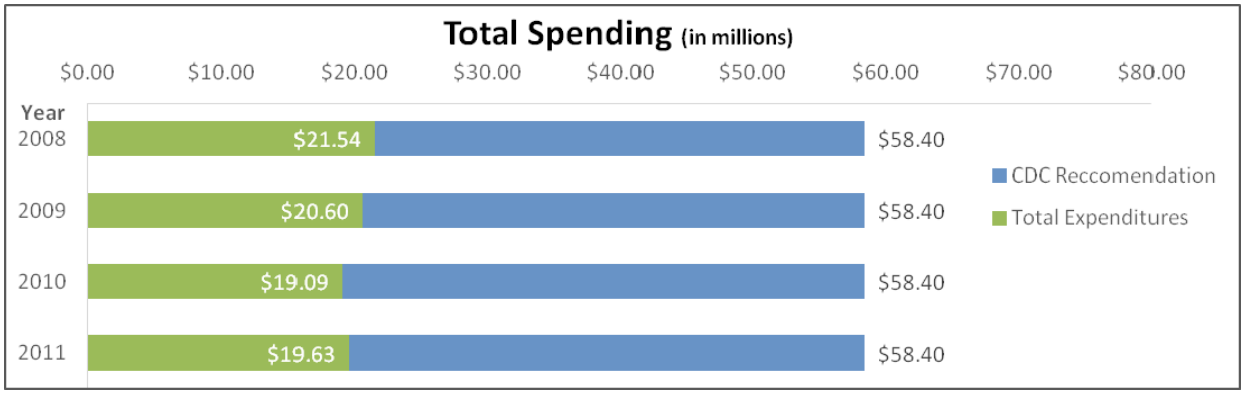
Minnesota reached 37% of the CDC's suggested spending on tobacco control by providing programs with $21.54 million during the 2008 fiscal year. Of these expenditures, 23% supported state and community interventions, 24% supported health communications, 11% supported cessation interventions, 24% supported surveillance and evaluation, and 18% supported administration and management. In fiscal year 2009, Minnesota's expenditure total decreased to 35% of the CDC's recommended level for tobacco control, with the state and foundations spending $20.6 million. In this fiscal year, approximately the state and foundations used 26% of tobacco control expenditures for state and community interventions, 25% for health communications, 16% for cessation interventions, 12% for surveillance and evaluation, and 21% for administration and management. The following fiscal year, Minnesota invested $19.1 million, 33% of the CDC's recommended spending level. Of this investment on tobacco control,

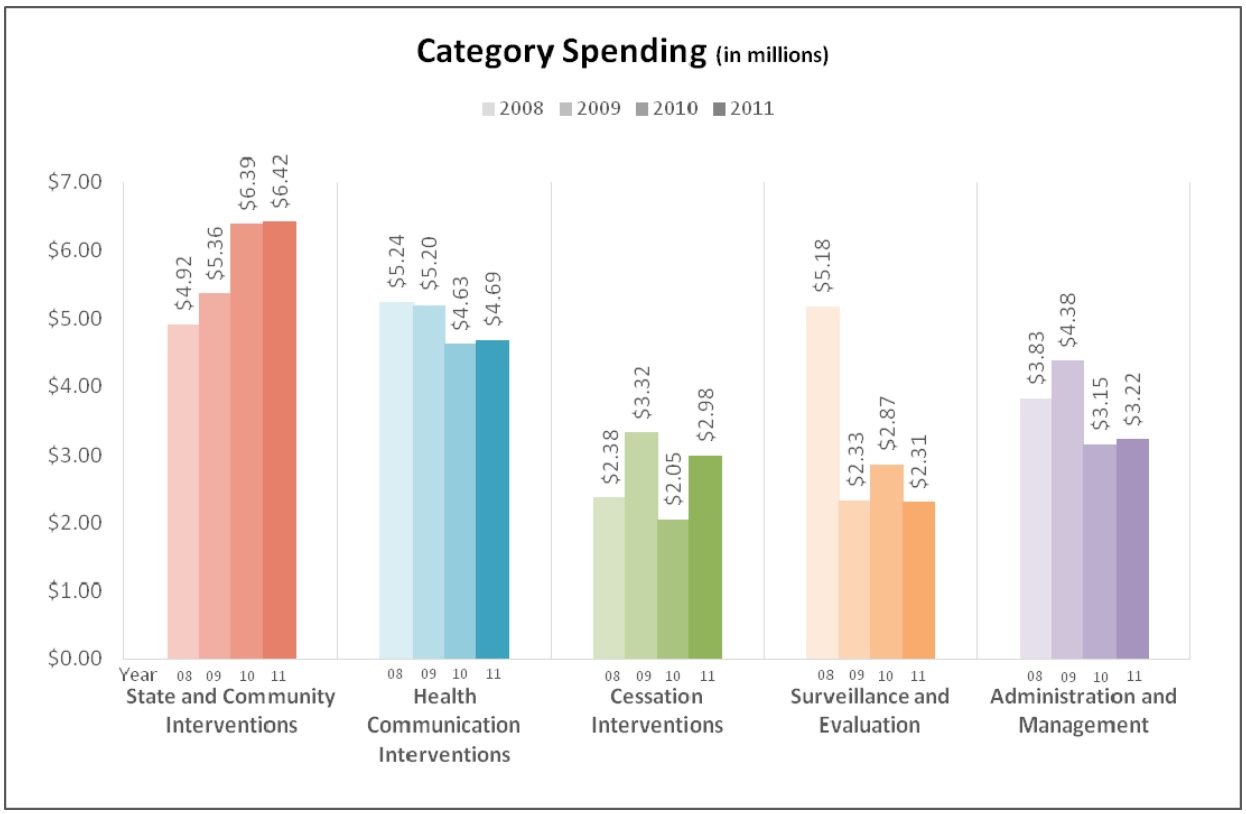
33% went to state and community interventions, 24% went to health communications, 11% went to cessation interventions, 15% went to surveillance and evaluation, and 17% went to administration and management. Minnesota provided $19.63 million for tobacco control, reaching 34% of the CDC's recommended investment level on tobacco control in 2010. Of the $19.63 million, Michigan provided 33% of the total to state and community interventions, 24% to health communications, 15% to cessation interventions, 12% to surveillance and evaluation, and 16% to administration and management.

Minnesota

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$4,919,000	$5,244,000	$2,377,000	$5,178,000	$3,826,000	$21,544,000	$4.1	37%
FY2009	$5,361,000	$5,203,000	$3,324,000	$2,334,000	$4,379,000	$20,601,000	$3.9	35%
FY2010	$6,388,000	$4,632,000	$2,050,000	$2,865,000	$3,153,000	$19,088,000	$3.6	33%
FY2011	$6,421,000	$4,689,000	$2,983,000	$2,309,000	$3,224,000	$19,626,000	$3.7	34%





Mississippi

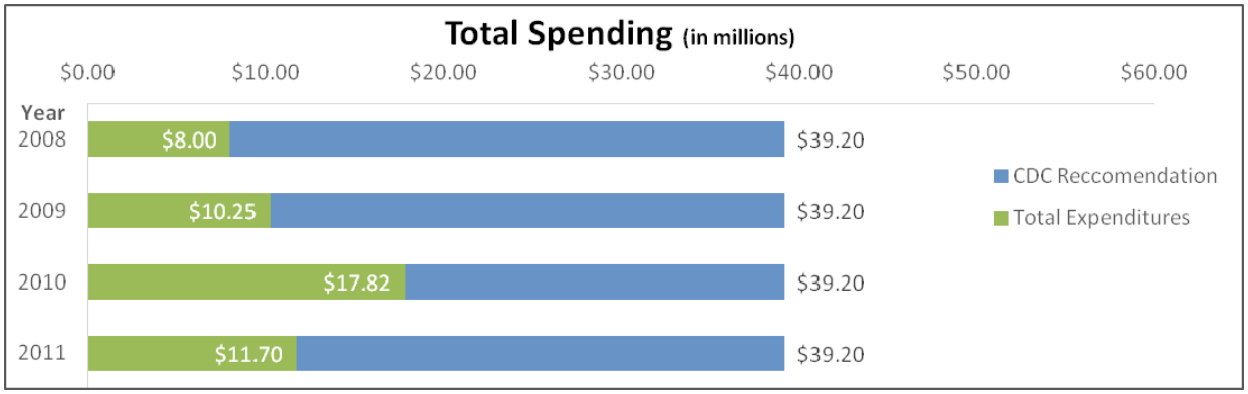
Mississippi is one of four states that had an independent settlement with the tobacco industry. Within the Department of Health is Mississippi's Office of Tobacco Control. The Mississippi Tobacco Control Advisory Board provides advice to the Office of Tobacco Control. The Tobacco Control Program Fund receives $20 million annually in tobacco settlement dollars, a portion of which is allocated to tobacco control. The Health Care Trust Fund and the Health Care Expendable Fund also receive tobacco settlement dollars yearly. In 1999, the Health Care Trust Fund received $280 million in settlement dollars. Each year, money is taken from this fund and placed into the Health Care Expendable Fund. Although it is supposed to remain inviolate, in fiscal years 2012 and 2013, principal from the Trust Fund was transferred to the Expendable Fund. Beginning in 2000, the monies in the Health Care Expendable Fund are appropriated for health care purposes. Starting in 2012 and following every calendar year thereafter, the entire settlement payment, with the exception of $10 million, will be deposited into the Health Care Expendable Fund. This will occur until the total is less than a specified amount in the Health Care Trust Fund. Mississippi increased its tax on cigarettes from $0.18 to $0.68 per pack in 2009. All tax revenue is placed in the state treasury to the credit of the state general fund (ALA, 2012).

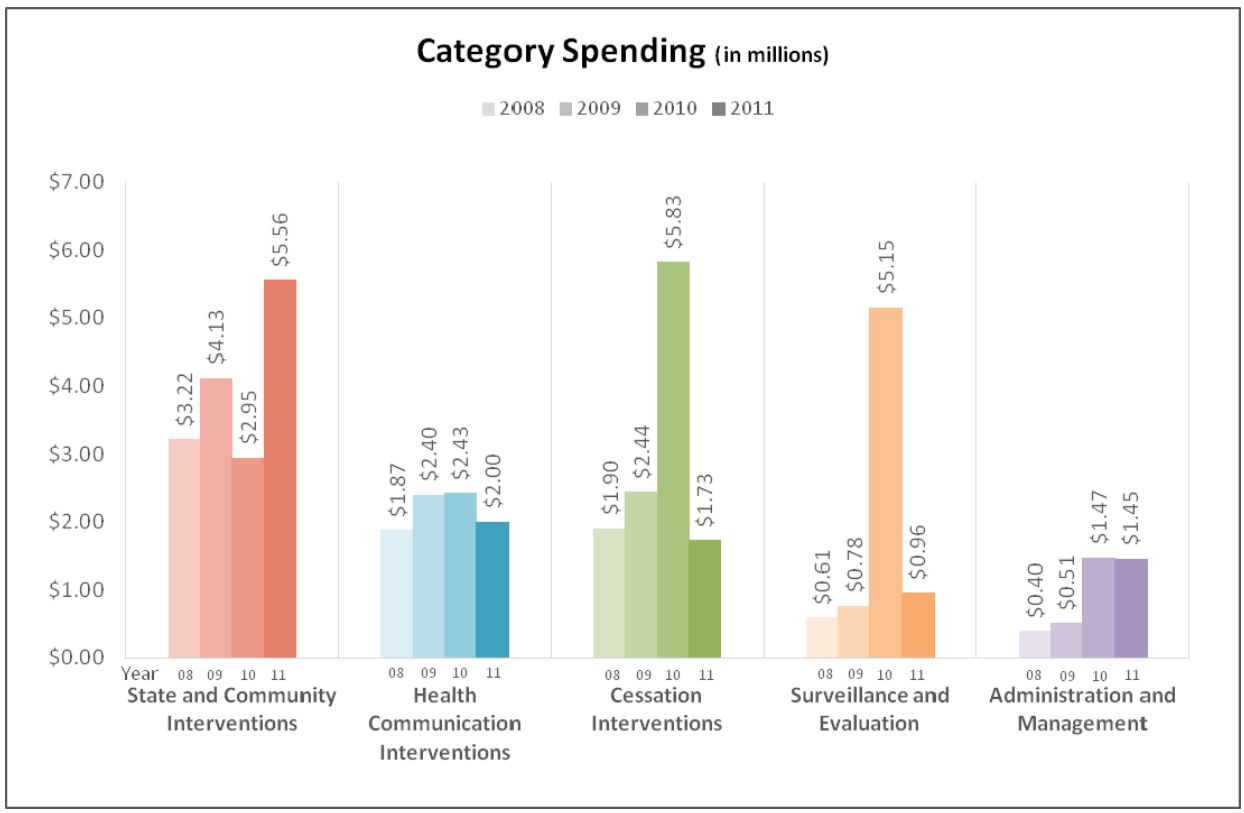
Throughout the 2008 fiscal year, Mississippi spent $8 million on tobacco control expenditures, meeting 20% of the CDC's recommended level. Of these expenditures, state and community interventions received 40%, health communications reveived 23%, cessation interventions received 24%, surveillance and evaluation received 8%, and administration and management received 5%. In fiscal year 2009, Mississippi's spending met 26% of the CDC's recommendation for tobacco control, which was $10.25 million. In this fiscal year, approximately the state used 40% of tobacco control expenditures for state and community interventions, 23% for health communications, 24% for cessation interventions, 8% for surveillance and evaluation, and 5% for administration and management. Mississippi invested $17.82 million, or 46% of the CDC's suggested spending level, in fiscal year 2010. Of this $17.82 million, 16% financed state and community interventions, 14% financed health communications, 33% financed cessation interventions, 29% financed surveillance and evaluation, and 8% financed administration and management. In the following fiscal year, 2011, the state provided $11.7 million for tobacco control, decreasing to 30% of the CDC's recommended investment level on tobacco control. Of the $11.7 million, Michigan delegated 48% to state and community interventions, 17% to health communications, 15% to cessation interventions, 8% to surveillance and evaluation, and 12% to administration and management.

Mississippi

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$3,220,000	$1,873,000	$1,902,000	$605,000	$400,000	$8,000,000	$2.7	20%
FY2009	$4,125,000	$2,400,000	$2,438,000	$775,000	$513,000	$10,251,000	$3.5	26%
FY2010	$2,948,000	$2,425,000	$5,827,000	$5,150,000	$1,470,000	$17,820,000	$6.0	46%
FY2011	$5,557,000	$2,000,000	$1,730,000	$959,000	$1,453,000	$11,699,000	$3.9	30%





Missouri

From fiscal years 2003 through 2007, Missouri's legislature allocated no funding towards tobacco control. The Missouri Department of Health and Senior Services houses the Comprehensive Tobacco Control Program (CTCP), which assists with tobacco control throughout the state of Missouri. CTCP's largest initiatives are community youth prevention and quitline cessation services. Current funding for the Department's tobacco control programs comes from the state budget appropriations, federal grants, and private donations. (TFK, 2009).

Additionally, the Missouri Foundation for Health, the largest non-governmental funder of community health activities in Missouri, established the Tobacco Prevention and Cessation Initiative (TPCI) in 2004. TPCI was a nine-year, multi-phase program which allocated $40 million in efforts to reduce tobacco use in Missouri through grant making, policy, evaluation, and communication activities. Activities included school- and workplace-based prevention and cessation programs, efforts to eliminate tobacco-related disparities, efforts to promote local tobacco control policy, and tobacco control capacity building. Given that the grants made by the Missouri Foundation for Health were not public funds, they were not included in the State Tobacco Control Expenditure Database (STCED). TPCI's funding ending in the 2013 fiscal year.

Beginning in 2001, Missouri's MSA payments were distributed to the Healthy Families Trust Fund, which was comprised of several funds, including the Health Care Treatment and Access Account, the Early Childhood Care and Education Account, the Life Sciences Research Account, the Tobacco Prevention, Education and Cessation Account, and the Seniors Catastrophic Prescription Drug Account. In 2006, the sub-accounts under the Healthy Families Trust Fund were eliminated and all monies were transferred from the sub-accounts into the Healthy Families Trust Fund (The Finance Project, 2011). Currently, this Trust Fund receives 75% of the tobacco settlement payments. These monies are directed through the annual appropriations process and fund a variety of health and social services and program. Starting in 2007, 25% of the MSA monies are dedicated to the Life Sciences Research Trust Fund, which focus on life sciences research. In 1993, Missouri increased its cigarette tax from $0.13 to $0.17 per pack of cigarettes, with a portion of the revenue deposited in the Health Initiatives Fund and the Fair Share Fund. Missouri has not increased its cigarette tax since (ALA, 2012).

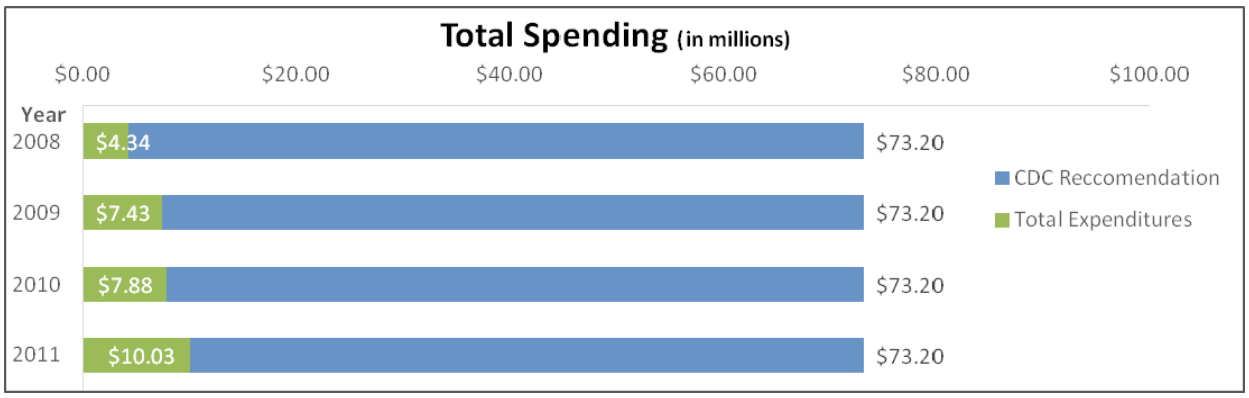
Missouri's $4.34 million expenditure on tobacco control and prevention for the 2008 fiscal year allowed it to fulfill 6% of the CDC's recommended level. Of this fiscal year's expenditures, 60% went to state and community interventions, 4% to health communications, 11% to cessation interventions, 14% to surveillance and evaluation, and 11% to administration and management. In fiscal year 2009, Missouri increased to 10% of the CDC's recommended level by supplying $7.43 million for tobacco control programs. Of the tobacco control expenditures, the state used 45% for state and community interventions, 8% for health communications, 31% for cessation interventions, 8% for surveillance and evaluation, and 8% for administration and management. The following fiscal year, Missouri increased contributions to $7.88 million, attaining 11% of the

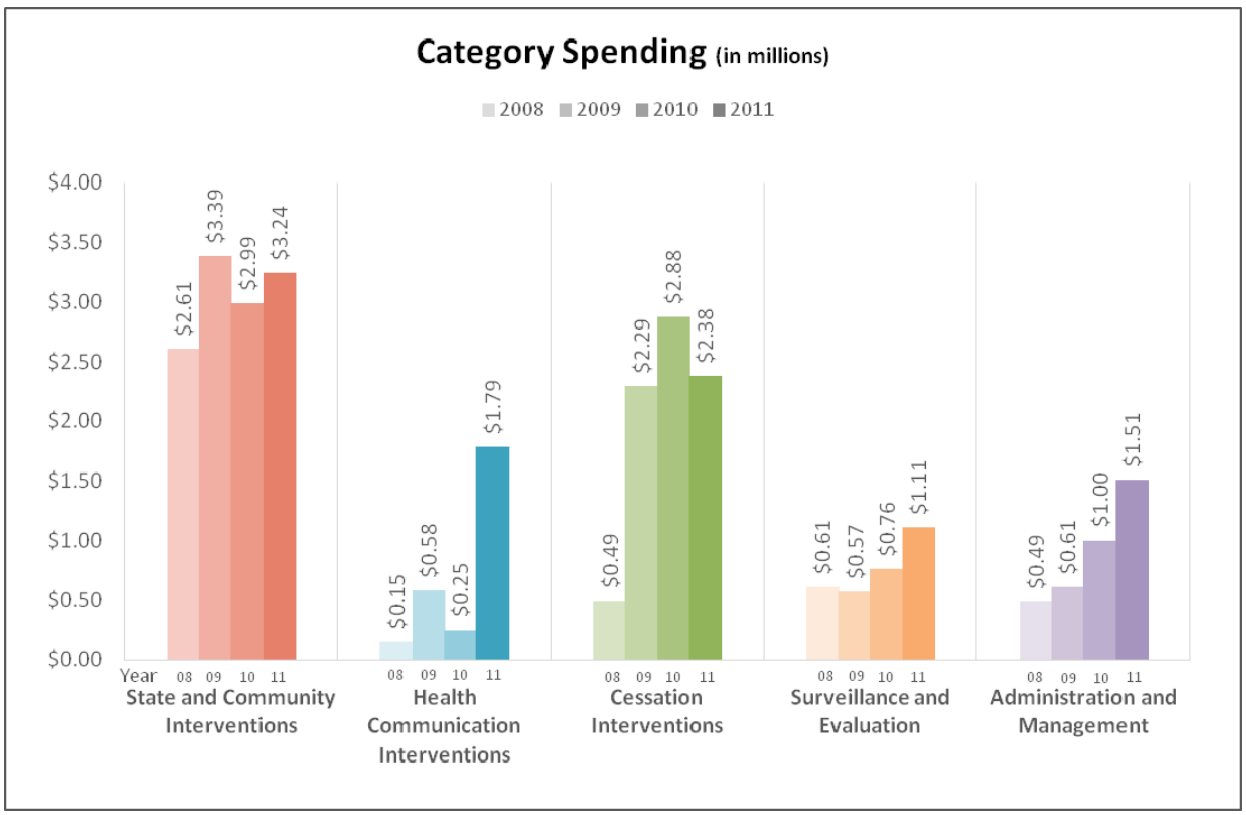
CDC's suggested spending level. Of this investment on tobacco control, the state contributed 38% to state and community interventions, 3% to health communications, 36% to cessation interventions, 10% to surveillance and evaluation, and 13% to administration and management. In the following fiscal year, 2011, Missouri invested $10.03 million, reaching 14% of the CDC's recommended investment level on tobacco control. Of the $10.03 million, Missouri invested 32% in state and community interventions, 18% in health communications, 24% in cessation interventions, 11% in surveillance and evaluation, and 15% in administration and management.

Missouri

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$2,605,000	$150,000	$490,000	$605,000	$488,000	$4,338,000	$0.7	6%
FY2009	$3,385,000	$580,000	$2,294,000	$569,000	$605,000	$7,433,000	$1.2	10%
FY2010	$2,985,000	$250,000	$2,876,000	$763,000	$1,001,000	$7,875,000	$1.3	11%
FY2011	$3,243,000	$1,785,000	$2,382,000	$1,109,000	$1,510,000	$10,029,000	$1.7	14%





Montana

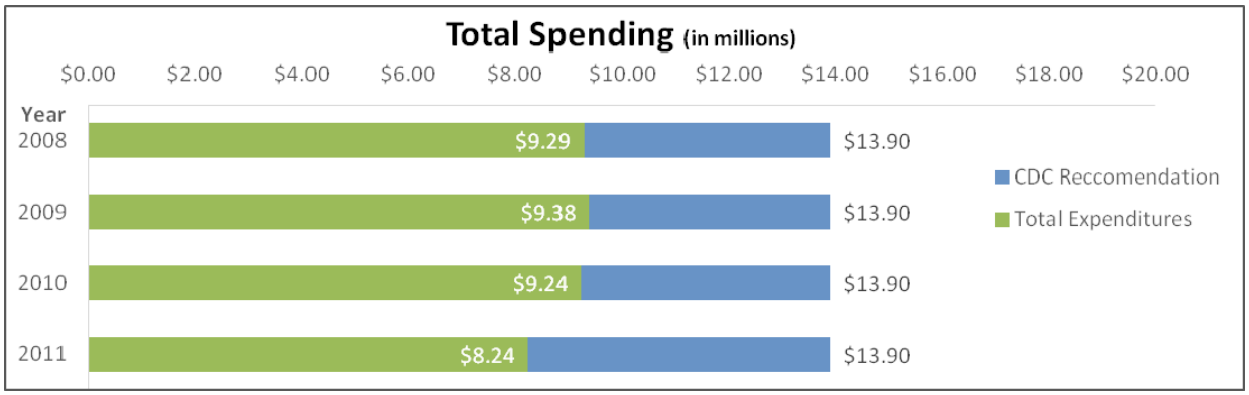
The Montana Tobacco Use Prevention Program (MTUPP) is managed by Montana's Department of Public Health. It is financed by the appropriations from the Master Settlement Agreement and grants from the CDC (Montana Prevention Advisory Board, 2004). MTUPP's mission is to address all forms of commercial tobacco product use, with a special emphasis on eliminating youth tobacco use (MTPAB, 2010). After Montana voters passed an initiative to implement and fund a statewide comprehensive tobacco control program using a portion of their MSA payments, MTUPP was formed. These payments are subject to legislative reviews and are distributed as follows: 32 % to state special revenue account to fund state tobacco control programs, 17 % to the Children's Health Insurance Program and Montana Comprehensive Health Association, 40 % to the Tobacco Trust Fund, and 11% to state general fund. Of the interest earned from the Tobacco Trust Fund, 90% is appropriated to address health care needs in Montana which may supplement tobacco control programs. Montana increased its cigarette excise tax in 2005 from $1 per pack to $1.70 per pack. About 44% of Montana's tax revenue is deposited to the Health and Medicaid Initiatives Account, which provides revenue for an increase in enrollment in the state children's health insurance program; a new need-based prescription drug program; increased Medicaid services and Medicaid provider rates; and help to fund new tax credits or programs to assist small businesses in providing health insurance. The majority of the remaining tax revenue goes to the state general fund (ALA, 2012).

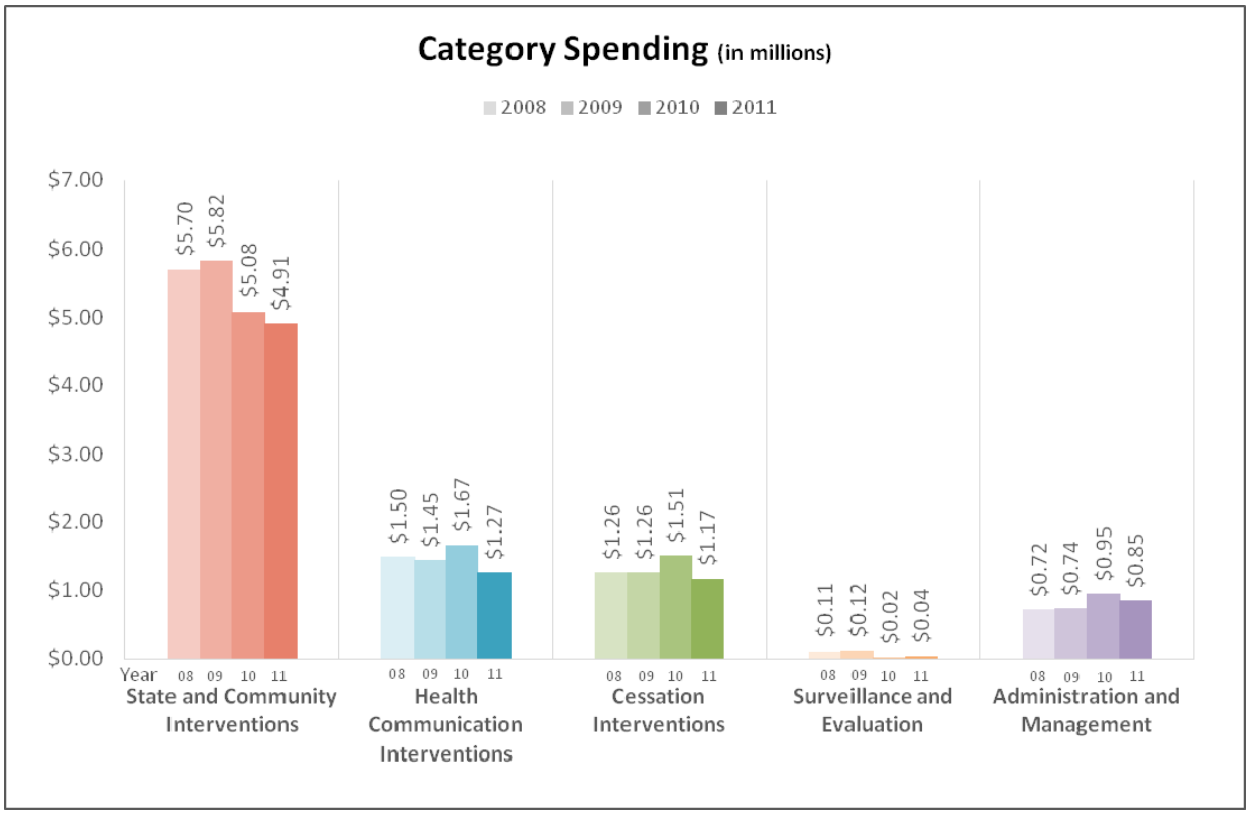
With $9.29 million spent on tobacco control expenditures in the 2008 fiscal year, Montana satisfied 67% of the CDC's recommended spending level. Of these expenditures, 61% was spent on state and community interventions, 16% on health communications, 14% on cessation interventions, 1% on surveillance and evaluation, and 8% on administration and management. For the following fiscal year, Montana's investment increased slightly to 68% of the CDC's recommendation with $9.38 million designated for tobacco control programs. In 2009, state and community interventions received 62% of the monies, health communications received 16%, cessation interventions received 13%, surveillance and evaluation received 1%, and administration and management received 8%. For the 2010 fiscal year, Montana invested $9.24 million, 67% of the CDC's spending suggestion. Of this investment on tobacco control, the state invested 55% in state and community interventions, 18% in health communications, 16% in cessation interventions, 1% in surveillance and evaluation, and 10% in administration and management. For the 2011 fiscal year, Montana spent $8.24 million, reaching 59% of the CDC's recommended investment number, on tobacco control. Of the $8.24 million, Montana authorized 60% for state and community interventions, 15% for health communications, 14% for cessation interventions, 1% for surveillance and evaluation, and 10% for administration and management.

Montana

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$5,698,000	$1,500,000	$1,262,000	$112,000	$716,000	$9,288,000	$9.6	67%
FY2009	$5,817,000	$1,450,000	$1,262,000	$115,000	$738,000	$9,382,000	$9.6	68%
FY2010	$5,084,000	$1,667,000	$1,511,000	$23,000	$952,000	$9,237,000	$9.4	67%
FY2011	$4,908,000	$1,268,000	$1,171,000	$42,000	$854,000	$8,243,000	$8.3	59%





Nebraska

Tobacco Free Nebraska (TFN), administered by the Nebraska Department of Health and Human Services (NDHHS), is Nebraska's comprehensive tobacco prevention program. Funding for the program comes from Nebraska's Master Settlement Agreement (MSA) payments and federal grants. TFN works with local tobacco prevention partners to implement school and community programs, to produce anti-tobacco advertising programs, and to maintain the state's quitline service (NDHHS, 2014). All monies from MSA payments are set up as an endowment, transferred into the Tobacco Settlement Trust Fund and then transferred to the Nebraska Health Care Cash Fund. Portions are transferred to a variety of other tobacco-related purposes, including community programs to reduce tobacco use, chronic disease programs, school programs, statewide programs, enforcement, counter-marketing, cessation programs, surveillance and evaluation, and administration. From 2005 to 2009, $2.5 million from the annual MSA payment was deposited into the Tobacco Prevention and Control Cash Fund rather than the Tobacco Settlement Fund. In 2009, the amount increased from $2.5 million to $3 million. In 2010, the Tobacco Prevention and Control Cash Fund began receiving an allocation from the Health Care Cash Fund (The Finance Project, 2011). According to Nebraska statutes, its cigarette tax revenue, raised in 2002 from $0.34 to $0.64 per pack of cigarettes, is distributed as follows: beginning October 1, 2004, the revenue from $0.49 of the cigarette tax is deposited into the state general fund; the remainder of the revenue is distributed to the following: 1) beginning July 1, 1980, one cent is placed in the Nebraska Outdoor Recreation Development Cash Fund; 2) beginning July 1, 1993, three cents is placed in the Department of Health and Human Services Finance and Support Cash Fund; 3) beginning October 1, 2002, seven cents is placed in the Building Renewal Allocation Fund; 4) beginning July 1, 2001, and continuing until June 30, 2016, $1 million dollars each fiscal year is placed in the City of the Primary Class Development Fund; 5) beginning July 1, 2001, and continuing until June 30, 2016, each fiscal year, $1.5 million dollars is placed in the City of the Metropolitan Class Development Fund; 6) beginning July 1, 2009, and continuing until June 30, 2016, $2.57 million dollars is placed in the Nebraska Public Safety Communication System Cash Fund; 7) any remaining money is placed in the Nebraska Capital Construction Fund (ALA, 2012).

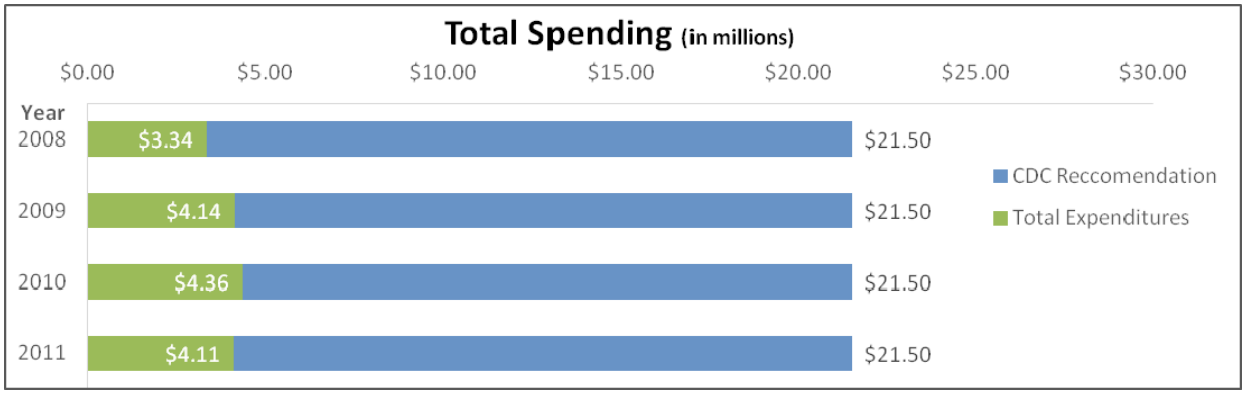
Nebraska spent $3.34 million on tobacco control expenditures, reaching 16% of the CDC's recommended level for the 2008 fiscal year. The largest percentage of these expenditures went towards state and community interventions, which spent 56% of the state's total expenditures, health communications spent 17%, cessation interventions spent 6%, surveillance and evaluation spent 5%, and administration and management spent 16%. In fiscal year 2009, Nebraska increased its investment to 19% of the CDC's recommendation for tobacco control by using $4.14 million for tobacco control programs. Again, state and community interventions received the largest proportion of this funding. Of the money, 50% funded state and community interventions, 15% funded for health communications, 17% funded cessation interventions, 5%

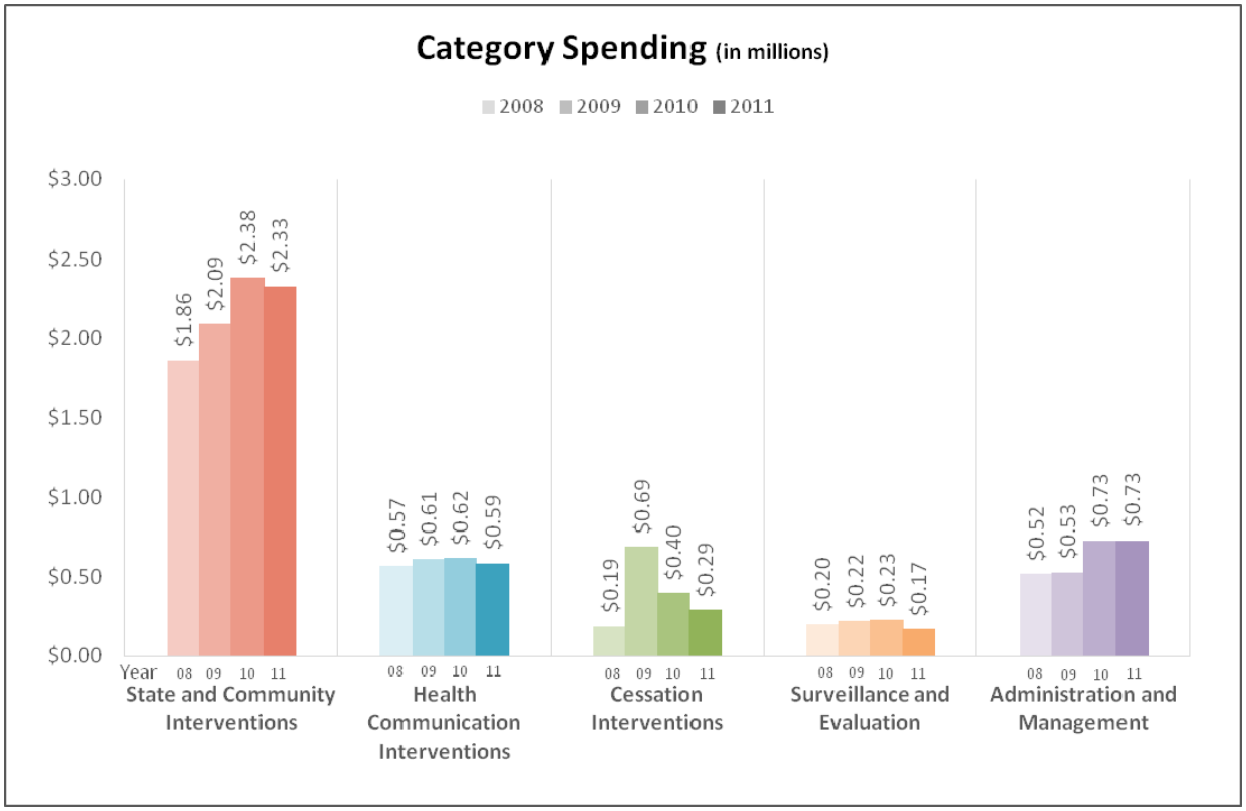
funded surveillance and evaluation, and 13% funded administration and management. The following fiscal year, Nebraska invested $4.36 million, 20% of the CDC's recommended spending level. Of this investment on tobacco control, the state invested 55% in state and community interventions, 14% in health communications, 9% in cessation interventions, 5% in surveillance and evaluation, and 17% in administration and management. In the following fiscal year, 2011, Nebraska utilized $4.11 million, reaching 19% of the CDC's suggested monetary level, on tobacco control. Of the $4.11 million, Nebraska delegated 57% to state and community interventions, 14% to health communications, 7% to cessation interventions, 4% to surveillance and evaluation, and 18% to administration and management.

Nebraska

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$1,860,000	$570,000	$190,000	$200,000	$520,000	$3,340,000	$1.9	16%
FY2009	$2,090,000	$610,000	$690,000	$220,000	$530,000	$4,140,000	$2.3	19%
FY2010	$2,384,000	$622,000	$397,000	$227,000	$725,000	$4,355,000	$2.4	20%
FY2011	$2,329,000	$587,000	$291,000	$174,000	$730,000	$4,111,000	$2.3	19%





Nevada

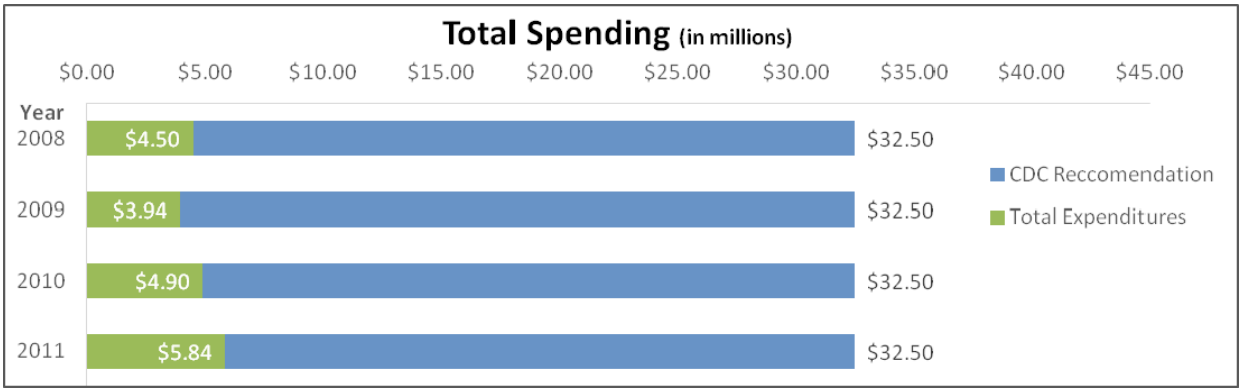
The Grants Management Unit (GMU), under the Nevada Department of Health and Human Services, allocates the appropriated funds from Nevada's Master Settlement Agreement payments towards the state's tobacco control programs and activities (NDPBH, 2013). In addition, the Nevada Department of Health and Human Services administers a tobacco control program using funds from the CDC. It focuses on preventing the initiation of tobacco use among young people, promoting cessation among smokers, eliminating nonsmoker's exposure to secondhand smoke, and identifying and eliminating the inequities related to tobacco use and its effects among different population groups (NDPBH, 2013). Beginning in 1999, Nevada's settlement money was divided between three trust funds: 40% to the Millennium Trust Fund, 10% to the Trust Fund for Public Health, and 50% to the Fund for Healthy Nevada. Nevada's state legislature appropriates these funds in its biennial budget process. Originally, monies from the Fund for Healthy Nevada were administered by a task force and released as competitive grants. In 2007, the state legislature transferred the task force's duty to the Grants Management Unit. Before the transfer, 20% of the money in the Fund for Healthy Nevada was allocated for tobacco control grants, but that amount has been reduced to 15% since GMU's takeover (The Finance Project, 2011). In the 2011 and 2012 fiscal years, state funding for tobacco control was completely eliminated. The CDC provides a small amount of funding. However, many grantees, including local health districts, no longer receive funding from the state of Nevada (TFK, 2012). Nevada's cigarette tax increased in 2003, from $0.35 per pack to $0.80 per pack. Of the revenue , $0.70 goes to the state general fund, and the remaining revenue goes to the Local Government Tax Distribution Account and is allocated to counties based on population size (ALA, 2012).

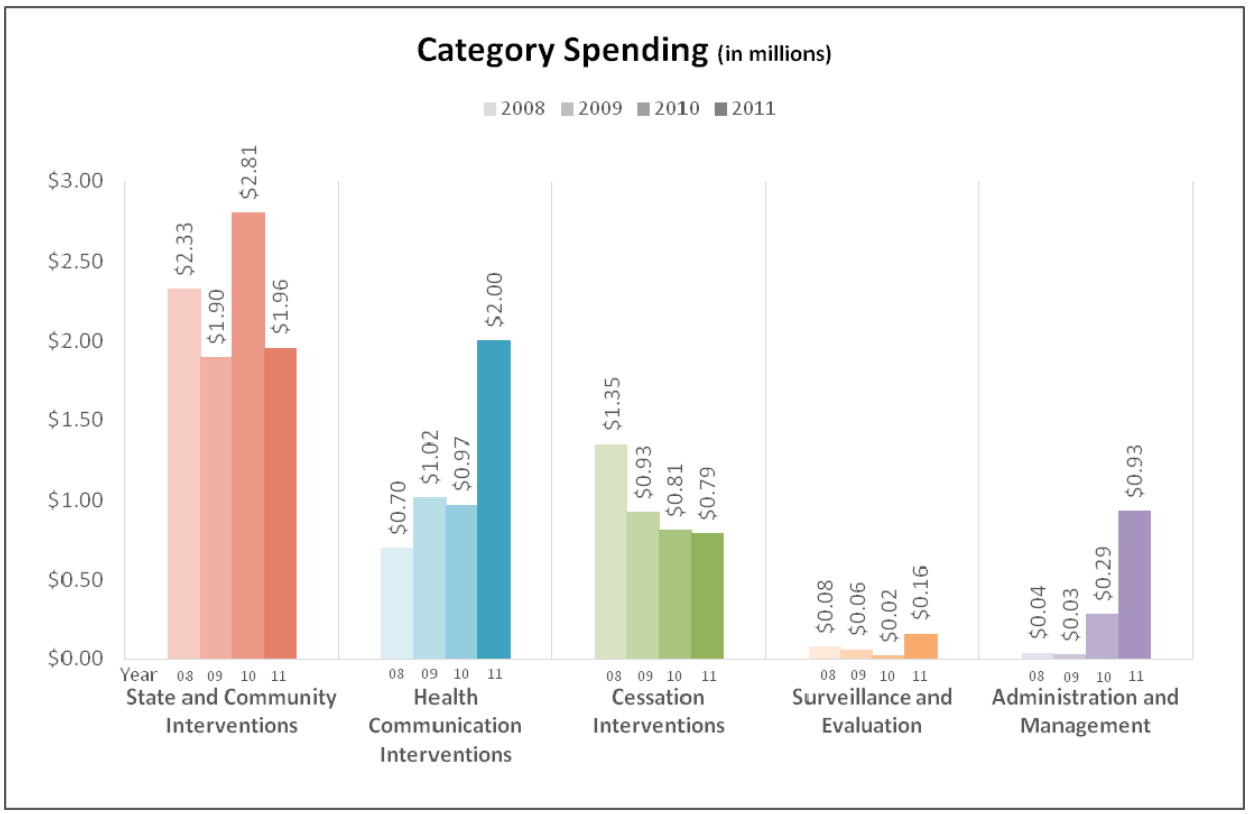
Nevada invested $4.5 million in tobacco control programs in the 2008 fiscal year, reaching 14% of the CDC's recommended level. Of this money, the state invested 52% in state and community interventions, 15% in health communications, 30% in cessation interventions, 2% in surveillance and evaluation, and 1% in administration and management. In fiscal year 2009, Nevada's expenditures reached 12% of the CDC's recommendation for tobacco control, placing the state's expenditures at $3.94 million. Of tobacco control expenditures, 48% went towards for state and community interventions, 26% went towards for health communications, 23% went towards for cessation interventions, 2% went towards for surveillance and evaluation, and 1% went towards for administration and management. The following fiscal year, 2010, Nevada spent $4.9 million, 15% of the CDC's recommended spending level. Of this spending total on tobacco control, the state allocated 57% for state and community interventions, 20% for health communications, 16% for cessation interventions, 1% for surveillance and evaluation, and 6% for administration and management. In the following fiscal year, 2011, Nevada used $5.84 million for tobacco control programs, reaching 18% of the CDC's suggested spending total. Of the $5.93 million, Nevada used 34% in state and community interventions, 34% in health communications, 13% in cessation interventions, 3% in surveillance and evaluation, and 16% in administration and management.

Nevada

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$2,326,000	$699,000	$1,353,000	$81,000	$41,000	$4,500,000	$1.7	14%
FY2009	$1,901,000	$1,018,000	$927,000	$61,000	$30,000	$3,937,000	$1.5	12%
FY2010	$2,811,000	$972,000	$809,000	$21,000	$286,000	$4,899,000	$1.8	15%
FY2011	$1,959,000	$2,003,000	$790,000	$161,000	$930,000	$5,843,000	$2.2	18%





New Hampshire

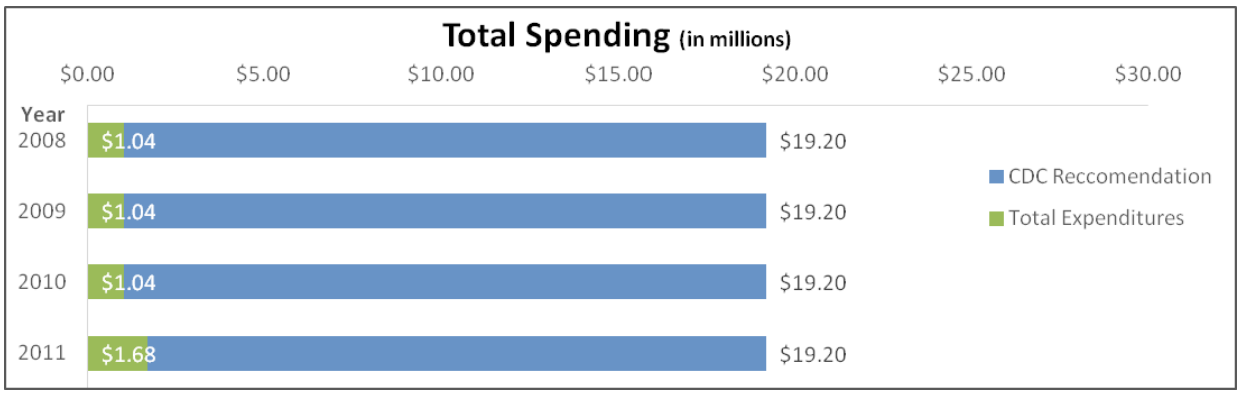
New Hampshire's Department of Health and Human Services (NHDHHS) established its Tobacco Prevention and Control Program (TPCP) to pursue the CDC's Best Practices guided tobacco control initiatives in 2000. TPCP's focus includes youth prevention, limiting exposure to secondhand smoke, promotion of quitting among tobacco users, and local efforts to reach those most affected by tobacco (NHDHHS, 2014). TPCP was initially funded by the allocations from New Hampshire's Master Settlement Agreement payments; however, TPCP is currently funded primarily by CDC federal grants. Between 1999 and 2005, the state legislature placed MSA payments into the Education Trust Fund and The Tobacco Use Prevention Fund. The Tobacco Use Prevention Fund for tobacco control measures was eliminated in 2005, with the $3 million being transferred to the state general fund for a budget shortfall. Limited funds were appropriated for tobacco control in the 2008-2009 biennium from the Comprehensive Cancer Plan Fund, but those funds were withdrawn shortly thereafter (The Finance Project, 2011). Since fiscal year 2010, no state funds have been allocated to tobacco prevention and control, but New Hampshire did receive $1 million in federal funding for tobacco control. Possible state dollars for tobacco control can come from the Comprehensive Cancer Plan Fund, and for the 2011 and 2012 fiscal year, $1.00 was donated by the New Hampshire legislature. In 2013, New Hampshire raised its cigarette tax from $1.68 per pack to $1.78 per pack. According to New Hampshire statutes, revenue from $1.00 of the cigarette tax is deposited in the state general fund, and the remaining revenue from the cigarette tax is deposited in the Education Trust Fund (ALA, 2012).

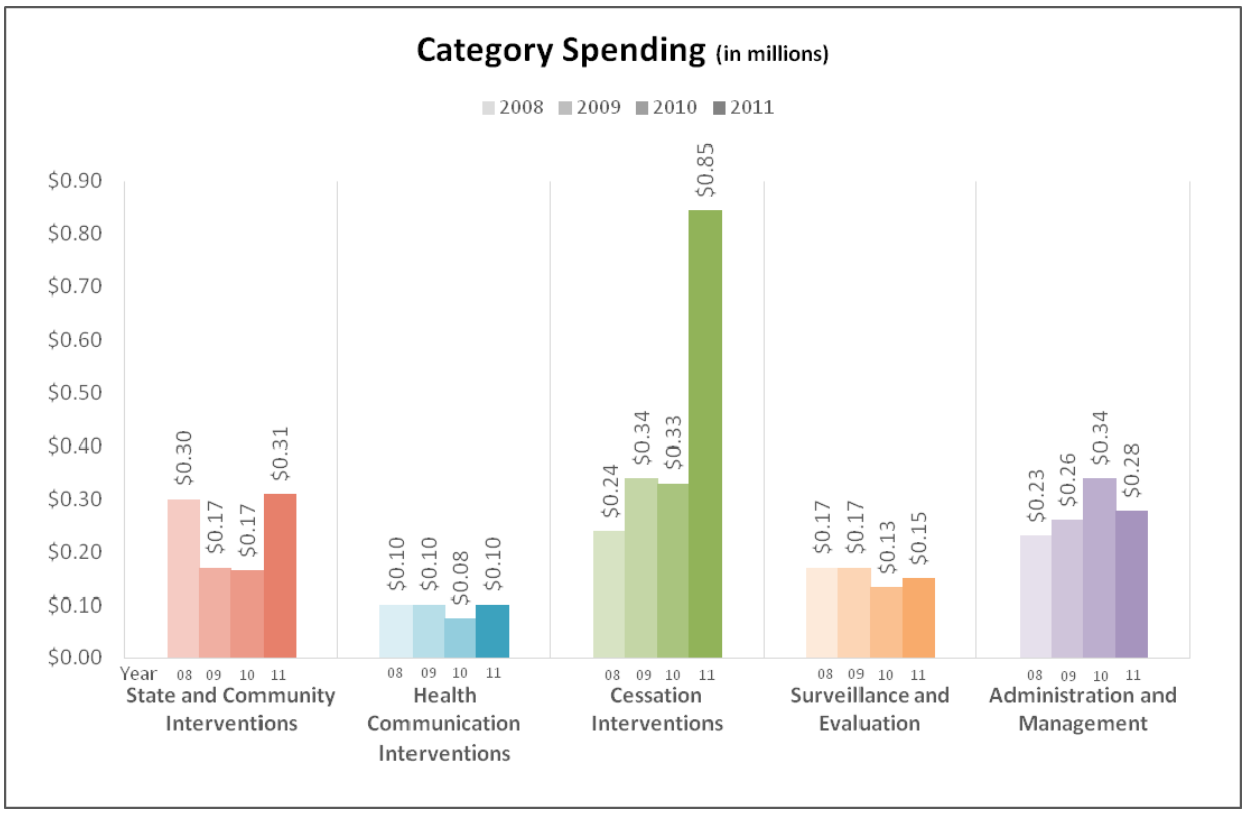
New Hampshire reached 5% of the CDC's suggested spending level, providing $1.04 million for use on tobacco control programs. Of this $1.04 million, the state spent 29% on state and community interventions, 10% on health communications, 23% on cessation interventions, 16% on surveillance and evaluation, and 22% on administration and management. In fiscal year 2009, New Hampshire again invested at 5% of the CDC's recommendation for tobacco control, with $1.04 million. Of tobacco control expenditures, New Hampshire used 16% for state and community interventions, 10% for health communications, 33% for cessation interventions, 16% for surveillance and evaluation, and 25% for administration and management. The following fiscal year, New Hampshire financed its tobacco control with the same amount of $1.04 million, or 5% of the CDC's recommended spending level. Of this investment on tobacco control, 16% went to state and community interventions, 7% went to health communications, 32% went to cessation interventions, 13% went to surveillance and evaluation, and 32% went to administration and management. In the following fiscal year, 2011, New Hampshire increased contributions to $1.68 million, reaching 9% of the CDC's recommended level for tobacco control. Of the $1.68 million, New Hampshire invested 18% in state and community interventions, 6% in health communications, 50% in cessation interventions, 9% in surveillance and evaluation, and 17% in administration and management.

New Hampshire

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$300,000	$100,000	$240,000	$170,000	$230,000	$1,040,000	$0.8	5%
FY2009	$170,000	$100,000	$340,000	$170,000	$260,000	$1,040,000	$0.8	5%
FY2010	$165,000	$75,000	$330,000	$133,000	$339,000	$1,042,000	$0.8	5%
FY2011	$309,000	$100,000	$845,000	$150,000	$278,000	$1,682,000	$1.3	9%





New Jersey

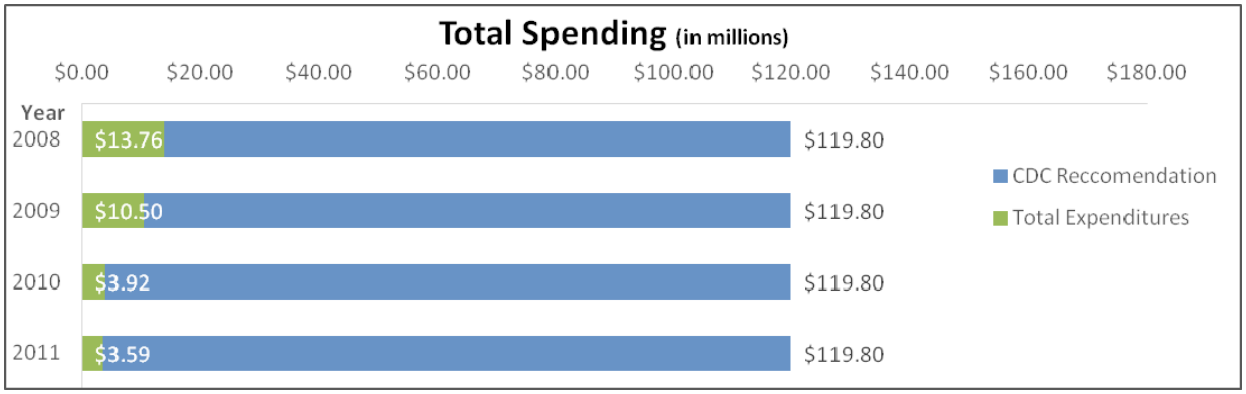
New Jersey's Master Settlement Agreement provided $10.3 million in initial funds to start New Jersey's Comprehensive Tobacco Control Program (CTCP) in 2000. These funds were appropriated by the state legislature for the expansion of the tobacco control program in New Jersey's Department of Health and Senior Services (NJCTCP, 2000). CTCP's funding was reduced when New Jersey's Master Settlement Agreement payments became securitized in 2002. The proceeds from the sale were reserved for capital expenditures, financing state deficits, and grants or aids to political subdivisions (The Finance Project, 2011). As a compromise, the state legislature promised to fund the program using a portion of New Jersey's tobacco tax revenues, which, from 2002, amounted to approximately $11 million per year.. In fiscal year 2010, however, CTCP faced additional reductions due to fiscal challenges in the state (TFK, 2010). New Jersey's current cigarette tax is $2.70, raised from the 2009 price of $2.575 per pack. Based on New Jersey's law, its first $1 million of annual cigarette tax revenue is deposited in the Cancer Research Fund, to be appropriated toward funding of the New Jersey State Commission on Cancer Research or to projects authorized and approved by the commission. After this deposit, beginning July 1, 2009 and each fiscal year thereafter, the next $150 million of cigarette tax revenue collected is dedicated to the Health Care Subsidy Fund. After that, the remaining revenue is deposited to the Dedicated Cigarette Tax Revenue Fund and the Health Care Subsidy Fund (ALA, 2012).

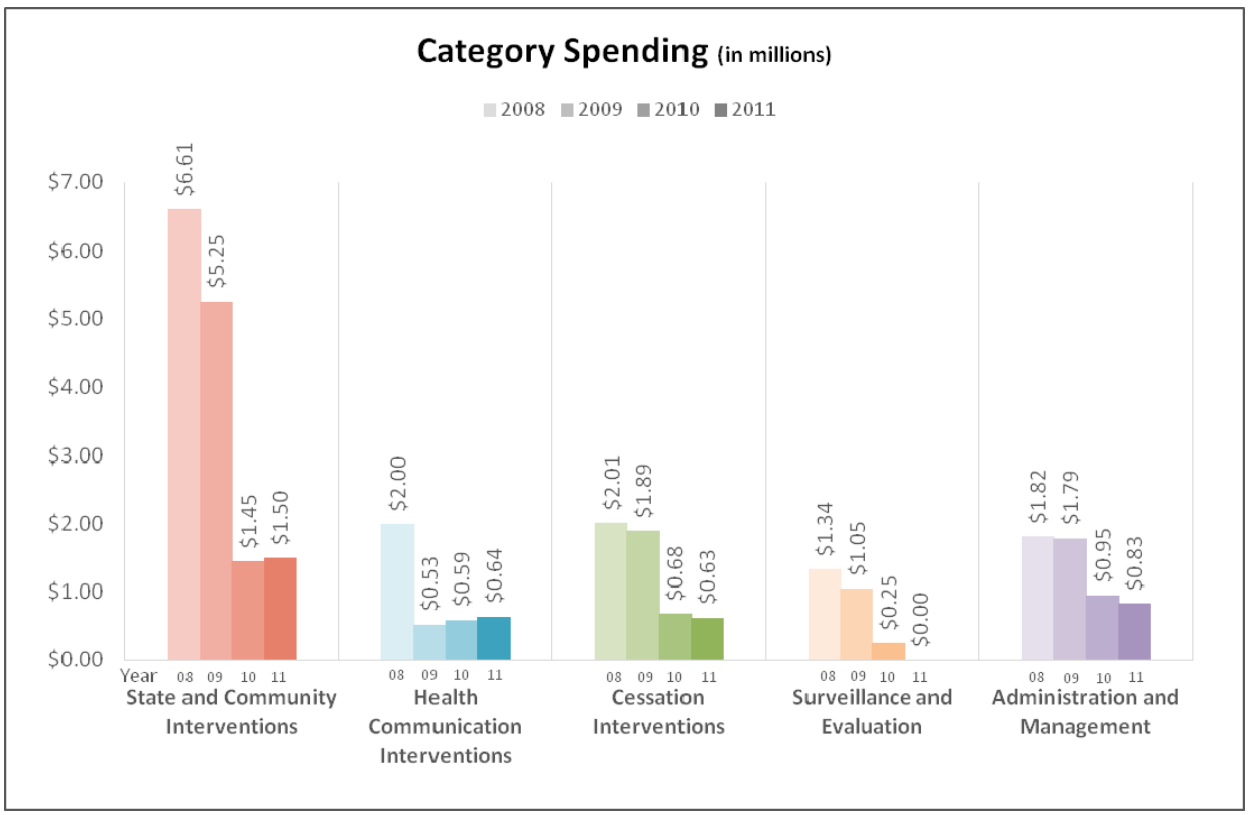
New Jersey spent $13.76 million on tobacco control expenditures in the 2008 fiscal year, reaching 12% of the CDC's recommended level. Of these expenditures, the state spent 48% on state and community interventions, 14% on health communications, 15% on cessation interventions, 10% on surveillance and evaluation, and 13% on administration and management. In fiscal year 2009, New Jersey contributed 9% of the CDC's recommendation for tobacco control, or $10.5 million. In this fiscal year, the state used approximately 50% of tobacco control expenditures for state and community interventions, 5% for health communications, 18% for cessation interventions, 10% for surveillance and evaluation, and 17% for administration and management. The following fiscal year, New Jersey expended $3.92 million, decreasing to 3% of the CDC's recommended spending level. Of this investment on tobacco control, New Jersey used 37% for state and community interventions, 15% for health communications, 17% for cessation interventions, 7% for surveillance and evaluation, and 24% for administration and management. In the following fiscal year, 2011, New Jersey invested $3.59 million, remaining consistent 3% of the CDC's recommended investment level on tobacco control. Of the $3.59 million, New Jersey used 42% in state and community interventions, 18% in health communications, 17% in cessation interventions, 0% in surveillance and evaluation, and 23% in administration and management.

New Jersey

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$6,605,000	$1,995,000	$2,009,000	$1,335,000	$1,816,000	$13,760,000	$1.6	12%
FY2009	$5,250,000	$525,000	$1,890,000	$1,050,000	$1,785,000	$10,500,000	$1.2	9%
FY2010	$1,448,000	$590,000	$680,000	$250,000	$950,000	$3,918,000	$0.5	3%
FY2011	$1,496,000	$640,000	$626,000	$0	$831,000	$3,593,000	$0.4	3%





New Mexico

New Mexico's Department of Health requires New Mexico's Tobacco Use Prevention and Control (TUPAC) to implement a comprehensive and evidence-based approach to reduce smoking in New Mexico. The program began in fiscal year 2001and was established using funds from New Mexico's annual Master Settlement Agreement payments appropriated to the Tobacco Settlement Program Fund. TUPAC focuses on four tobacco control goals: preventing smoking initiation, promoting quitting among youth and adults, limiting exposure to second hand smoke, and eliminating disparities in smoking (TUPAC, 2009)..

New Mexico distributes about 50% of their MSA funds to the Tobacco Settlement Permanent Fund and 50% to the Tobacco Settlement Program Fund for numerous health related programs, including tobacco control programs. The Program Fund monies are subject to the state's annual budget allocation process. From fiscal years 2003 through 2006, 100% settlement payments were deposited into New Mexico's general fund. In fiscal year 2007, the 50/50 allocation of MSA payments resumed (The Finance Project, 2011). In addition to MSA payments, New Mexico has a tobacco tax, which increased from $0.91 to $1.66 per pack in 2010. A portion of its cigarette tax revenue is distributed as follows: 1.35% to the County and Municipality Recreational Fund; 2.69% to the County and Municipal Cigarette Tax Fund; 1.35% to the Cancer Research and Treatment Center at the University of New Mexico Health Sciences Center; 2.02% to the New Mexico Finance Authority; 14.37% to the New Mexico Finance Authority on behalf of and for the benefit of the University of New Mexico Health Sciences Center; 6.05% to the New Mexico Finance Authority for land acquisition and the planning, designing, construction and equipping of the Department of Health facilities or improvements to such facilities; 15.979% to the New Mexico Finance Authority for deposit in the credit enhancement account created in the authority; and 1% to the New Mexico Finance Authority on behalf of and for the benefit of the Rural County Cancer Treatment Fund. The remaining tax revenue goes to the state general fund (ALA, 2012).

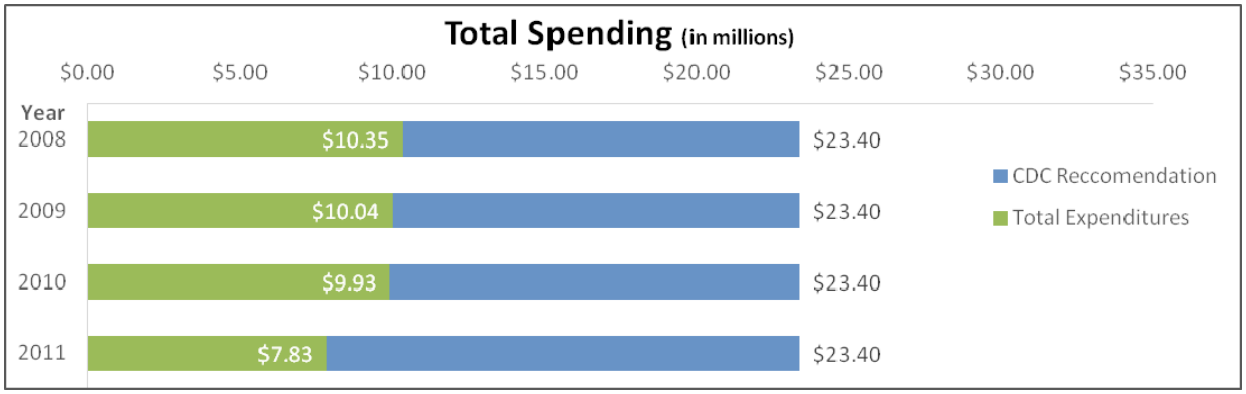
During the 2008 fiscal year, New Mexico spent $10.35 million on tobacco control programs, satisfying 44% of the CDC's recommended expenditure level. Of these monies, the state spent 9% on state and community interventions, 33% on health communications, 38% on cessation interventions, 8% on surveillance and evaluation, and 12% on administration and management. In fiscal year 2009, New Mexico invested at 43% of the CDC's recommendation for tobacco control, or $10.04 million. In this fiscal year, New Mexico funded state and community expenditures with 9% of the total, health communications with 34% of the total, cessation interventions with 40% of the total, surveillance and evaluation with 8% of the total, and administration and management with 9% of the total. The following fiscal year, New Mexico invested slightly less than fiscal year 2009, with $9.93 million, thus meeting 42% of the CDC's recommended spending level. Of this investment on tobacco control, New Mexico invested 30% in state and community interventions, 20% in health communications, 33% in cessation interventions, 6% in surveillance and evaluation, and 11% in administration and management.

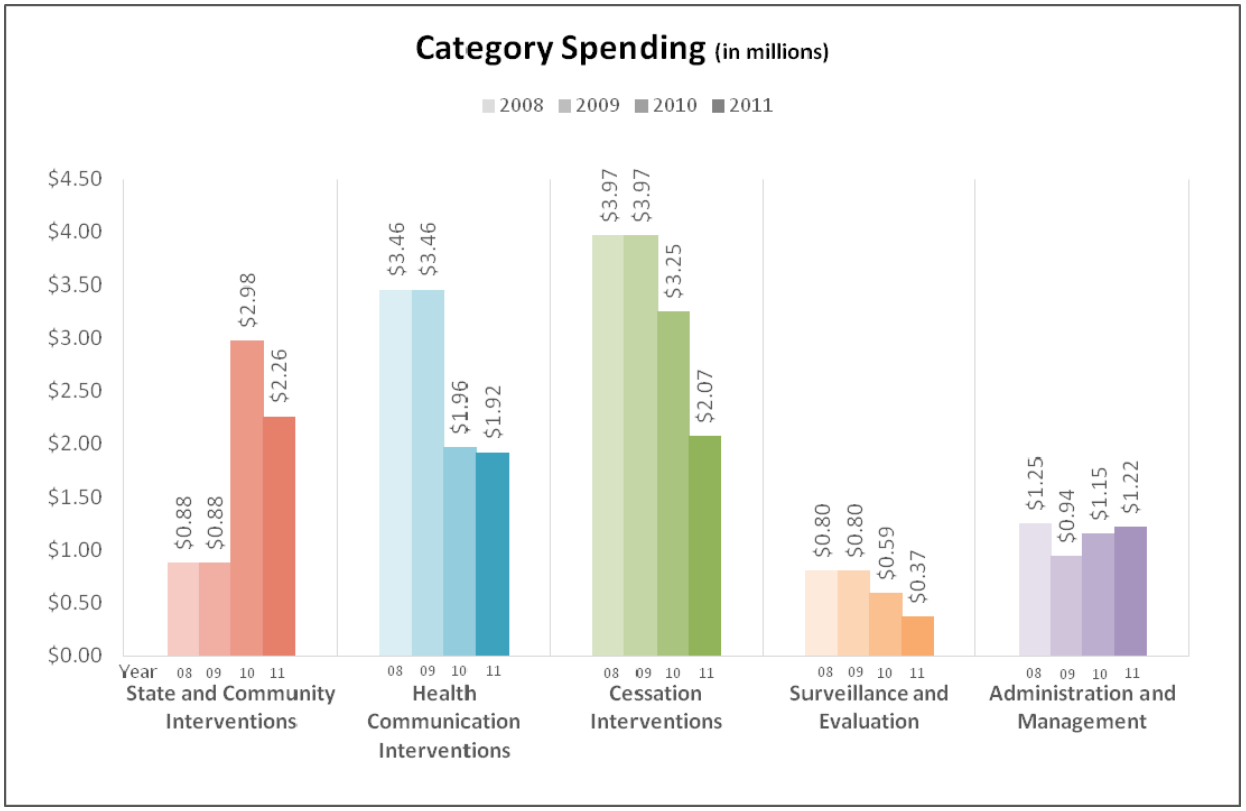
For the final fiscal year, 2011, New Mexico decreased spending to $7.83 million, or 34% of the CDC's suggested level on tobacco control. Of the $7.83 million, 29% went towards state and community interventions, 24% went towards health communications, 26% went towards cessation interventions, 5% went towards surveillance and evaluation, and 16% went towards administration and management.

New Mexico

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$875,000	$3,458,000	$3,969,000	$798,000	$1,250,000	$10,350,000	$5.2	44%
FY2009	$875,000	$3,458,000	$3,969,000	$798,000	$941,000	$10,041,000	$5.0	43%
FY2010	$2,980,000	$1,960,000	$3,250,000	$590,000	$1,150,000	$9,930,000	$4.9	42%
FY2011	$2,256,000	$1,915,000	$2,069,000	$367,000	$1,221,000	$7,828,000	$3.8	34%





New York

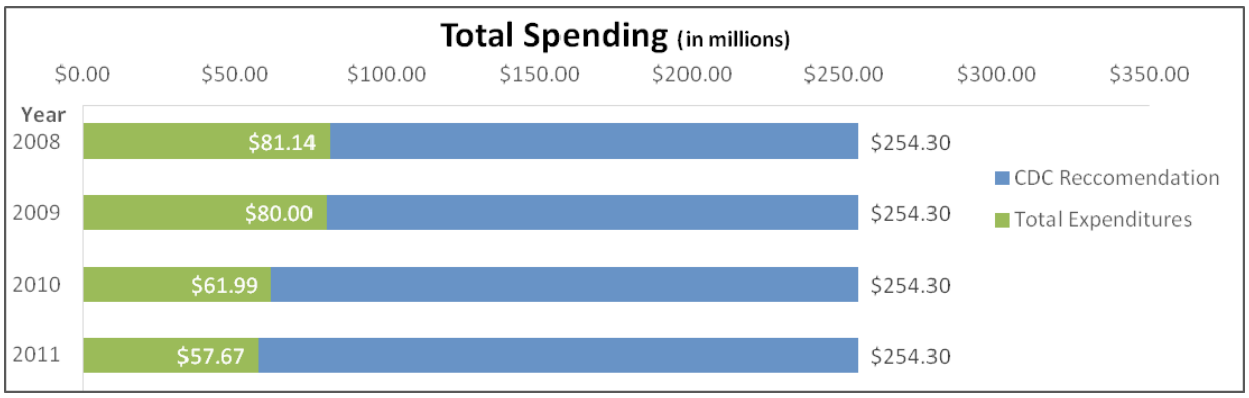
The New York Department of Health's Tobacco Control Program (NYTCP) was established in January 2000 using the appropriated funds from New York's Master Settlement Agreement (MSA) payments and a portion of the tax revenue from New York's cigarette excise tax. MSA payments are distributed to the state of New York (51.2%), New York City (26.6%), and the 57 counties outside of New York City (22.2%). Percentage divisions are based upon the location's contributions to Medicaid. Currently, tobacco control is funded through the annually budgeted state general fund. In fiscal years 2008, 2010, and 2011- due to revenue shortfalls- funding for tobacco prevention and cessation was reduced (TFK, 2012). The rights to nearly all of New York's MSA payments were sold as bonds to receive a smaller up-front, one lump payment. Statutes/laws revealing the details of this action have not been disclosed. New York does have a cigarette tax, which increased in 2010 from $2.75 to $4.35 per pack. Beginning in July of 2010, 76% of the revenue from this tax is distributed to the tobacco control and insurance initiatives pool (ALA, 2012).

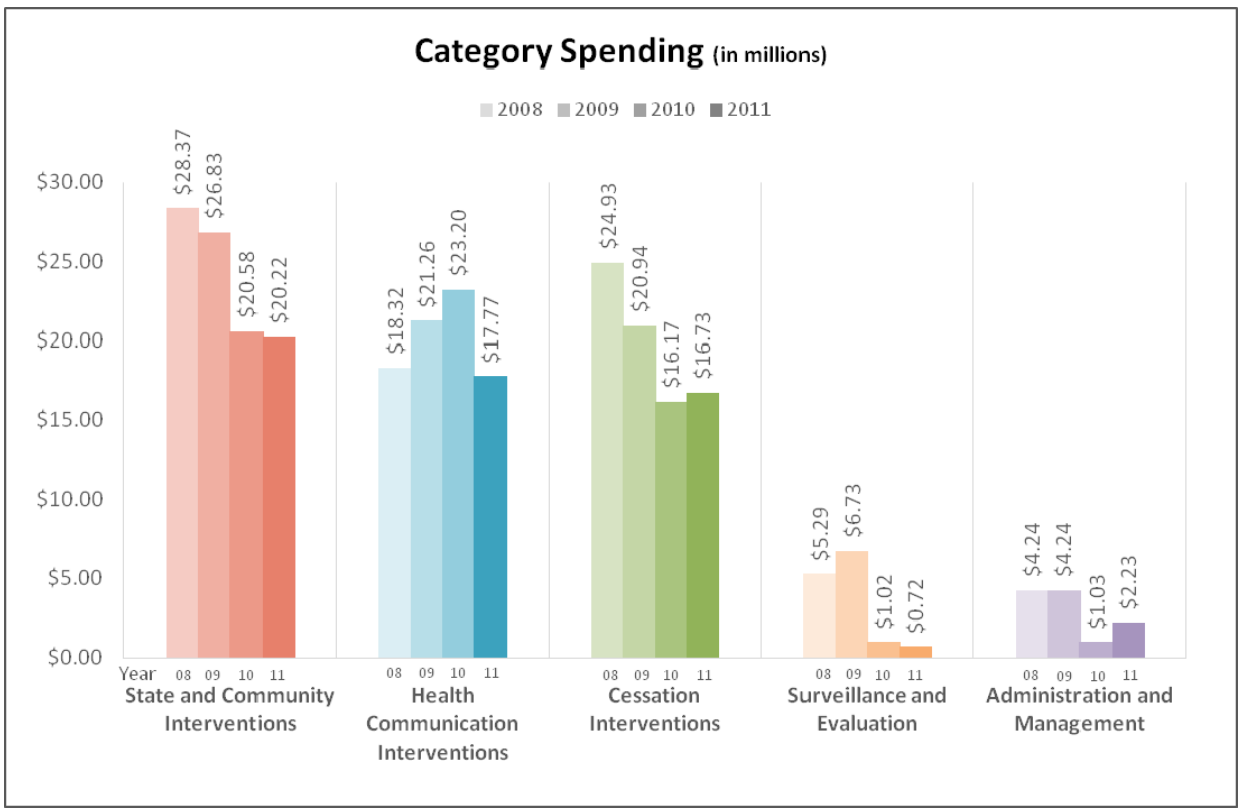
New York spent $81.14 million on tobacco control expenditures in the 2008 fiscal year, reaching 32% of the CDC's recommended level. Of these expenditures, the state spent 35% on state and community interventions, 23% on health communications, 31% on cessation interventions, 6% on surveillance and evaluation, and 5% on administration and management. In fiscal year 2009, New York again invested at 32% of the CDC's recommendation for tobacco control, or $80 million. Of the $80 million, New York utilized 34% of tobacco control expenditures for state and community interventions, 27% for health communications, 26%for cessation interventions, 8% for surveillance and evaluation, and 5% for administration and management. The following fiscal year, New York's reduced its contribution to $61.99 million, satisfying 24% of the CDC's recommended spending level. Of this contribution towards tobacco control, the state used 33% for state and community interventions, 37% for health communications, 26% for cessation interventions, 2% for surveillance and evaluation, and 2% for administration and management. In 2011, New York provided $57.67 million, reaching 23% of the CDC's recommended investment level on tobacco control. Of the $57.67 million, New York provided 35% to state and community interventions, 31% to health communications, 29% to cessation interventions, 2% to surveillance and evaluation, and 4% to administration and management.

New York

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$28,370,000	$18,317,000	$24,928,000	$5,291,000	$4,238,000	$81,144,000	$4.2	32%
FY2009	$26,834,000	$21,261,000	$20,936,000	$6,732,000	$4,238,000	$80,001,000	$4.1	32%
FY2010	$20,577,000	$23,195,000	$16,166,000	$1,023,000	$1,031,000	$61,992,000	$3.2	24%
FY2011	$20,223,000	$17,771,000	$16,732,000	$716,000	$2,225,000	$57,667,000	$3.0	23%





North Carolina

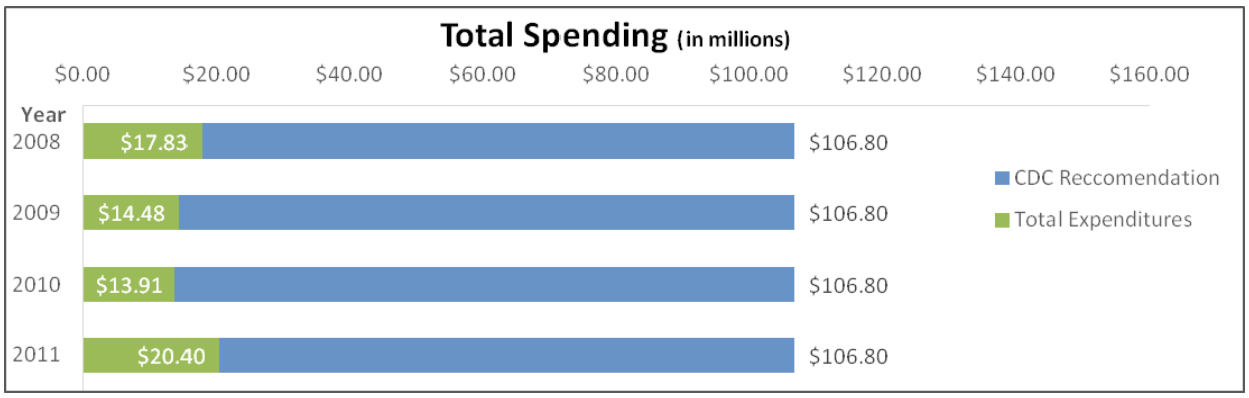
North Carolina's Department of Health conducts its tobacco control programs through the Tobacco Prevention and Control Branch (TPCB). The branch is commonly known and referred to throughout the state by its former namesake, ASSIST (American Stop Smoking Intervention Study) (NCDHHS, 2014). Twenty-five percent of MSA monies are placed into the Health and Wellness Trust fund to support TPCB. With these monies, TPCB implements quitlines, funds eight local anti-tobacco coalitions who work in their communities to address tobacco related health disparities among populations, eliminates exposure to secondhand smoke, and provides cessation services. The remaining MSA monies are split into two other trust funds: the Golden LEAF Foundation receives 50% of MSA funding to assist tobacco-dependent communities, and the Tobacco Trust Fund receives 25% of MSA funding to aid tobacco farmers and related workers (NCDHHS, 2014). In the 2002 fiscal year, $60 million in settlement payments was diverted to address the state's budget crisis. In fiscal years 2004 and 2005, $25 million was taken from the Health and Wellness Trust Fund again to address budget shortfalls. In fiscal year 2008, $80 million of the MSA payment was diverted for budget shortfalls. In 2011, the Health and Wellness Trust fund was phased out, and the remaining $22 million in the fund was deposited into the North Carolina Department for Health and Human Services. This money was to be used for funding public health services, including tobacco control (TFK, 2012). North Carolina increased its cigarette tax in 2009 from $0.35 to $0.45 per pack.

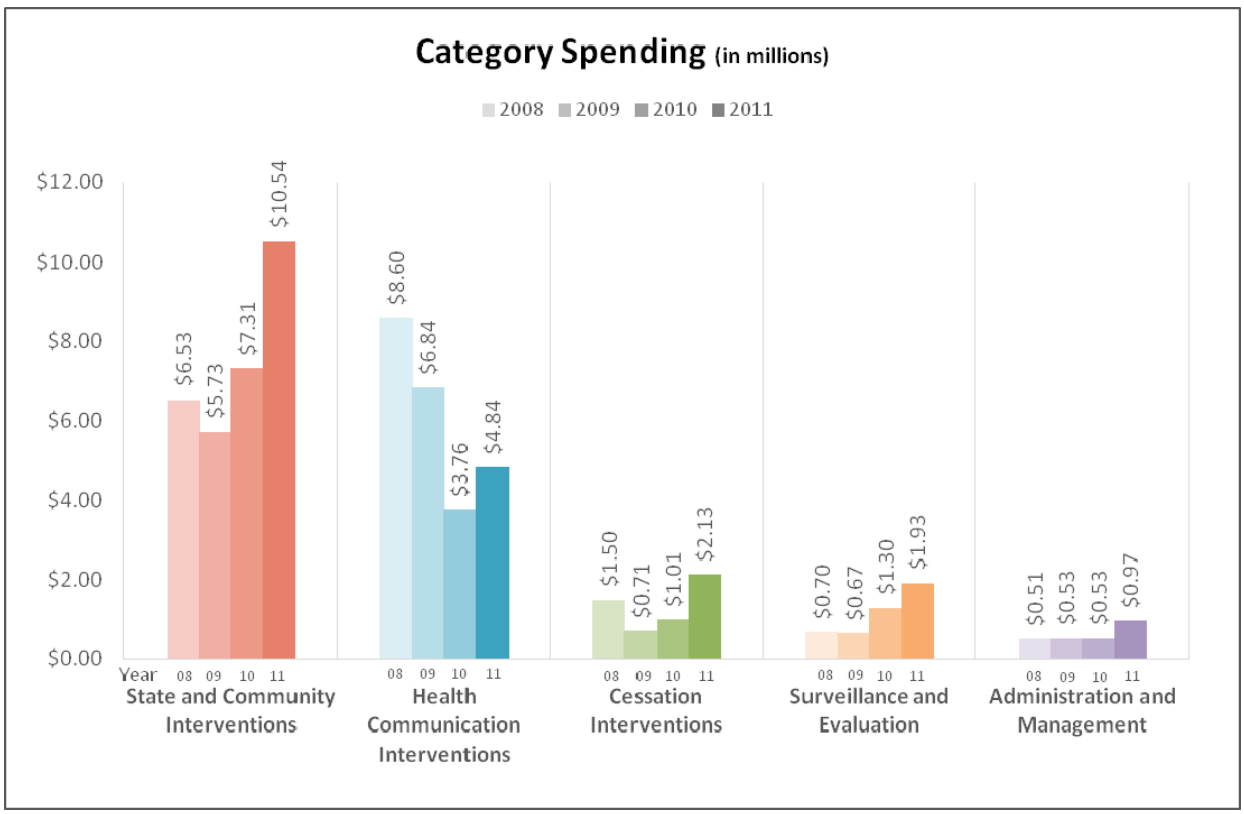
North Carolina spent $17.83 million and reached 17% of the CDC's suggested level for tobacco control expenditures in the 2008 fiscal year. The $17.38 million was divided as follows: 37% for state and community interventions, 48% for health communications, 8% for cessation interventions, 4% for surveillance and evaluation, and 3% for administration and management. The next fiscal year, 2009, North Carolina supported tobacco programs at 14% of what the CDC's recommends, with $14.48 million. In this fiscal year, the state used approximately 40% of tobacco control expenditures for state and community interventions, 47% for health communications, 5% for cessation interventions, 4% for surveillance and evaluation, and 4% for administration and management. The following fiscal year, North Carolina invested $13.9 million, 13% of the CDC's recommended spending level. Of this investment on tobacco control, North Carolina invested 53% in state and community interventions, 27% in health communications, 7% in cessation interventions, 9% in surveillance and evaluation, and 4% in administration and management. For fiscal year 2011, North Carolina financed tobacco control at $20.4 million, reaching 19% of the CDC's suggested spending total. Of the $20.4 million, North Carolina spent 52% in state and community interventions, 24% in health communications, 10% in cessation interventions, 9% in surveillance and evaluation, and 5% in administration and management.

North Carolina

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$6,528,000	$8,597,000	$1,499,000	$696,000	$512,000	$17,832,000	$1.9	17%
FY2009	$5,734,000	$6,838,000	$705,000	$667,000	$533,000	$14,477,000	$1.5	14%
FY2010	$7,311,000	$3,759,000	$1,009,000	$1,300,000	$531,000	$13,910,000	$1.5	13%
FY2011	$10,535,000	$4,842,000	$2,129,000	$1,925,000	$970,000	$20,401,000	$2.1	19%





North Dakota

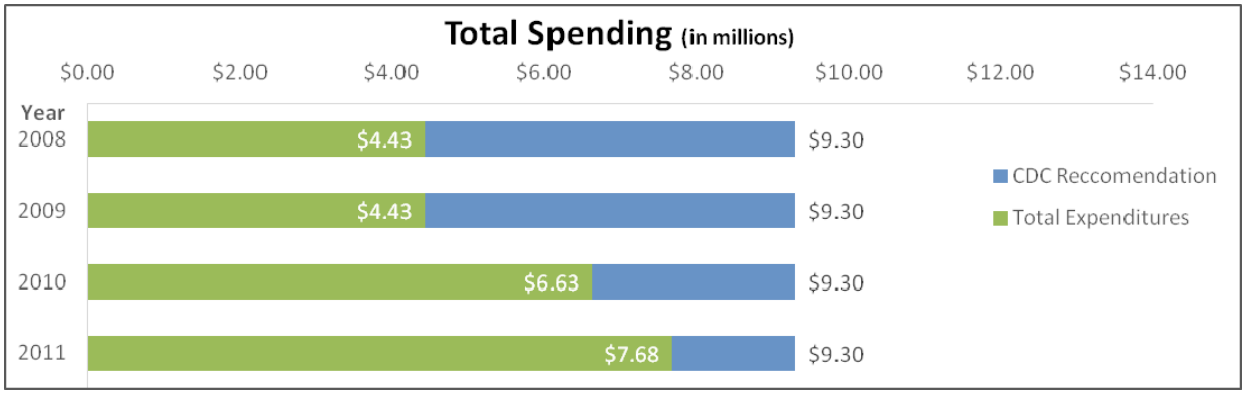
Using funds from North Dakota's Master Settlement Agreement, the North Dakota Department of Health first implemented a statewide tobacco prevention and control program in 2001. (NDDH, 2008). The program maintains community programs, cessation services, local school and tribal initiatives, and statewide public education campaign. North Dakota's MSA payments are divided three ways: 45% goes to the Water Development Trust Fund, 45% goes to the Common Schools Trust Fund, and 10% goes to the Community Health Trust Fund. From the Community Health Trust Fund, the state uses at least 80% for tobacco control (TFK, 2012). In late 2008, North Dakota voters approved a ballot measure to fund its tobacco prevention and cessation program at the CDC's recommended level using the MSA funds. If funds coming from the Community Health Trust Fund were inadequate in meeting the CDC's recommended level, it is required that money be withdrawn from the Water Development Trust Fund. This measure started with the 2010-2011 fiscal year biennium and established the only state tobacco program in the country that is fully funded at the CDC's recommended levels for those years (ALA, 2012). North Dakota has a cigarette excise tax, raised in 1993 from $0.29 to $0.44 per pack. All revenue from the cigarette excise tax is credited to the state general fund, except $0.03 of the tax, which is distributed to incorporated cities in North Dakota based on their population size.

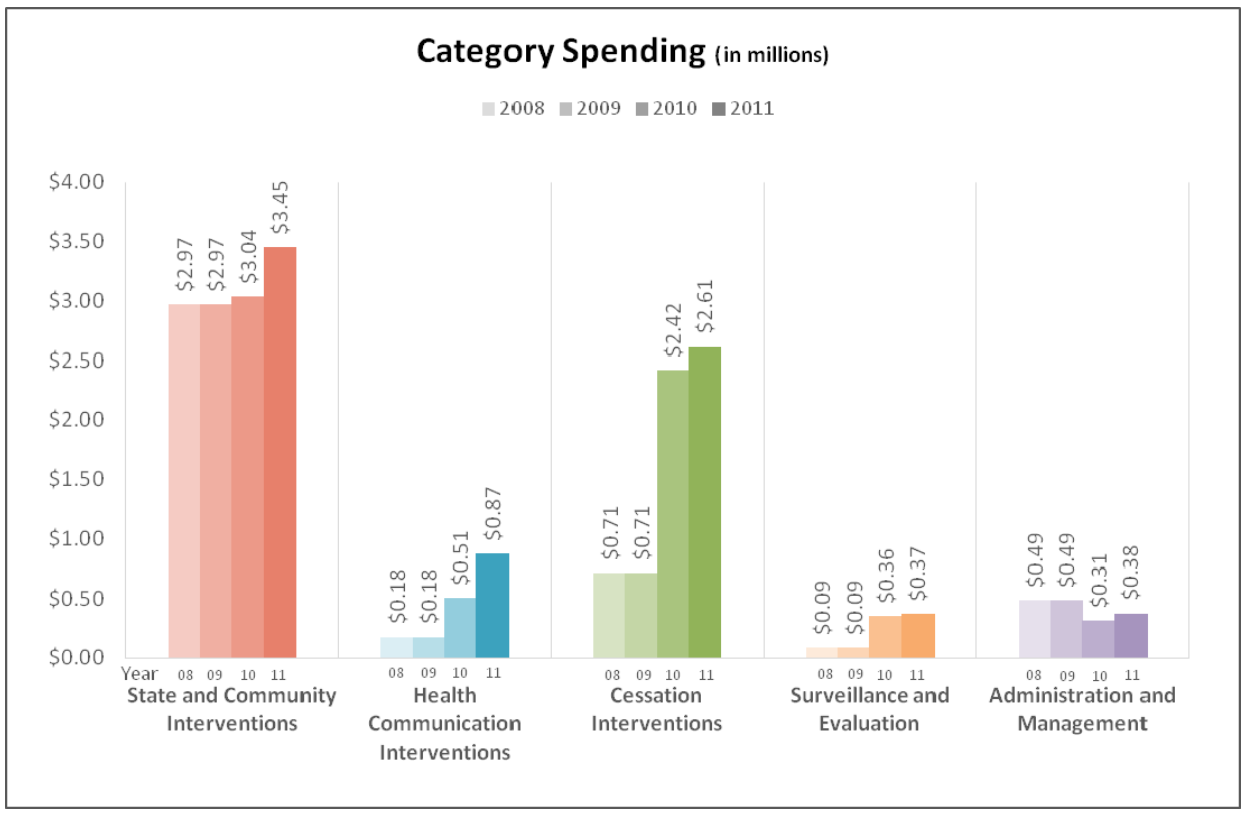
North Dakota invested $4.43 million on tobacco control expenditures in the 2008 fiscal year, reaching 48% of the CDC's recommended level. Of this investment, the state spent 67% on state and community interventions, 4% on health communications, 16% on cessation interventions, 2% on surveillance and evaluation, and 11% on administration and management. In fiscal year 2009, North Dakota met 48% of the CDC's recommendation for tobacco control, spending $4.43 million. For this fiscal year, the state allocated 67% for state and community interventions, 4% for health communications, 16% for cessation interventions, 2% for surveillance and evaluation, and 11% for administration and management. The following fiscal year of 2010, North Dakota increased spending to $6.63 million, fulfilling 71% of the CDC's recommendation. Of this increase, North Dakota used 46% for state and community interventions, 8% for health communications, 36% for cessation interventions, 5% for surveillance and evaluation, and 5% for administration and management. North Dakota relinquished $7.68 million, increasing to 83% of the CDC's suggested contribution level, to tobacco control in the 2011 fiscal year. Of the $7.68 million, North Dakota utilized 45% in state and community interventions, 11% in health communications, 34% in cessation interventions, 5% in surveillance and evaluation, and 5% in administration and management.

North Dakota

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$2,968,000	$177,000	$709,000	$89,000	$487,000	$4,430,000	$6.9	48%
FY2009	$2,968,000	$177,000	$709,000	$89,000	$487,000	$4,430,000	$6.9	48%
FY2010	$3,037,000	$507,000	$2,415,000	$356,000	$311,000	$6,626,000	$10.0	71%
FY2011	$3,450,000	$871,000	$2,612,000	$371,000	$375,000	$7,679,000	$11.4	83%





Ohio

In the year 2000, The Ohio Tobacco Prevention Foundation (OTPF) was created by law. The foundation was set up to receive a portion of Ohio's $300 million annual settlement funds to implement tobacco control and prevention programs (The Finance Project, 2011). In 2007, Ohio securitized all future Master Settlement Agreement payments to the Buckeye Tobacco Settlement Financing Authority to receive an up-front, one lump payment (ALA, 2012). In 2008, Ohio's governor and legislative leaders proposed to divert more than 85% of the funds out of OTPF's endowment fund for other budgetary items. Subsequently, in an effort to ensure its funds were used as intended for tobacco prevention programs, OTPF contracted a transfer of $190 million of its funds to the American Legacy Foundation. This contract was executed shortly before the state legislature passed and the Governor signed emergency legislation to liquidate OTPF's endowment. In response, OTPF filed a lawsuit challenging the constitutionality and legality of the law. In 2009, an Ohio judge ruled that the governor and the state legislature acted illegally when they sought to take back $230 million in tobacco settlement funds and issued a permanent injunction on the diversion of the funds. The ruling ordered that the funds must be used to finance programs that prevent youth smoking and assist smoking cessation. In December 2009, the 10th District Ohio Court of Appeals reversed this decision. The Legacy Foundation filed an appeal to the decision. Shortly following in 2010, the Ohio Supreme Court ruled that the state had the authority to shut down the Ohio Tobacco Prevention Foundation (TFK, 2011). The Tobacco Prevention and Cessation Program (TUPCP) functions as the state's tobacco control program. TUPCP is supported by state appropriations from Ohio's MSA payments and grants from the CDC's Office of Smoking and Health. TUPCP focuses on reducing tobacco use among youth, minority, and regional populations. It implements surveys as means of evaluation and administers grants to youth tobacco prevention programs (ODH, 2014). Ohio does have a cigarette tax, which was increased from $0.55 to $1.25 per pack in 2005. After all refunds of taxes are paid, the remaining revenue is deposited into the state's general fund.

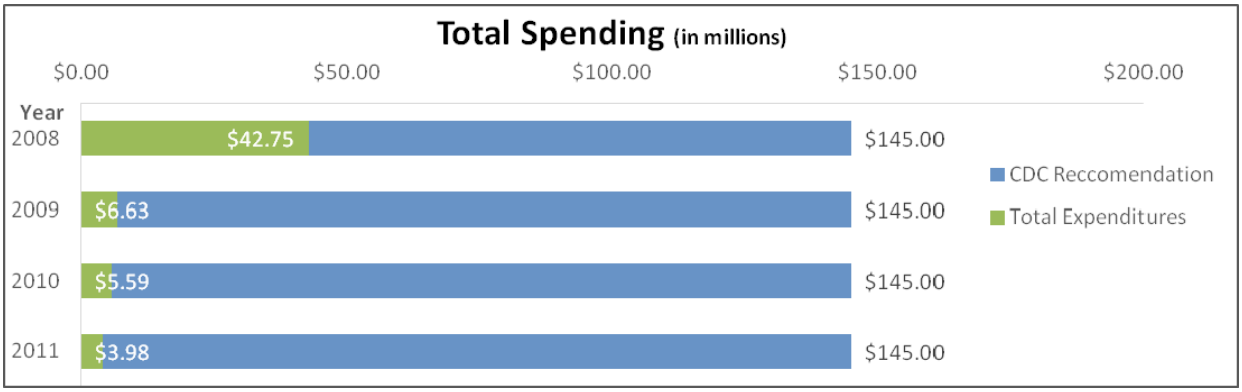
The $42.75 million that Ohio used on tobacco control expenditures in the 2008 fiscal year allowed it to fulfill 30% of the CDC's suggested tobacco control spending. Of these expenditures, state and community interventions received 33%, health communications received 26%, cessation interventions received 29%, surveillance and evaluation received 9%, and administration and management received 3%. Ohio invested at 5% of the CDC's recommendation for tobacco control, or $6.63 million, for the following fiscal year. The 2009 fiscal year saw 31% of tobacco control expenditures support state and community interventions, 15% support health communications, 45% support cessation interventions, 1% support surveillance and evaluation, and 8% support administration and management. The following fiscal year, Ohio decreased investments to $5.59 million, 4% of the CDC's recommended spending level. Of this investment on tobacco control, Ohio invested 43% in state and community interventions, 3% in health communications, 32% in cessation interventions, 9% in surveillance and evaluation, and 13% in administration and management. In the following fiscal

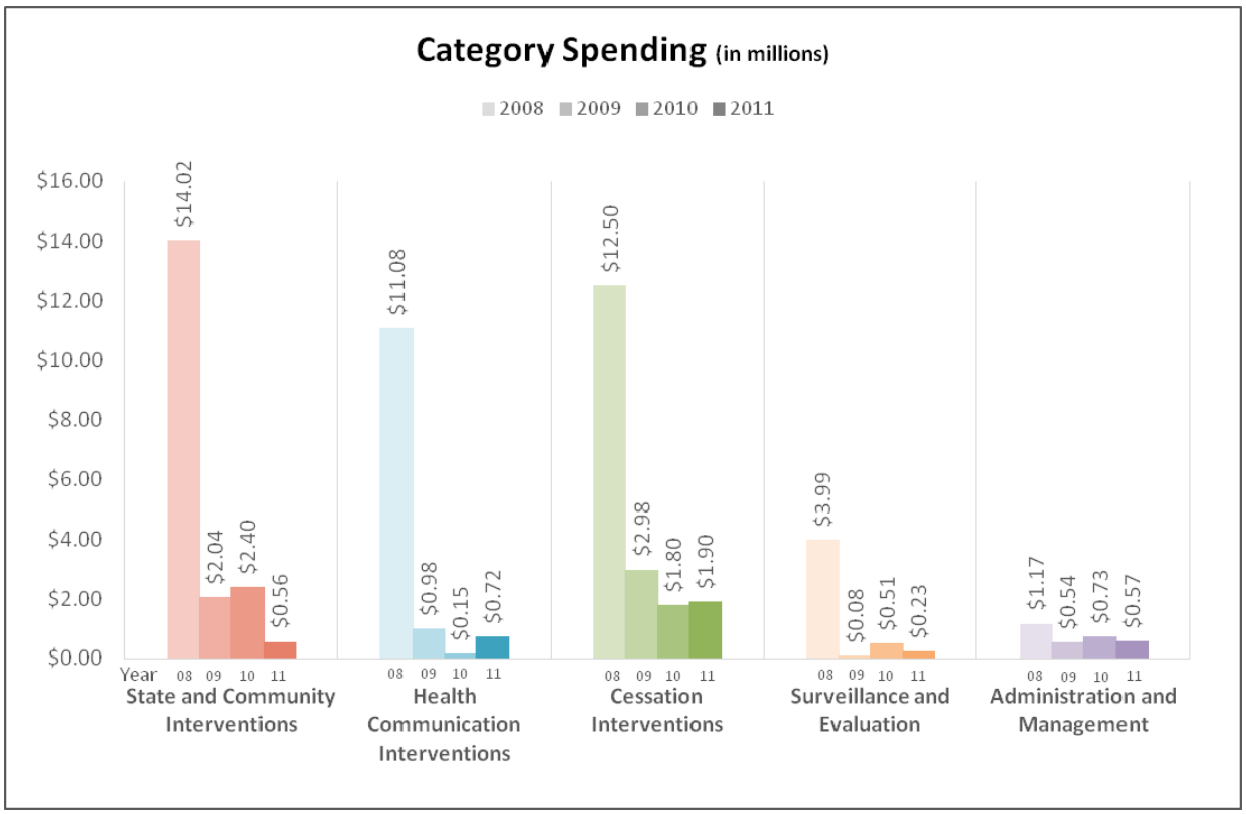
year, 2011, Ohio lessened spending to $3.98 million, satisfying 3% of the CDC's recommended investment level on tobacco control. Of the $3.98 million, Ohio used 14% in state and community interventions, 18% in health communications, 48% in cessation interventions, 6% in surveillance and evaluation, and 14% in administration and management.

Ohio

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$14,017,000	$11,075,000	$12,500,000	$3,987,000	$1,167,000	$42,746,000	$3.7	30%
FY2009	$2,043,000	$984,000	$2,982,000	$81,000	$537,000	$6,627,000	$0.6	5%
FY2010	$2,400,000	$150,000	$1,800,000	$510,000	$730,000	$5,590,000	$0.5	4%
FY2011	$560,000	$720,000	$1,900,000	$230,000	$570,000	$3,980,000	$0.4	3%





Oklahoma

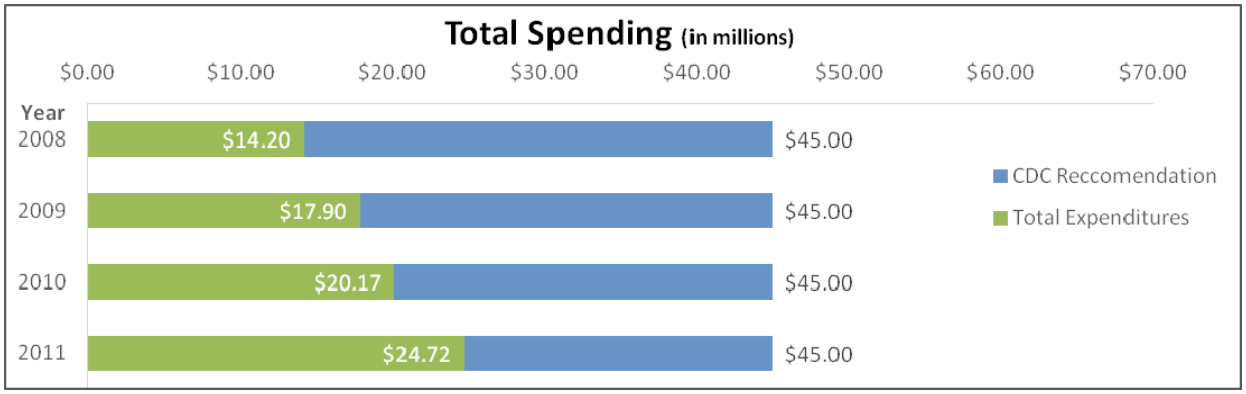
Oklahoma is the only state in the country that has the majority of its Master Settlement Agreement (MSA) funds constitutionally protected in an endowment. Approved by voters in 2000, the constitutional amendment established the Oklahoma Tobacco Settlement Endowment Trust Fund (TSET). Beginning in 2002, the amendment directed 50% of its MSA payments to the endowment. From 2007 forward, 75% of Oklahoma's annual MSA payments have been directed to the endowment. The remaining 25% of the MSA payment is split, with 75% going to the Tobacco Settlement Fund and 25% going to the Attorney General's for the Evidence Fund. In addition, the amendment established a seven member Board of Directors to strategically fund programs to improve the state's health. TSET provides funding for state quitline services, community interventions, and counter marketing campaigns (ALA, 2012). In 2005, Oklahoma increased its cigarette tax from $0.23 to $1.03 per pack. The cigarette revenue is distributed as follows: $0.18 goes to the Oklahoma Building Bonds of 1992 Sinking Fund, $0.05 goes to the General Revenue Fund, and the remaining $0.80 is distributed as follows: 22.06% goes to the Health Employee and Economy Improvement Act; 3.09% goes to the Comprehensive Cancer Center Debt; 7.50% goes to Trauma Care Assistance; 3.09% goes to Oklahoma State University College of Osteopathic Medicine; 26.38% goes to Oklahoma Health Care Authority Medicaid; 2.65% goes to the Department of Mental Health and Substance Abuse Services; 0.44% goes to Belle Maxine Hilliard Breast and Cervical Cancer Treatment; 1% goes to the Teachers' Retirement System; 2.07% goes to Education Reform; 0.66% goes to Tobacco Prevention and Cessation; 16.83% goes to General Revenue; and 14.23% goes to municipalities and counties that have a sales tax (ALA, 2012).

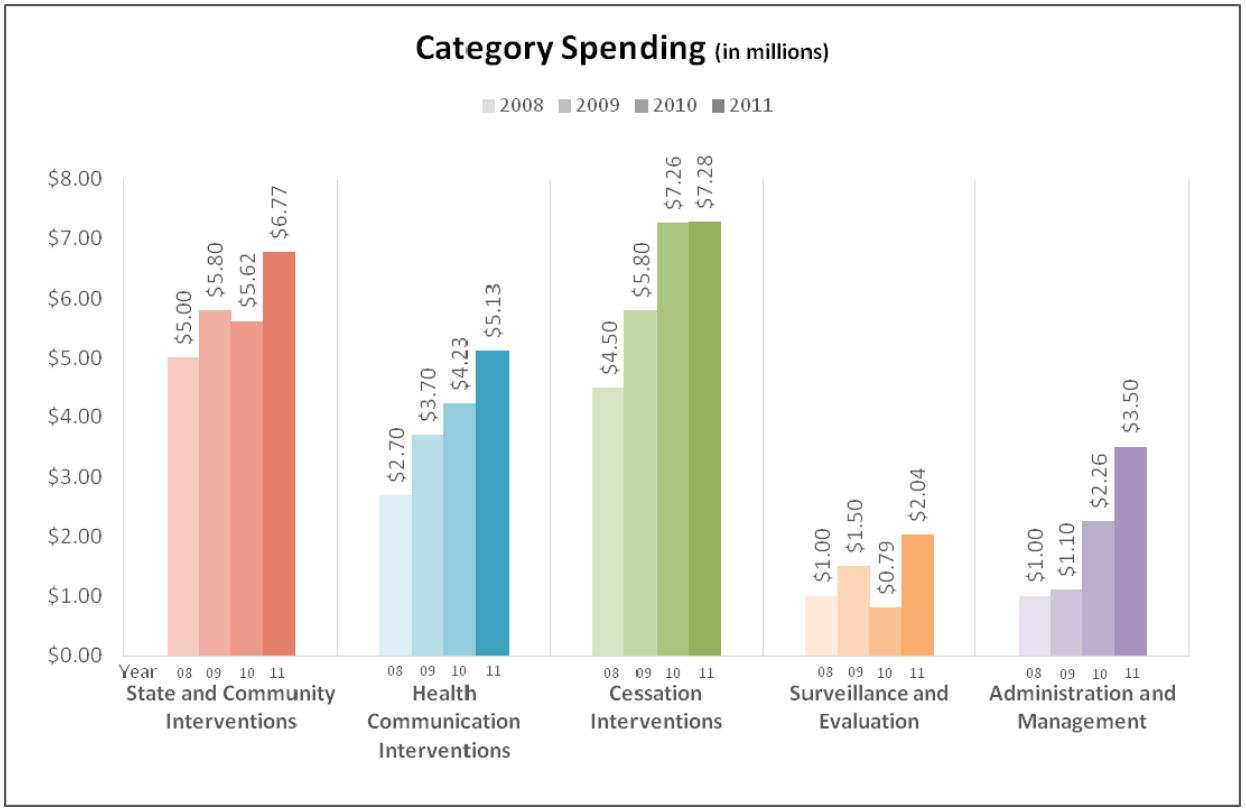
Oklahoma's investment for tobacco control totaled $14.2 million in the 2008 fiscal year. With this investment, the state achieved 32% of the CDC's recommended level. Of this total, the state directed 35% to state and community interventions, 19% to health communications, 32% to cessation interventions, 7% to surveillance and evaluation, and 7% to administration and management. In fiscal year 2009, Oklahoma funded tobacco control at 40% of the CDC's recommendation, using $17.9 million for tobacco control and prevention. Of this funding, Oklahoma used 33% of tobacco control expenditures for state and community interventions, 21% for health communications, 32% for cessation interventions, 8% for surveillance and evaluation, and 6% for administration and management. Oklahoma increased spending to $20.17 million, 45% of the CDC's suggested spending level. Of this spending, state and community interventions received 28%, health communications received 21%, cessation interventions received 36%, surveillance and evaluation received 4%, and administration and management received 11%. In the following fiscal year, 2011, Oklahoma increased tobacco control expenditures to $24.72 million, reaching 55% of the CDC's suggested investment level on tobacco control. Of the $24.72 million, Ohio expended 28% on state and community interventions, 21% on health communications, 36% on cessation interventions, 4% on surveillance and evaluation, and 11% on administration and management.

Oklahoma

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$5,000,000	$2,700,000	$4,500,000	$1,000,000	$1,000,000	$14,200,000	$3.9	32%
FY2009	$5,800,000	$3,700,000	$5,800,000	$1,500,000	$1,100,000	$17,900,000	$4.9	40%
FY2010	$5,624,000	$4,229,000	$7,262,000	$792,000	$2,259,000	$20,166,000	$5.4	45%
FY2011	$6,769,000	$5,127,000	$7,282,000	$2,038,000	$3,499,000	$24,715,000	$6.6	55%





Oregon

As a result of Measure 44, Oregon's Tobacco Prevention and Education Program (TPEP) began in 1996. This Measure increased Oregon's tobacco taxes and appropriated a portion of the tax revenue for state tobacco control programs. TPEP's funding was cut in 2004 and the money was diverted for other purposes. Funding for the program was reinstated with the restoration of Measure 44 in 2008. The program continues to use these tax revenues to implement comprehensive tobacco control initiatives (TFK, 2012).

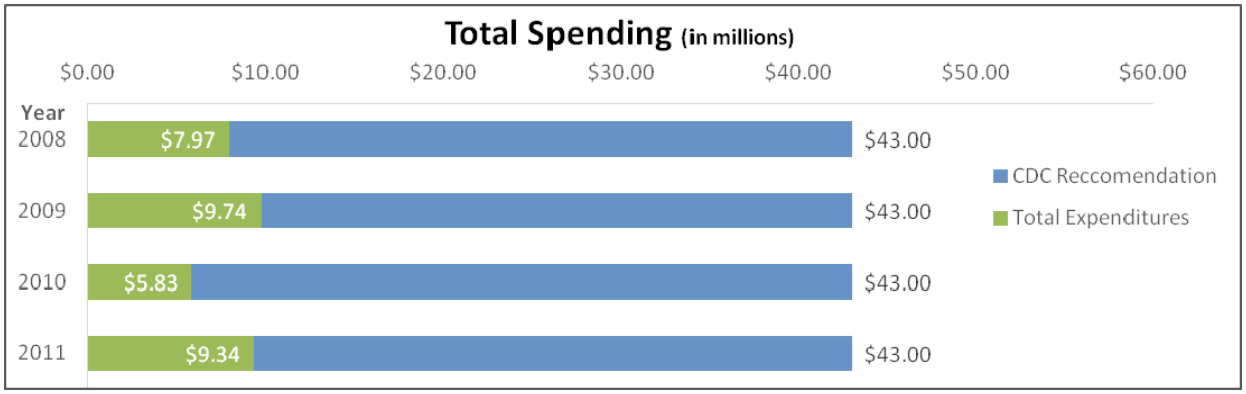
Oregon places its MSA funds into the Tobacco Settlement Funds Account. The funds in the account are allocated by the state legislature, and in odd numbered years, a small portion is allocated to the Department of Justice for MSA enforcement. No MSA money is used to fund tobacco control programs in Oregon, rather, these programs are funded through tobacco tax revenue. Oregon increased their cigarette tax in 2004 from $1.18 to $1.28 per pack. The revenues are placed into a suspense account for administration and enforcement of cigarette taxes. After, the revenues are distributed to the state general fund, the Oregon Health Plan Fund, cities and counties, and other purposes (ALA, 2012).

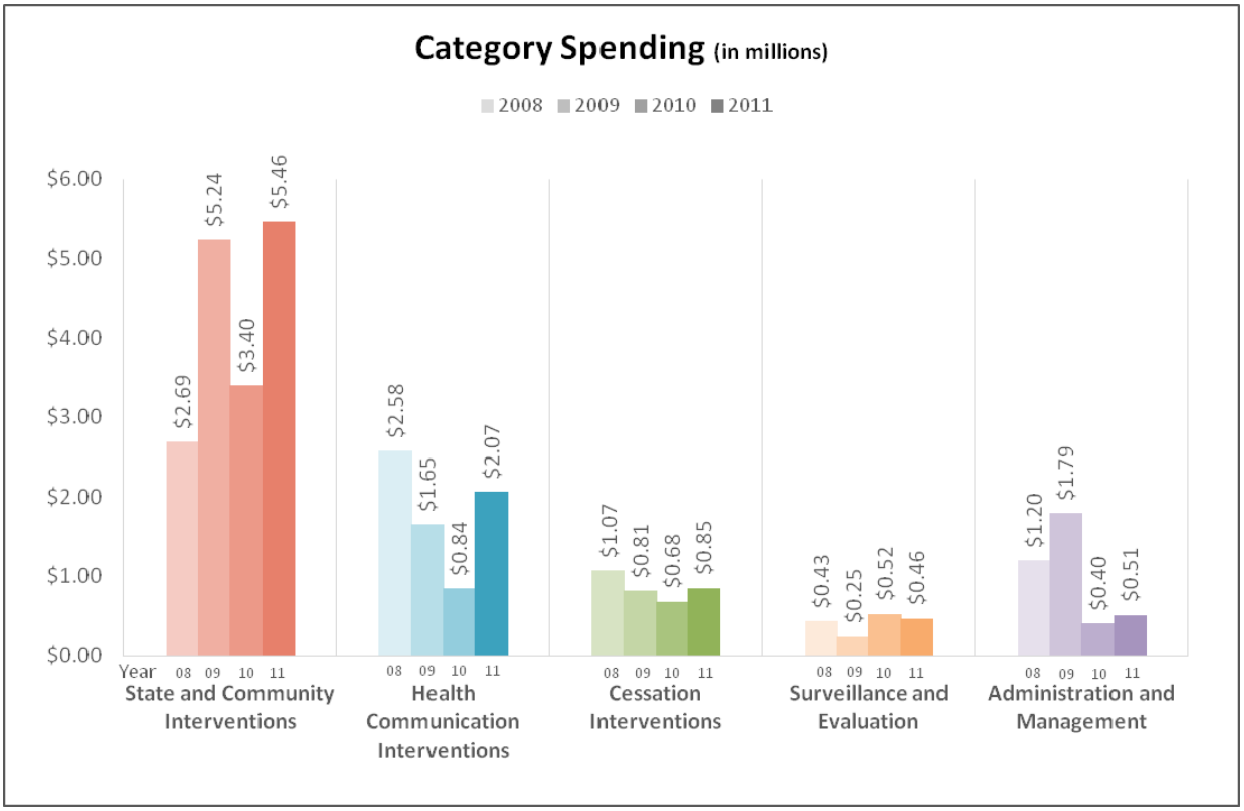
Oregon funded tobacco control with $7.97 million in the 2008 fiscal year. This funding allowed the state to meet 19% of the CDC's recommended level. Of the $7.97 million, 34% went towards state and community interventions, 32% went towards health communications, 13% went towards cessation interventions, 5% went towards surveillance and evaluation, and 15% went towards administration and management. In fiscal year 2009, Oregon increased to 23% of the CDC's recommendation for tobacco control, providing $9.74 million for tobacco control. In this fiscal year, state and community interventions utilized the majority of the $9.74 million, at 54% of the total, health communications utilized 17%, cessation interventions utilized 8%, surveillance and evaluation utilized 3%, and administration and management utilized 18%. Oregon decreased its spending for the following fiscal year, lowering to $5.83 million, 14% of what the CDC suggested the state spend on tobacco control. Of this amount delegated for tobacco control, the state used 58% for state and community interventions, 14% for health communications, 12% for cessation interventions, 9% for surveillance and evaluation, and 7% for administration and management. The final fiscal year, 2011, Oregon invested $9.34 million, reaching 22% of the CDC's recommended investment level on tobacco control. Of the $9.34 million, Oregon invested 58% in state and community interventions, 22% in health communications, 9% in cessation interventions, 5% in surveillance and evaluation, and 6% in administration and management.

Oregon

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$2,691,000	$2,576,000	$1,073,000	$433,000	$1,197,000	$7,970,000	$2.1	19%
FY2009	$5,236,000	$1,649,000	$814,000	$247,000	$1,793,000	$9,739,000	$2.6	23%
FY2010	$3,395,000	$837,000	$679,000	$521,000	$398,000	$5,830,000	$1.5	14%
FY2011	$5,457,000	$2,067,000	$848,000	$463,000	$508,000	$9,343,000	$2.4	22%





Pennsylvania

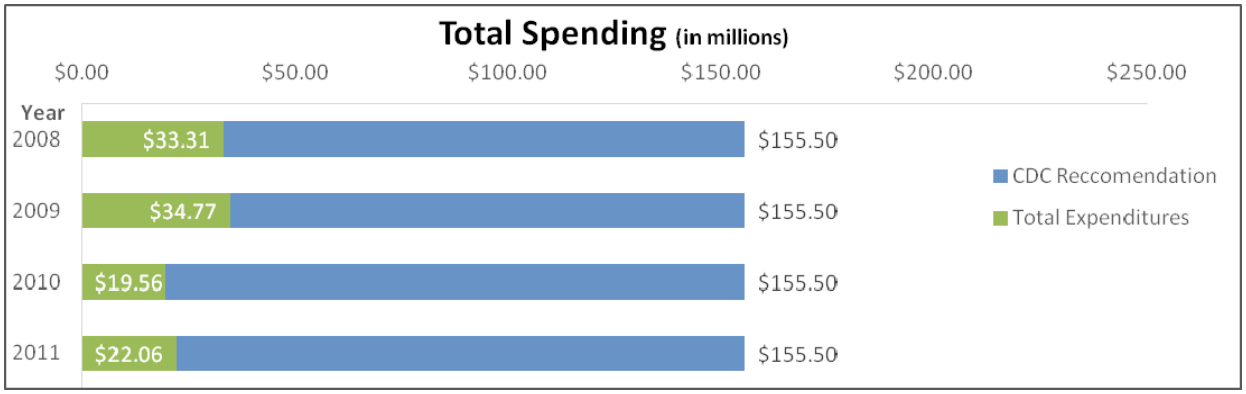
Funded by a portion of its annual MSA payments, Pennsylvania created a comprehensive Tobacco Use Prevention and Cessation Program within its Department of Health (DoH) in 2001. Pennsylvania's DoH distributes 70% of its tobacco control and prevention funds to local programs and 30% to statewide programs (ALA, 2012). Not only does the Tobacco Use Prevention and Cessation Advisory make recommendations regarding tobacco control priorities, but it also collects and reviews information relating to tobacco use prevention and cessation in the state (ALA, 2012). Since 2001, Pennsylvania's MSA payments were generally distributed as follows: 8% towards a health endowment, 30% towards adult health insurance and assistance for persons with disabilities, 13% for home and community based care, 12% for tobacco prevention services, 10% for health care costs that were uncompensated, 8% for pharmaceutical assistance, and 19% for health research. In 2010 and 2013, funds for tobacco control were temporarily diverted for other purposes due to a state legislative action. Additionally, the MSA strategic contribution payment received in 2012 was deposited in the Tobacco Settlement Fund. Pennsylvania does have a cigarette tax of $1.60, increased from $1.35 in 2009 (ALA, 2012).

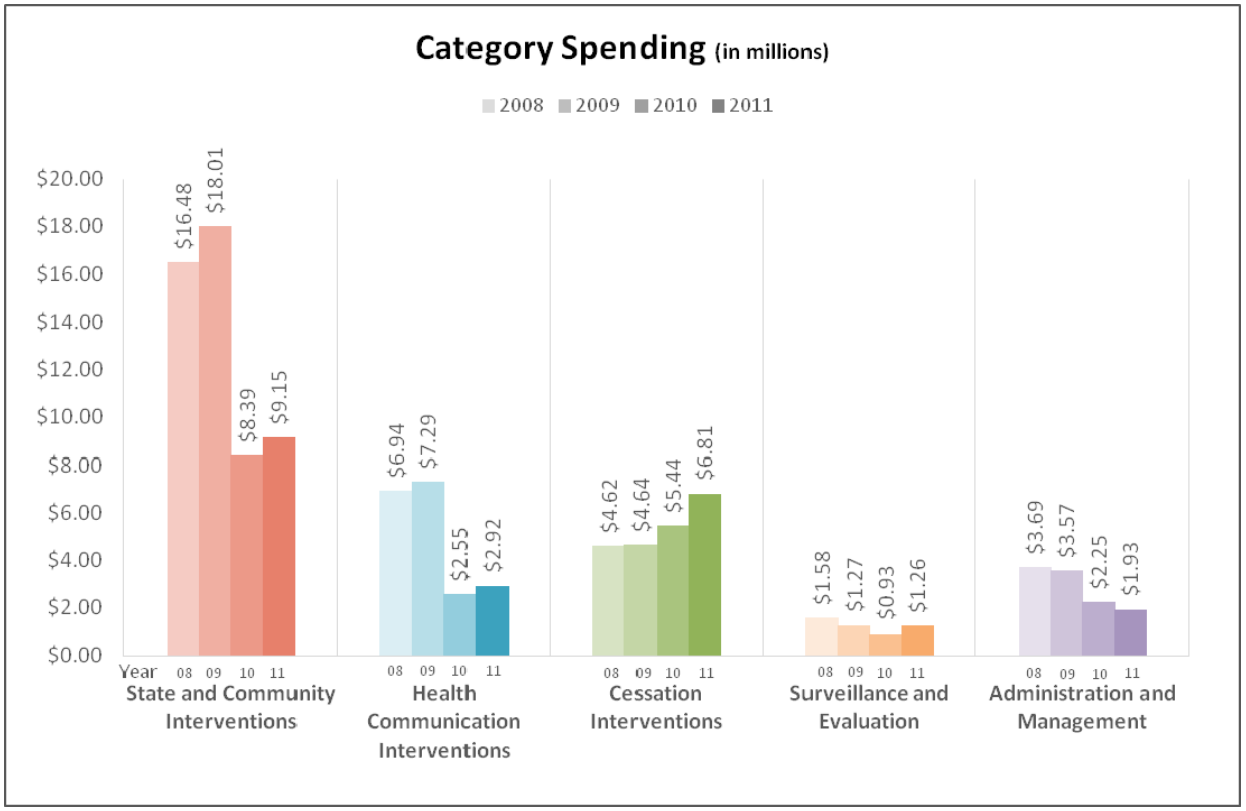
Pennsylvania spent $33.31 million on tobacco control expenditures in the 2008 fiscal year, reaching 21% of the CDC's recommended level. Of these expenditures, the state spent 49% on state and community interventions, 21% on health communications, 14% on cessation interventions, 5% on surveillance and evaluation, and 11% on administration and management. Pennsylvania increased funding to 22% of the CDC's recommendation for tobacco control, or $34.77 million, for the 2009 fiscal year. The largest portion of this funding, 52%, went to state and community interventions. The remaining portion of the funding was appropriated as follows: 21% for health communications, 13% for cessation interventions, 4% for surveillance and evaluation, and 10% for administration and management. The following fiscal year, 2010, Pennsylvania invested $19.56 million, 13% of the CDC's suggested spending level. Of this investment on tobacco control, Pennsylvania provided 43% for state and community interventions, 13% for health communications, 28% for cessation interventions, 5% for surveillance and evaluation, and 11% for administration and management. Pennsylvania contributed $22.06 million towards tobacco control in 2011, and with this dollar amount, it met 14% of the CDC's recommended investment. Of the $22.06 million, Pennsylvania spent 41% in state and community interventions, 13% in health communications, 31% in cessation interventions, 6% in surveillance and evaluation, and 9% in administration and management.

Pennsylvania

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$16,482,000	$6,944,000	$4,620,000	$1,578,000	$3,687,000	$33,311,000	$2.7	21%
FY2009	$18,009,000	$7,289,000	$4,635,000	$1,266,000	$3,570,000	$34,769,000	$2.8	22%
FY2010	$8,386,000	$2,551,000	$5,441,000	$934,000	$2,247,000	$19,559,000	$1.5	13%
FY2011	$9,150,000	$2,918,000	$6,809,000	$1,257,000	$1,929,000	$22,063,000	$1.7	14%





Rhode Island

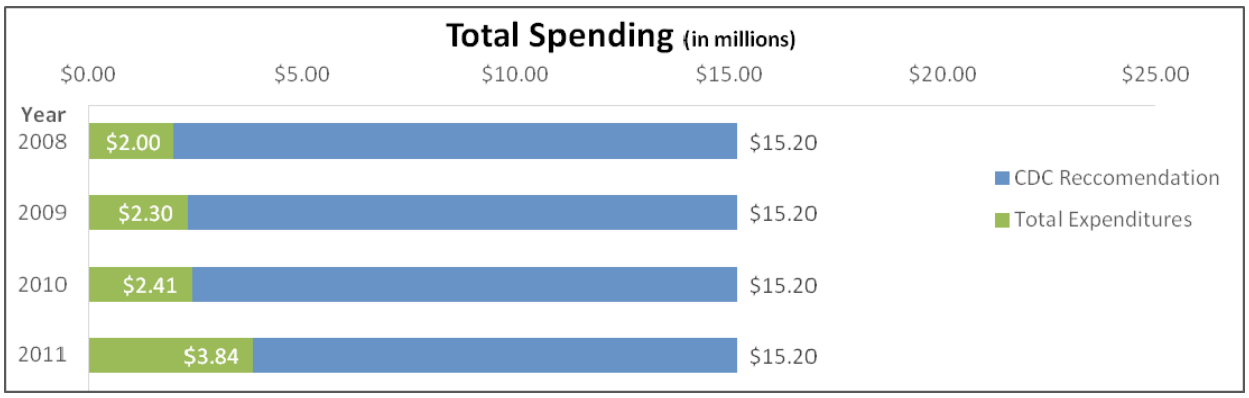
Rhode Island's tobacco control program is part of the Rhode Island Department of Health (RIDH) and receives funding from the CDC and from the state general appropriations. It maps tobacco industry media and hopes to then counter the industries' actions and promotes cessation services in collaboration with the National Alliance for Tobacco Cessation and the American Legacy Foundation (RIDPH, 2014). In 2002, Rhode Island sold a portion of MSA payments to the Rhode Island Tobacco Settlement Financing Corporation (TSFC) for a smaller, one-time, lump sum payment. The funds were used to address state budget shortfalls and pay capital and operating expenses. After 2004, Rhode Island had no MSA funding available for tobacco prevention (ALA, 2012). In 2007, Rhode Island allowed TSFC to issue additional asset-backed bonds, took the proceeds, and distributed them as follows: $42.5 million to state general revenues, $6.4 million to the Fleet Replacement Restricted Receipt Account, and for fiscal year 2008 only, $124 million to state general revenues. All residual net proceeds went to the Rhode Island Capital Plan Fund (The Finance Project, 2011). The state's cigarette tax is currently $3.50 per pack, up from $3.46 per pack in 2012. Revenues from the cigarette tax go to the general treasurer (ALA, 2012).

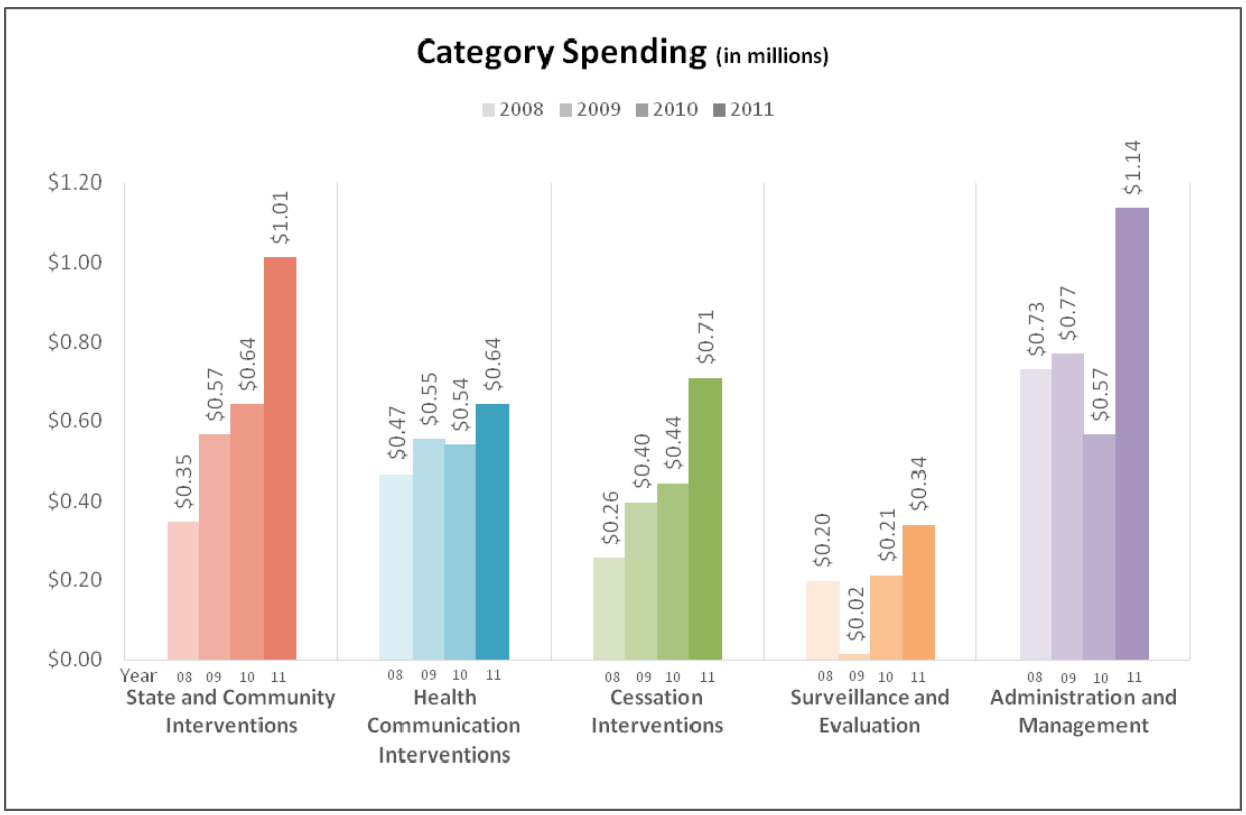
Throughout the 2008 fiscal year, Rhode Island spent $2 million on tobacco control expenditures, fulfilling 13% of the CDC's recommended spending level. Of these expenditures, the state provided 17% to state and community interventions, 23% to health communications, 13% to cessation interventions, 10% to surveillance and evaluation, and 37% to administration and management. Rhode Island's investments increased to 15% of the CDC's recommendation for tobacco control, or $2.30 million, for the following fiscal year. In 2009, Rhode Island used approximately 25% of tobacco control investment for state and community interventions, 24% for health communications, 17% for cessation interventions, 1% for surveillance and evaluation, and 33% for administration and management. For the 2010 fiscal year, Rhode Island financed $2.41 million in tobacco control, or 16% of what the CDC suggested. Of these monies spent in 2010, the state utilized 27% for state and community interventions, 22% for health communications, 18% for cessation interventions, 9% for surveillance and evaluation, and 24% for administration and management. In the following fiscal year, 2011, Rhode Island increased to $3.82 million, reaching 25% of the CDC's recommended investment level on tobacco control. Of the $3.82 million, Rhode Island spent 26% on state and community interventions, 17% on health communications, 18% on cessation interventions, 9% on surveillance and evaluation, and 30% on administration and management.

Rhode Island

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$347,000	$468,000	$257,000	$198,000	$731,000	$2,001,000	$1.9	13%
FY2009	$566,000	$554,000	$397,000	$15,000	$771,000	$2,303,000	$2.2	15%
FY2010	$644,000	$541,000	$443,000	$212,000	$567,000	$2,407,000	$2.3	16%
FY2011	$1,013,000	$642,000	$710,000	$340,000	$1,137,000	$3,842,000	$3.7	25%





South Carolina

In the year 2000, South Carolina's Department of Health and Environmental Control (DHEC) established its tobacco prevention and control program using special funds from South Carolina's Master Settlement Agreement payments. Its tobacco control program awards youth smoking prevention grants to local agencies, organizations, and entities based on criteria developed by DHEC. The South Carolina Youth Smoking Prevention Advisory Commission advises DHEC in the development, implementation, and evaluation of the state youth smoking plan (ALA, 2012). Carolina's annual MSA payments were securitized for a smaller, lump-sum payment (The Finance Project, 2011). The money from the securitization was transferred into four trust funds, a Health Care Endowment Fund, an economic assistance fund for tobacco farmers, a fund for rural economic development, and a fund for water and sewer projects. The interest earnings from the Healthcare Tobacco Settlement Trust Fund are used for a variety of public health policy initiatives, including youth smoking cessation and prevention programs coordinated by the Department of Health and Environmental Control and the Department of Alcohol and Other Drug Abuse Services. The state legislature is responsible for appropriating the money from the trust funds to those programs. In subsequent years, some funding has been taken out of the Healthcare Trust Fund and used for other purposes, primarily to supplement the state Medicaid program. No tobacco settlement funds have been dedicated to tobacco control and prevention programs since 2003, rather state funding for tobacco control is through the state cigarette tax revenue. South Carolina increased the tax in 2010 from $0.07 to $0.57. With this revenue, $5 million goes every year to the Medical University of South Carolina Hollings Cancer Center for tobacco-related cancer research, $5 million goes every year to the Smoking Prevention and Cessation Trust Fund to fund a state tobacco control program, and any remaining revenue goes to the South Carolina Medicaid Reserve Fund (ALA, 2012).

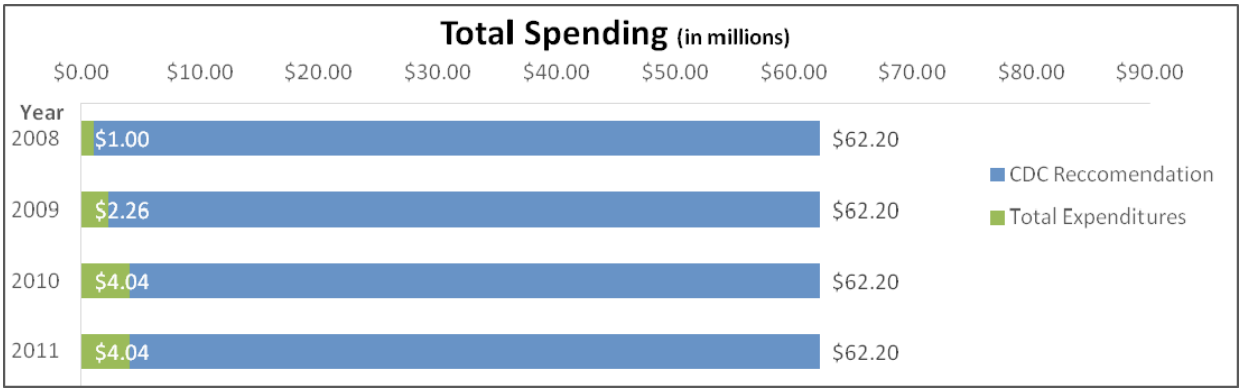
South Carolina supported tobacco control programs in the 2008 fiscal year by spending $1 million, or 2% of the CDC's recommended level. Of these expenditures, the state expended 21% on state and community interventions, 0% on health communications, 23% on cessation interventions, 3% on surveillance and evaluation, and 53% on administration and management. In fiscal year 2009, South Carolina's contribution to tobacco control increased to 4% of the CDC's recommendation for tobacco control, or $2.26 million. Of this $2.26 million, 16% went towards state and community interventions, 22% went towards for health communications, 22% went towards cessation interventions, 9% went towards for surveillance and evaluation, and 31% went towards administration and management. South Carolina increased its monetary amount for tobacco control again in 2010, providing programs with $4.04 million, or 7% of what the CDC suggested. With the 2010 increase, state and community interventions used 45%, health communications used 5%, cessation interventions used 34%, surveillance and evaluation used 2%, and administration and management used 14%. In the following fiscal year, 2011, South Carolina invested $4.04 million, reaching 7% of the CDC's recommended investment level on tobacco control. Of the $4.04 million, South Carolina invested 45% in state and community

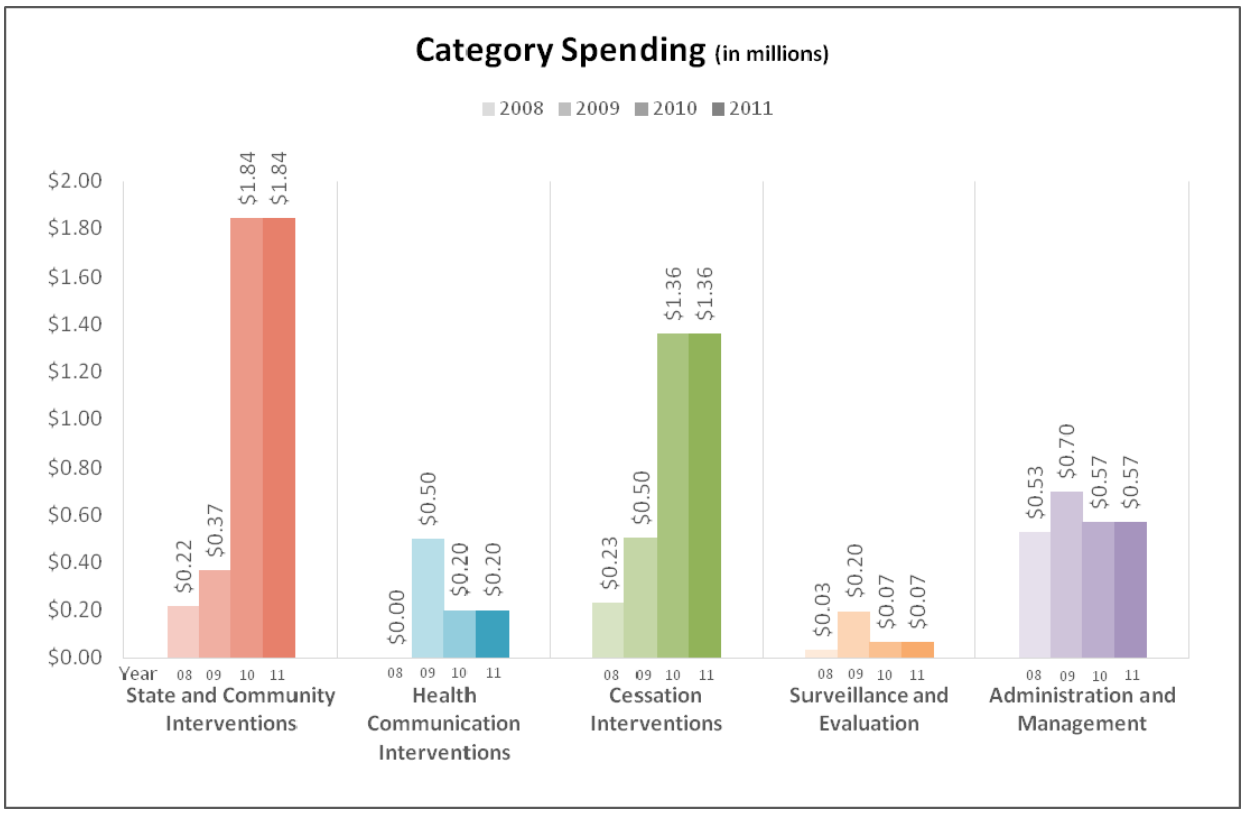
interventions, 5% in health communications, 34% in cessation interventions, 2% in surveillance and evaluation, and 14% in administration and management.

South Carolina

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$215,000	$0	$228,000	$33,000	$528,000	$1,004,000	$0.2	2%
FY2009	$365,000	$500,000	$502,000	$195,000	$696,000	$2,258,000	$0.5	4%
FY2010	$1,843,000	$200,000	$1,361,000	$67,000	$570,000	$4,041,000	$0.9	7%
FY2011	$1,843,000	$200,000	$1,361,000	$67,000	$570,000	$4,041,000	$0.9	7%





South Dakota

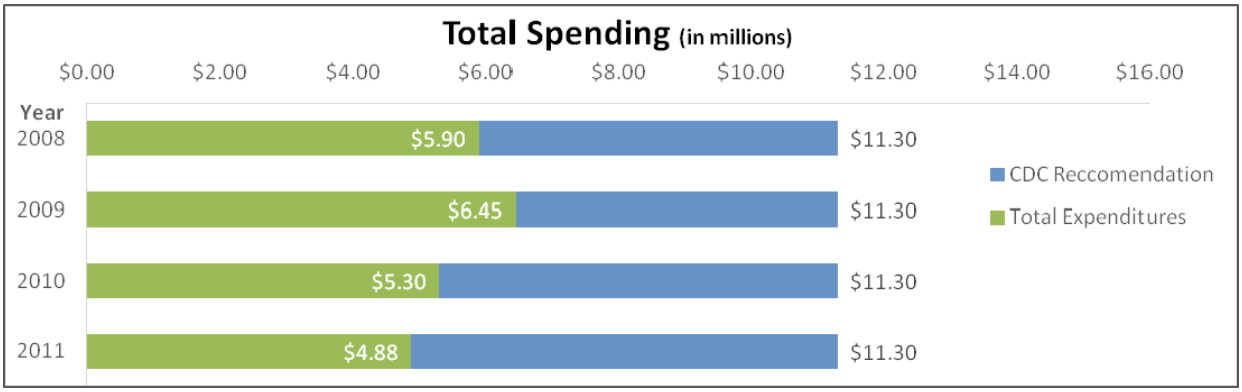
South Dakota does not allocate its Master Settlement Agreement (MSA) payments for tobacco control purposes; they use tobacco tax revenue. The entirety of the states' MSA payments were securitized in 2003 in exchange for a lump sum payment of $243.6 million. The securitized proceeds were used for the state debt services, social services, state schools, and education programs (The Finance Project, 2011). Prior to 2007, South Dakota maintained a tobacco control program through South Dakota's Department of Health. The program's funding was provided by CDC grants. South Dakota's Department of Health took on the task of developing a strategic state-wide plan to prevent and reduce tobacco use. In addition to this implementation, the Department of Health was to release an annual report on their progress to the public. In 2007, South Dakota increased its tobacco tax from $0.53 to $1.53 per pack. The first $30 million from the cigarette tax revenue is placed into the general fund. After this placement, all remaining revenue is deposited into the Tobacco Prevention and Reduction Trust Fund to be used for tobacco control and prevention programs. If the funds exceed $5 million, 33% of the excess goes toward reducing property taxes, 33% goes toward the Educational Enhancement Tobacco Tax Fund, and 34% of the excess is transferred to the Health Care Tobacco Tax Fund (ALA, 2012). (TFK, 2012).

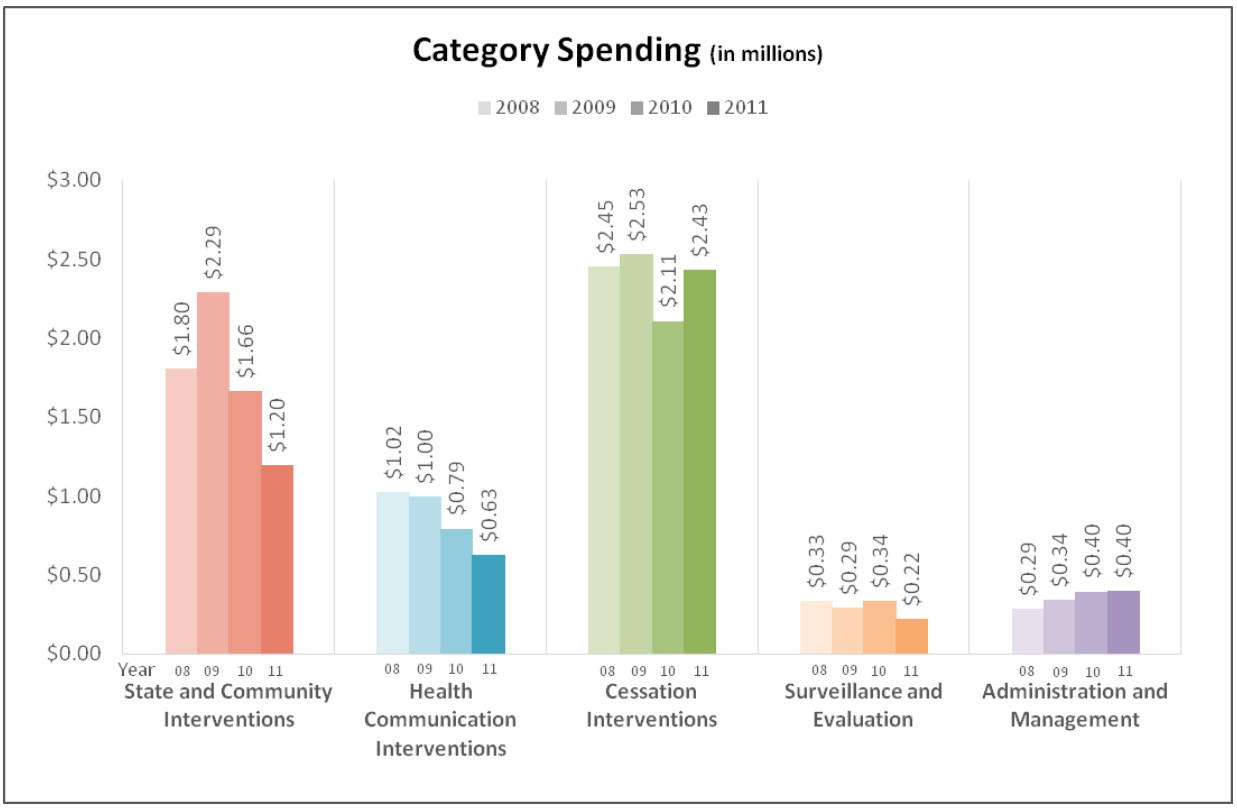
Tobacco control expenditures for the 2008 fiscal year reached 52% of the CDC's recommended level, meaning South Dakota spent $5.9 million on tobacco control. Of these expenditures, 31% funded state and community interventions, 17% funded health communications, 42% funded cessation interventions, 6% funded surveillance and evaluation, and 5% funded administration and management. In fiscal year 2009, South Dakota invested at 57% of the CDC's recommendation for tobacco control, or $6.45 million. In this fiscal year, the state spent 36% of tobacco control monies on state and community interventions, 15% on health communications, 39% on cessation interventions, 5% on surveillance and evaluation, and 5% on administration and management. South Dakota's funding for tobacco control programs increased to $5.3 million, or 47% of the CDC's suggested amount, for the 2010 fiscal year. Of this fiscal year's total, state and community interventions spent 31%, health communications spent 15%, cessation interventions spent 40%, surveillance and evaluation spent 6%, and administration and management spent 8%. In the following fiscal year, 2011, South Dakota decreased funding to $4.88 million, achieving 43% of the CDC's recommended investment level on tobacco control. Of the $4.88 million, South Dakota utilized 24% in state and community interventions, 13% in health communications, 50% in cessation interventions, 5% in surveillance and evaluation, and 8% in administration and management.

South Dakota

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$1,804,000	$1,024,000	$2,453,000	$334,000	$285,000	$5,900,000	$7.3	52%
FY2009	$2,292,000	$996,000	$2,532,000	$290,000	$343,000	$6,453,000	$7.9	57%
FY2010	$1,664,000	$793,000	$2,108,000	$338,000	$395,000	$5,298,000	$6.6	47%
FY2011	$1,195,000	$626,000	$2,433,000	$221,000	$401,000	$4,876,000	$6.0	43%





Tennessee

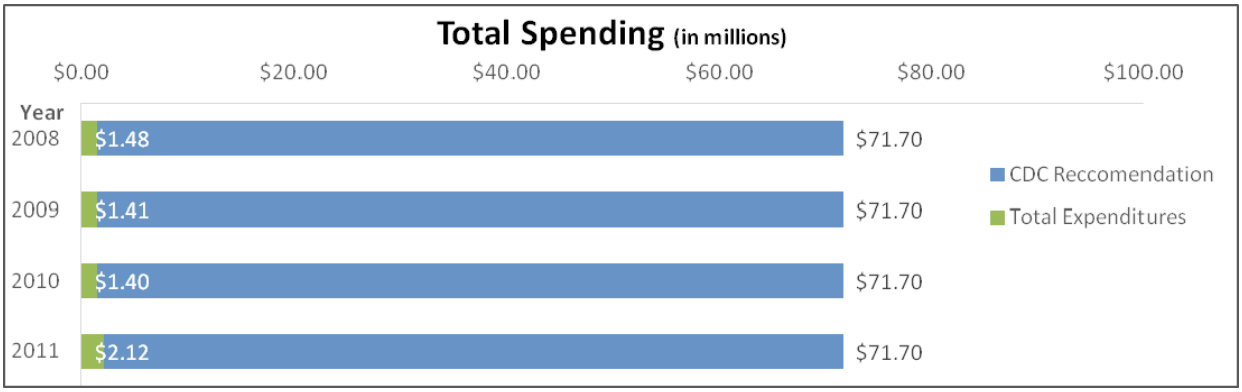
Tennessee's tobacco control program is part of the Tennessee Department of Health and it administers community and statewide programs to reduce tobacco use. With the help of federal CDC grants, Tennessee provides quitline cessation services, but is unable to establish a comprehensive tobacco control and prevention program. It does not dedicate its MSA funds to a specific trust fund or purpose, but since 2000, has allocated all of its MSA funds to the state general fund to be appropriated by the state legislature on an annual basis (The Finance Project, 2011). A significant portion of Tennessee's MSA funds have been used to cover state budget shortfalls in previous years, particularly due to the state's rising health care costs. Minimal amounts of funds were provided toward tobacco control in Tennessee before fiscal year 2008. Tennessee did increase its tobacco tax in 2007, from $0.20 to $0.62 per pack. The revenue is used for education-related programs and funding and a small amount funds the state trauma centers (ALA, 2012).

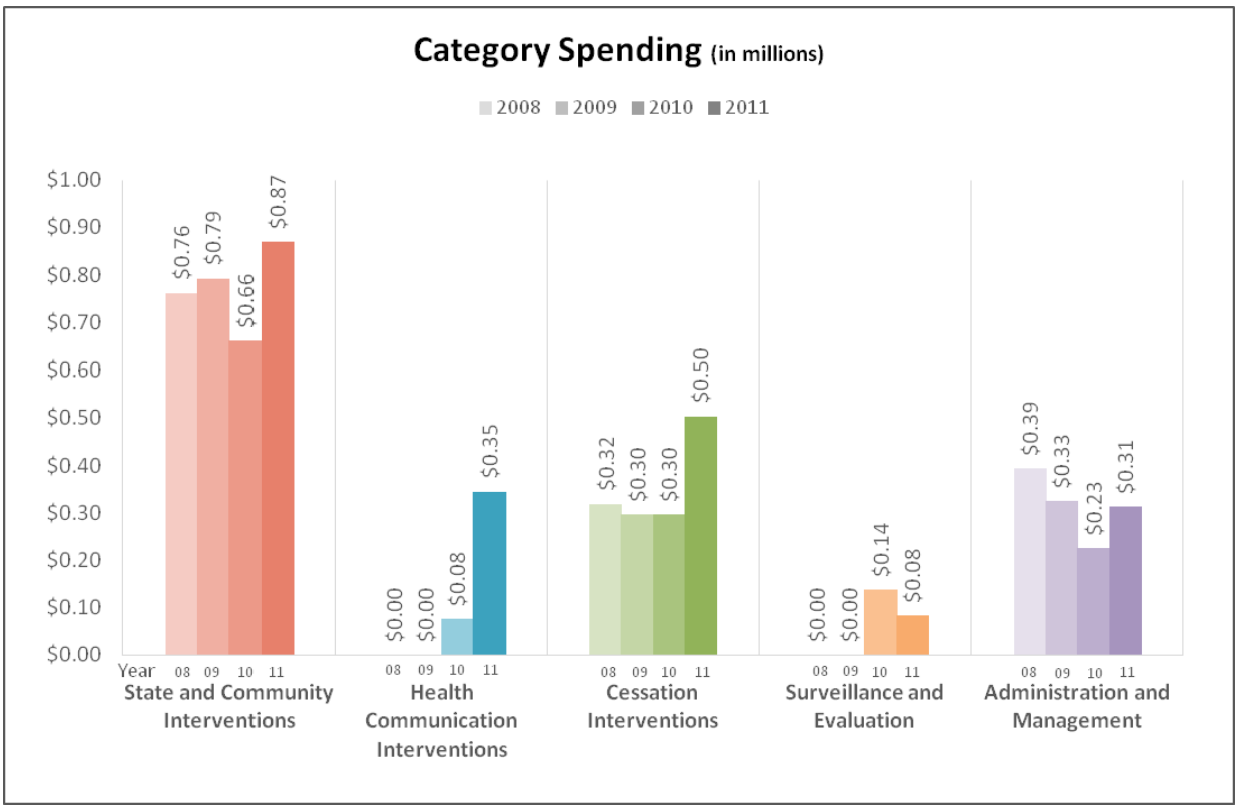
Tennessee's expenditures of $1.48 million on tobacco prevention and control in the 2008 fiscal year meant it met 2% of the CDC's suggested total for spending. Of these expenditures, the state spent 52% on state and community interventions, 0% on health communications, 21% on cessation interventions, 0% on surveillance and evaluation, and 27% on administration and management. Again, in fiscal year 2009, Tennessee invested at 2% of the CDC's recommendation, providing $1.41 million for tobacco control. In similar portions to the prior year, the state used 56% of tobacco control expenditures for state and community interventions, 0% for health communications, 21% for cessation interventions, 0% for surveillance and evaluation, and 23% for administration and management. Following this trend, the state spent $1.4 million, or 2% of the CDC's recommended total, on tobacco control for the 2010 fiscal year. Of this total provided for tobacco control, Tennessee provided 47% for state and community interventions, 6% for health communications, 21% for cessation interventions, 10% for surveillance and evaluation, and 16% for administration and management. In the following fiscal year, 2011, Tennessee increased its investment to $2.12 million, reaching 3% of the CDC's recommended investment level on tobacco control. Of the $2.12 million, Tennessee invested 41% in state and community interventions, 16% in health communications, 24% in cessation interventions, 4% in surveillance and evaluation, and 15% in administration and management.

Tennessee

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$762,000	$0	$319,000	$0	$394,000	$1,475,000	$0.2	2%
FY2009	$793,000	$0	$296,000	$0	$325,000	$1,414,000	$0.2	2%
FY2010	$662,000	$77,000	$296,000	$138,000	$226,000	$1,399,000	$0.2	2%
FY2011	$869,000	$345,000	$504,000	$84,000	$314,000	$2,116,000	$0.3	3%





Texas

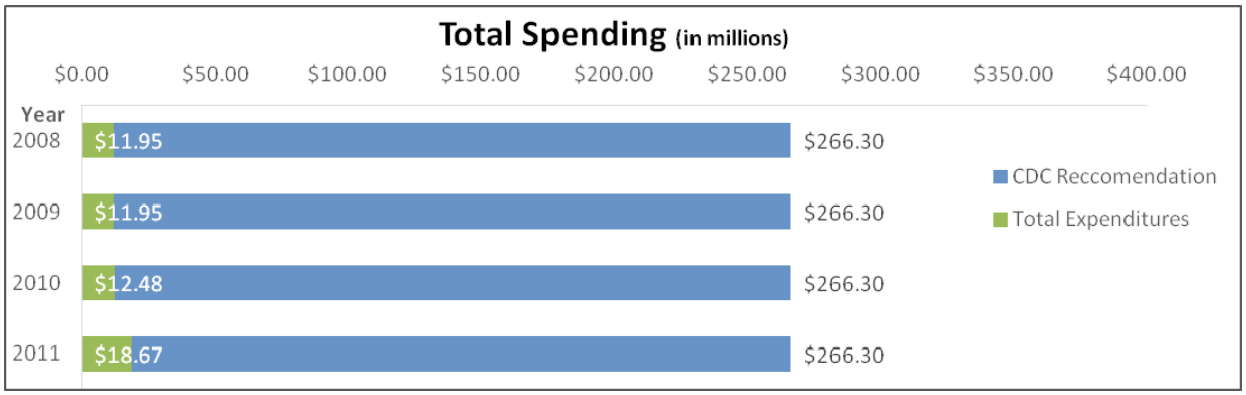
Texas is one of the four states which settled with tobacco companies individually before the Master Settlement Agreement. Annual settlement payments have been placed in several permanent endowments earmarked for the state health related programs, state schools, education and research programs, and social services. The interest from the settlement endowment, approximately $10 million a year, is supposed to be spent on tobacco prevention. The state general fund also helps supplement tobacco control programs. The funds are appropriated by the state legislature on a biennial basis, but they are not specifically reserved for tobacco control (TFK, 2011). By using a portion of its tobacco settlement funds, the Texas Department of State Health Services implemented a tobacco prevention and control program from 1998 to 2006 (ALA, 2012). The program was then moved to the Mental Health and Substance Abuse Division from the Health Promotion Unit/Chronic Disease Prevention Branch. Texas does have a cigarette tax and increased it in 2007 from $0.41 to $1.41 per pack. Additionally, during 2013, another fee of $0.55 has been established on cigarettes and cigarette products sold by manufacturers who did not sign the Texas tobacco settlement agreement. This fee will increase every year. Revenue from the tax on cigarettes is directed to the state general revenue fund, the Property Tax Relief Fund, and the state Foundation School Fund (ALA, 2012).

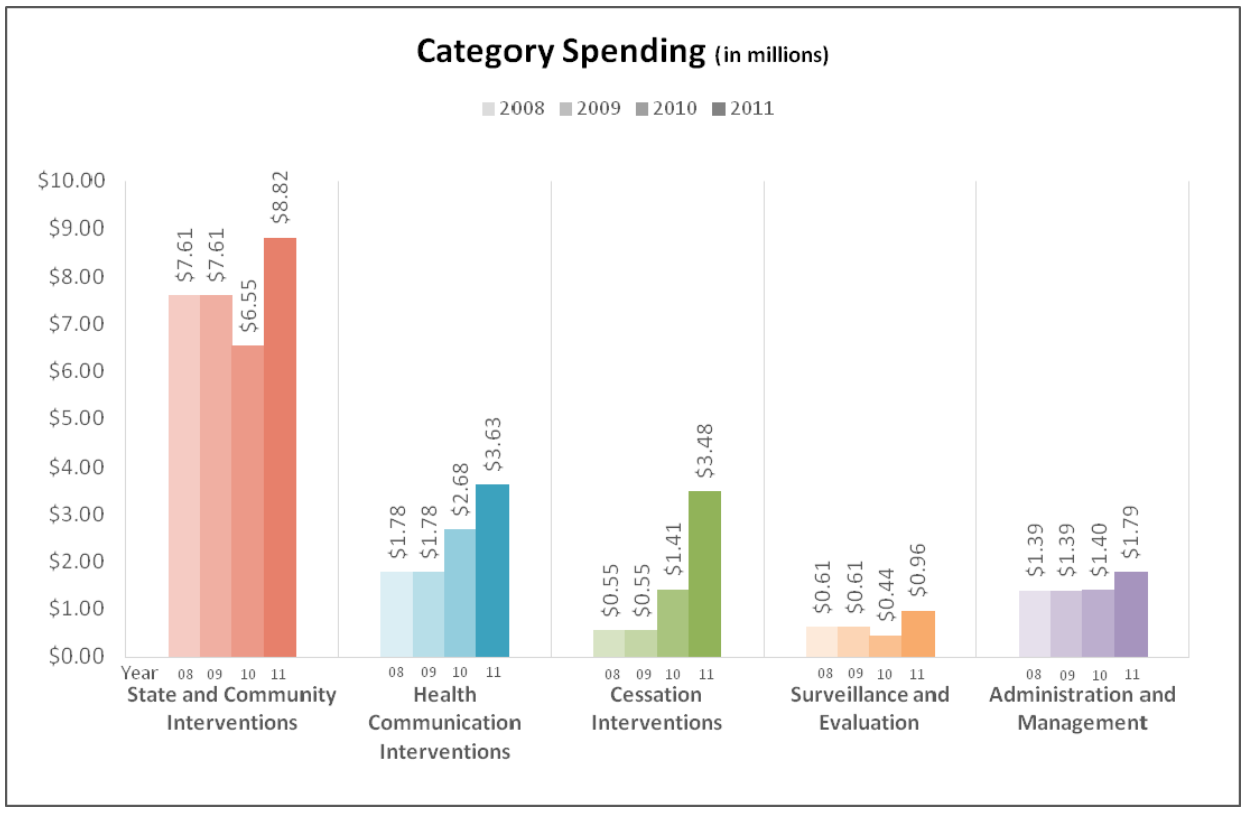
Texas spent $11.95 million on tobacco control expenditures in the 2008 fiscal year, reaching 5% of the CDC's recommended level. With this $11.95 million, state and community interventions expended 64%, health communications expended 15%, cessation interventions expended 4%, surveillance and evaluation expended 5%, and administration and management expended 12%. In fiscal year 2009, Texas again invested at 5% of the CDC's recommendation for tobacco control, or $11.95 million. Of this investment, 64% went towards state and community interventions, 15% went towards health communications, 4% went towards cessation interventions, 5% went towards surveillance and evaluation, and 12% went towards for administration and management. The following fiscal year, although Texas increased its dollar amount to $12.48 million, it met 5% of the CDC's recommended spending level again. Of this increase on tobacco control, the state allocated 53% for state and community interventions, 21% for health communications, 11% for cessation interventions, 4% for surveillance and evaluation, and 11% for administration and management. In the following fiscal year, 2011, Texas increased investment to $18.67 million, fulfilling 7% of the CDC's recommended investment level on tobacco control. Of the $18.67 million, Texas invested 47% in state and community interventions, 19% in health communications, 19% in cessation interventions, 5% in surveillance and evaluation, and 10% in administration and management.

Texas

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$7,613,000	$1,784,000	$550,000	$614,000	$1,390,000	$11,951,000	$0.5	5%
FY2009	$7,613,000	$1,784,000	$550,000	$614,000	$1,390,000	$11,951,000	$0.5	5%
FY2010	$6,546,000	$2,675,000	$1,413,000	$442,000	$1,402,000	$12,478,000	$0.5	5%
FY2011	$8,816,000	$3,626,000	$3,478,000	$962,000	$1,786,000	$18,668,000	$0.7	7%





Utah

Beginning in the year 2000, Utah's Tobacco Prevention and Control Program (TPCP), under Utah's Department of Health, has administered Utah's tobacco control and prevention initiatives. On top of federal funds, TPCP receives its current funding from Utah's Master Settlement Agreement payments and cigarette tax revenue. In addition to implementing comprehensive statewide tobacco control measures, TPCP partners with Utah's 12 local health departments and communities to ensure its anti-tobacco initiative are far-reaching (UDH, 2013). Since 2000, a portion of MSA payments have been placed into the Permanent Trust Fund Endowment and the remaining portion is appropriated by the state legislature. In 2000, voters approved reinvesting half of the interest earned from the Permanent Trust Fund and using the remaining portion for health care programs. As July of 2007, 60% of the MSA payments have been deposited into the Tobacco Settlement Restricted Account and 40% have been deposited into the Permanent State Trust Fund. Tobacco Settlement Restricted Account funds are distributed to fund the state children's health insurance program; alcohol, tobacco, and other drug prevention, reduction, cessation, and control programs; expansion of the drug court program; and the University of Utah Health Sciences Center, the enforcement of the MSA; and the enforcement of the Tobacco Tax Settlement Agreement. of. As of 2011, the 40% of MSA payments allocated to the Permanent State Trust Fund have been allocated to the state general fund (ALA, 2012). In 2010, Utah increased their cigarette tax from $0.695 to $1.70 per pack. The revenue from the cigarette tax is deposited into a Cigarette Tax Restricted Account in the state general fund. From there, it is allocated to a variety of programs, including media targeted toward children for tobacco prevention; tobacco prevention, reduction, cessation, and control programs; cancer research; and medical education. The remaining funds are allocated by the state legislature, with specific consideration of Medicaid reimbursement and medical coverage for the uninsured (ALA, 2012).

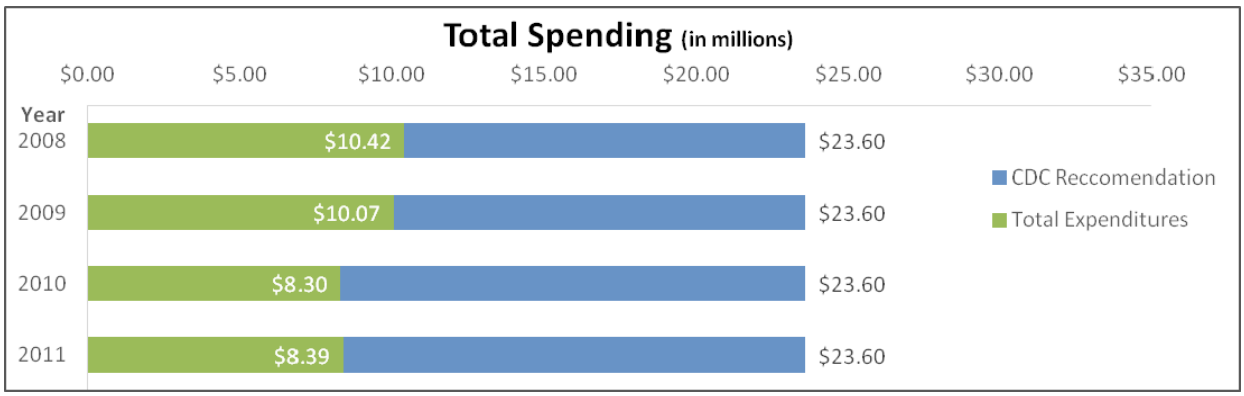
Utah supported tobacco control with a $10.42 million investment in the 2008 fiscal year, satisfying 44% of the CDC's recommended level. Of this fiscal year's investment, the state used 31% for state and community interventions, 39% for health communications, 18% for cessation interventions, 4% for surveillance and evaluation, and 8% for administration and management. Utah's contribution decreased slightly to 43% of the CDC's recommended spending for tobacco control, to $10.07 million for the 2009 fiscal year. The proportions of this contribution were spent as follows: 31% of tobacco control expenditures for state and community interventions, 39% for health communications, 18% for cessation interventions, 4% for surveillance and evaluation, and 8% for administration and management. The following fiscal year, 2010, Utah spent $8.3 million, or 35% of the CDC's suggested spending amount. Of this total used on tobacco control, 35% went towards state and community interventions, 19% went towards health communications, 21% went towards cessation interventions, 11% went towards surveillance and evaluation, and 14% went towards administration and management. Utah increased to $8.39 million, reaching 36% of the CDC's recommended investment level on tobacco control for the

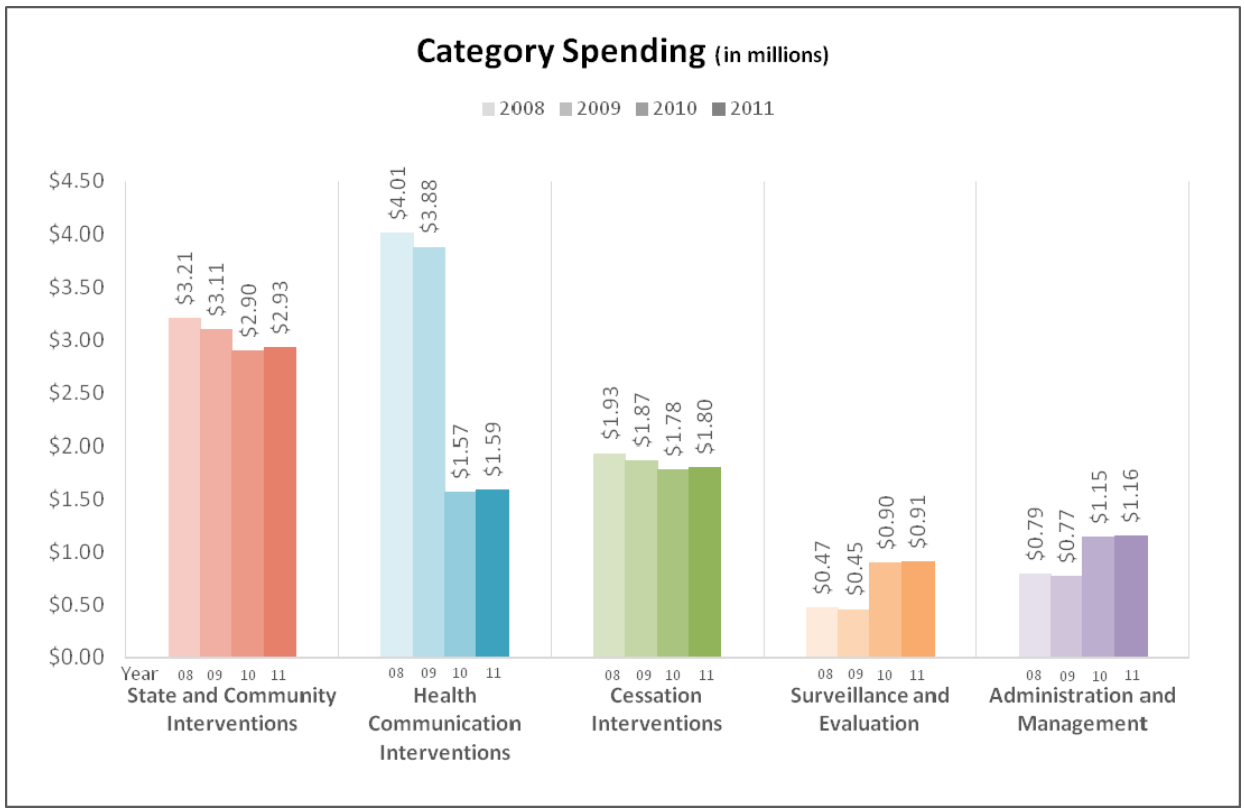
2011 fiscal year. Of the increase to $8.39 million, Utah saw 35% go to state and community interventions, 19% go to health communications, 21% go to cessation interventions, 11% go to surveillance and evaluation, and 14% go to administration and management.

Utah

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$3,211,000	$4,014,000	$1,929,000	$469,000	$792,000	$10,415,000	$3.8	44%
FY2009	$3,105,000	$3,882,000	$1,865,000	$454,000	$766,000	$10,072,000	$3.6	43%
FY2010	$2,903,000	$1,573,000	$1,781,000	$896,000	$1,145,000	$8,298,000	$3.1	35%
FY2011	$2,934,000	$1,590,000	$1,800,000	$906,000	$1,157,000	$8,387,000	$3.0	36%





Vermont

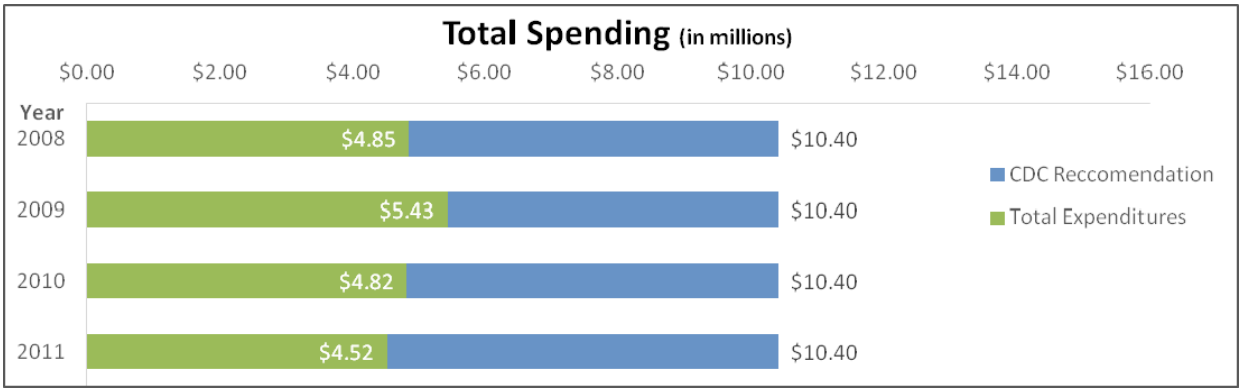
Since 2000, Vermont's Department of Health has operated the tobacco control program. The Vermont Tobacco Evaluation and Review Board, an independent state board, was created to work in partnership with the Department of Health tobacco control program in administering and coordinating the state tobacco control and prevention measures and cessation services. Additionally, the Department of Liquor Control administers enforcement activities and the Department of Education administers school-based tobacco control programs. A portion of Vermont's MSA payments fund these tobacco control efforts (The Finance Project, 2011). MSA payments are first deposited into Vermont's Tobacco Litigation Settlement Fund and then appropriations must be made by the state general assembly to the Tobacco Trust Fund to finance tobacco control programs (ALA, 2012). In 2011 and 2012, monies from the Tobacco Trust Fund were used to fund budget shortfalls. Vermont does have a cigarette tax, which increased in 2011 from $2.24 per pack of cigarettes to $2.62 per pack. All revenue from Vermont's cigarette tax is distributed to the State Health Care Resources Fund. This finances health care coverage for beneficiaries of the state health care assistance programs. The remaining 15.5% is allocated to the Catamount Fund to help fund the Catamount Health assistance program (ALA, 2012).

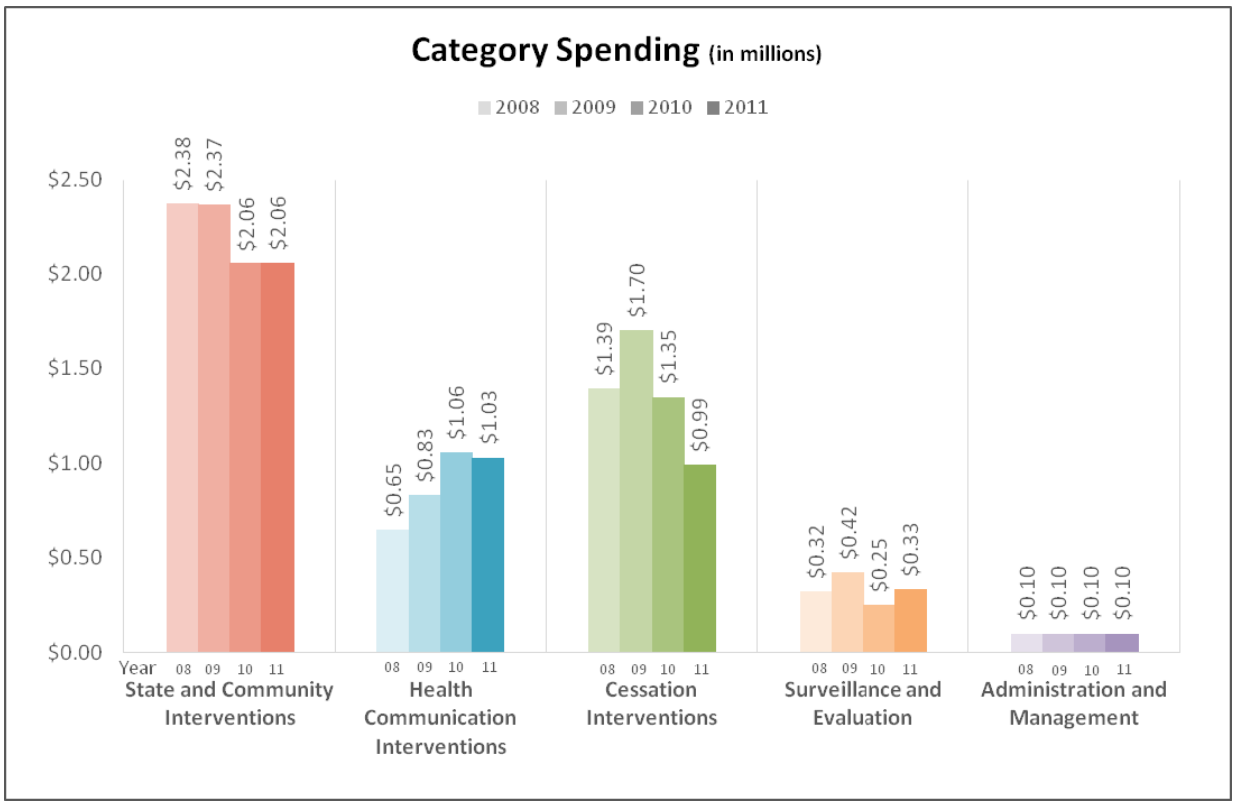
By funding tobacco control with $4.85 million in the 2008 fiscal year, Vermont fulfilled 47% of the CDC's recommended level for spending. Of these funds, 49% financed state and community interventions, 13% financed health communications, 29% financed cessation interventions, 7% financed surveillance and evaluation, and 2% financed administration and management. In the next fiscal year, 2009, the state increased investment to $5.43 million, reaching 52% of the CDC's recommendation for tobacco control. In this fiscal year, the state used 44% of tobacco control expenditures for state and community interventions, 15% for health communications, 31% for cessation interventions, 8% for surveillance and evaluation, and 2% for administration and management. With the 2010 fiscal year, Vermont decreased expenditures to $4.82 million, or 46% of the total CDC suggested spending amount. Of this expenditure on tobacco control, 43% supported state and community interventions, 22% supported health communications, 28% supported cessation interventions, 5% supported surveillance and evaluation, and 2% supported administration and management. In the following fiscal year, 2011, Vermont's total for tobacco control decreased to $4.52 million, reaching 43% of the CDC's recommended investment level on tobacco control. Of the $4.52 million, state and community interventions used 46%, health communications used 23%, cessation interventions used 22%, surveillance and evaluation used 7%, and administration and management used 2%.

Vermont

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$2,379,000	$650,000	$1,394,000	$322,000	$100,000	$4,845,000	$7.8	47%
FY2009	$2,372,000	$833,000	$1,703,000	$421,000	$100,000	$5,429,000	$8.7	52%
FY2010	$2,057,000	$1,058,000	$1,349,000	$252,000	$100,000	$4,816,000	$7.7	46%
FY2011	$2,060,000	$1,030,000	$992,000	$333,000	$100,000	$4,515,000	$7.2	43%





Virginia

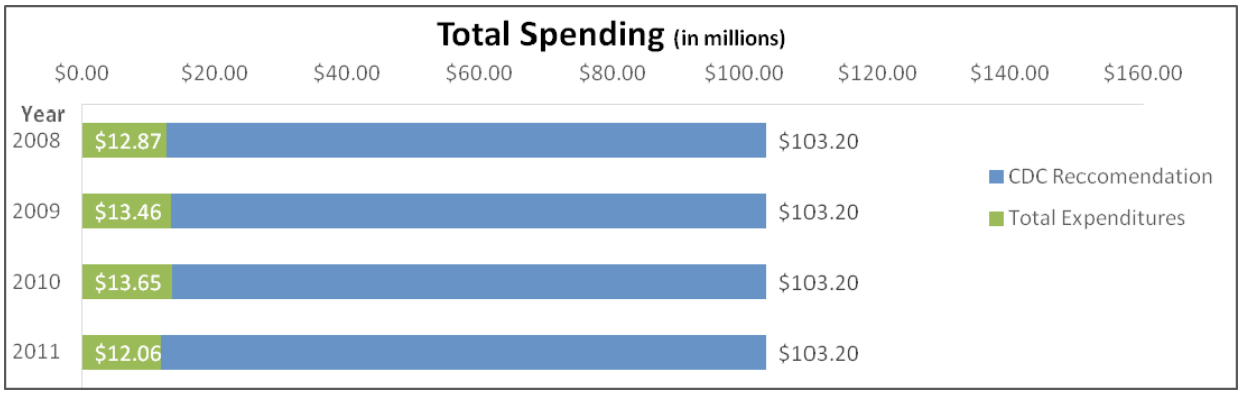
Virginia's tobacco control and prevention efforts began in 1999. The Virginia Legislature established three separate funds to receive Master Settlement Agreement monies: 50% to the Tobacco Indemnification and Community Revitalization Trust Fund aiding tobacco growers and tobacco dependent communities, 40% to state's general fund, and 10% to the Virginia Tobacco Settlement Foundation (The Finance Project, 2011). Ten years later, the Virginia Tobacco Settlement Foundation was changed to the Virginia Foundation for Health Youth (VFHY) and put in charge of childhood obesity prevention in addition to tobacco prevention. For fiscal years 2011 and 2012, VFHY received 8.5% MSA money. Of this 8.5%, the state general fund received 41.5%, and obesity prevention received $1 million (ALA, 2012). In addition, the state of Virginia also has the Tobacco Use Control Project (TUCP).. TUCP is a tobacco control and prevention program within the Virginia Department of Health and is funded by the grants from the Centers for Disease Control and Prevention's Office on Smoking and Health. In implementing its comprehensive approaches to reduce tobacco use in Virginia, TUCP works closely with various health coalitions and partnering organizations to reduce youth tobacco use, increase cessation support, and eliminate disparities in smoking in Virginia (VDPH, 2014). In addition to its MSA payments, Virginia has a cigarette tax of $0.30, increased in 2005 from $0.20 per pack. All revenue generated by the cigarette tax is deposited into the Virginia Health Care Fund. Monies in the fund are used for the provision of health care services.

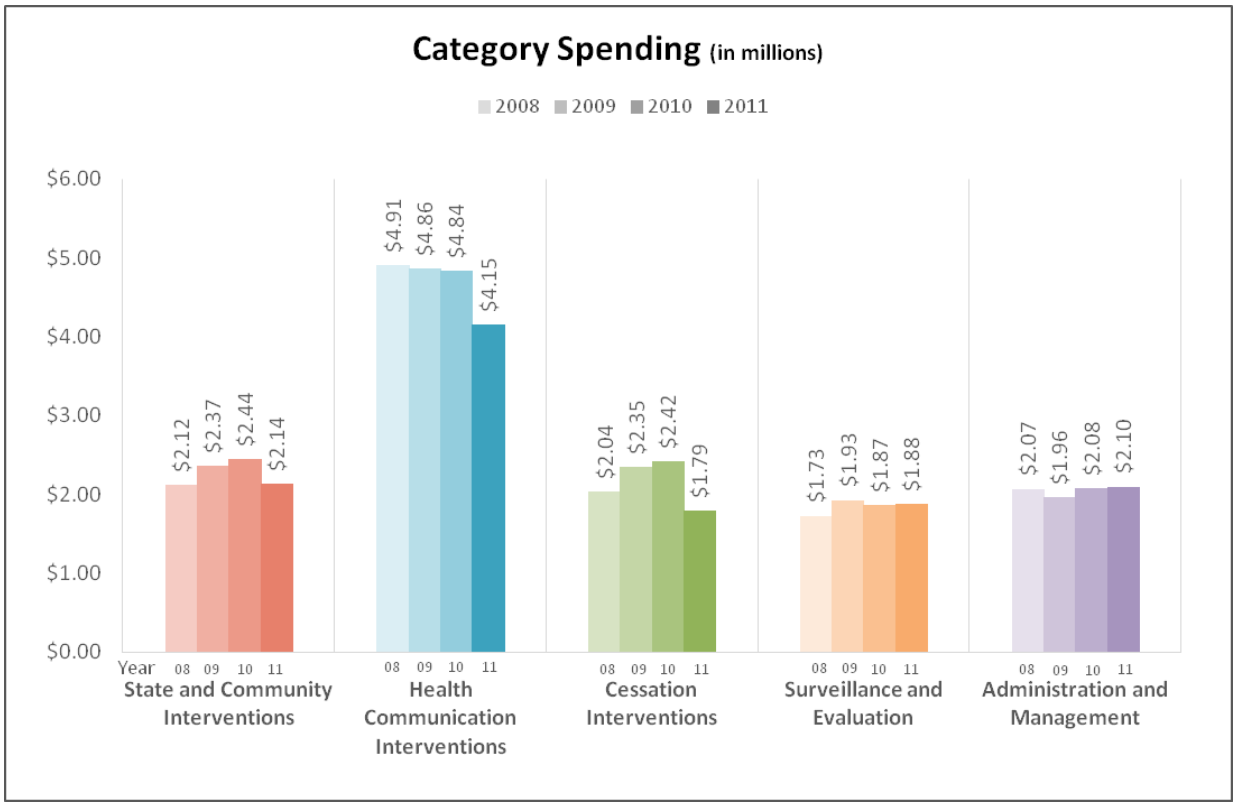
Virginia's total for tobacco control in the 2008 fiscal year was $12.87 million. This total met 13% of the CDC's recommended level of spending for Virginia's tobacco control. Of this $12.87 million total, the state17% on state and community interventions, 38% on health communications, 16% on cessation interventions, 13% on surveillance and evaluation, and 16% on administration and management. In fiscal year 2009, Virginia's money for tobacco control again amounted to 13% of the CDC's recommendation for tobacco control, totaling $13.46 million. In this fiscal year, Virginia used 18% of tobacco control money for state and community interventions, 36% for health communications, 17% for cessation interventions, 14% for surveillance and evaluation, and 15% for administration and management. Remaining consistent, Virginia invested $13.65 million on tobacco control for the fiscal year of 2010. Again, this satisfied 13% of the CDC's recommended spending level for tobacco control expenditures. Of expenditures on tobacco control, the state allocated18% for state and community interventions, 35% for health communications, 18% for cessation interventions, 14% for surveillance and evaluation, and 15% for administration and management. In the following fiscal year, 2011, Virginia decreased investment to $12.06 million, thus decreasing to 12% of the CDC's recommended investment level on tobacco control. Of the $12.06 million, Virginia expended 18% on state and community interventions, 34% on health communications, 15% on cessation interventions, 16% on surveillance and evaluation, and 17% on administration and management.

Virginia

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$2,119,000	$4,910,000	$2,040,000	$1,730,000	$2,071,000	$12,870,000	$1.7	13%
FY2009	$2,366,000	$4,860,000	$2,347,000	$1,928,000	$1,961,000	$13,462,000	$1.7	13%
FY2010	$2,442,000	$4,839,000	$2,418,000	$1,870,000	$2,078,000	$13,647,000	$1.7	13%
FY2011	$2,136,000	$4,151,000	$1,790,000	$1,880,000	$2,099,000	$12,056,000	$1.5	12%





Washington

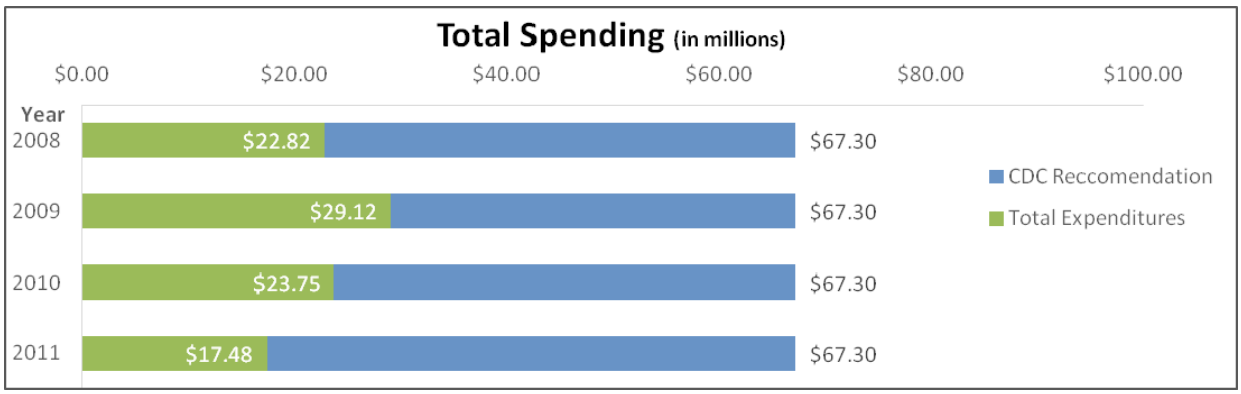
Washington's Tobacco Prevention and Control Program began in 1991 when the State Department of Health participated in the American Stop Smoking Intervention Study (ASSIST). Later, in 1999, The Washington state legislature set aside $100 million from its initial $430 million Master Settlement Agreement to the Tobacco Prevention and Control Account (TPCA). It was set up to fund and establish a more comprehensive tobacco program in Washington while following the CDC's Best Practices guidelines. In 2002, Washington sold 30% of its tobacco payments to help correct the state budget deficit. The remaining money is deposited to the General State Fund. Money from the General State Fund supplements Medicaid and State Children's Health Insurance Program (SCHIP), the state Basic Health Plan, local public health funding, and other health-related programs (The Finance Project, 2011). Tobacco control in Washington is funded through the State General Fund and retailer licensing fees. All money, except for that sold to the Tobacco Settlement Authority in 2002, is deposited into the Tobacco Settlement Account. From here, money can only be transferred to the Tobacco Prevention and Control Account or to the State General Fund. In 2007, $50 million was directed to the Tobacco Prevention and Control Account, which was depleted by June of 2011, so no funds were available to sustain the program (TFK, 2012). Additionally, MSA payments from 2008 to 2017 are to be designated to the Life Sciences Discovery Fund; however, from fiscal year 2010 through fiscal year 2013, monies were diverted from these funds. Washington does have a cigarette tax, raised from $2.025 to $3.025 in 2010. Revenue from this tax is placed in the State General Fund (ALA, 2012).

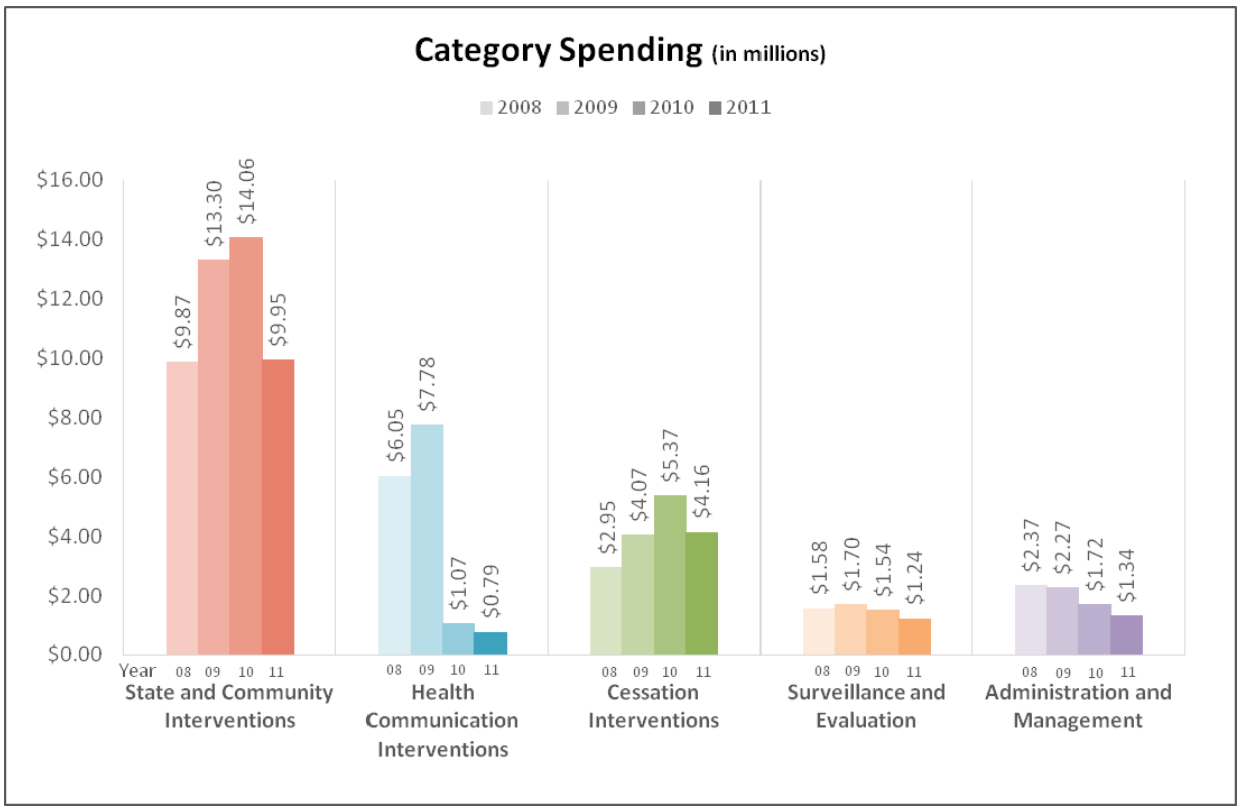
For the 2008 fiscal year, Washington's tobacco control programs received $22.82 million, thus reaching 34% of the CDC's recommended level. Of this total, 43% went to state and community interventions, 27% went to health communications, 13% went to cessation interventions, 7% went to surveillance and evaluation, and 10% went to administration and management. In fiscal year 2009, Washington increased to 43% of the CDC's recommendation for tobacco control, or $29.12 million. With this higher amount of money, the state used 45% for state and community interventions, 27% for health communications, 14% for cessation interventions, 6% for surveillance and evaluation, and 8% for administration and management. The 2010 fiscal year showed a decrease for Washington towards tobacco control expenditures. Washington spent $23.75 million, or 35% of the CDC's suggested spending level. The 2010 fiscal year spending was proportioned as follows: 59% for state and community interventions, 5% for health communications, 23% for cessation interventions, 6% for surveillance and evaluation, and 7% for administration and management. In the following fiscal year, 2011, Washington invested $17.48 million, lowering to 26% of the CDC's recommended investment level on tobacco control. Of the $17.48 million, Washington invested 57% in state and community interventions, 5% in health communications, 24% in cessation interventions, 7% in surveillance and evaluation, and 7% in administration and management.

Washington

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$9,870,000	$6,050,000	$2,950,000	$1,580,000	$2,370,000	$22,820,000	$3.5	34%
FY2009	$13,300,000	$7,780,000	$4,070,000	$1,700,000	$2,270,000	$29,120,000	$4.4	43%
FY2010	$14,056,000	$1,067,000	$5,374,000	$1,535,000	$1,715,000	$23,747,000	$3.6	35%
FY2011	$9,949,000	$788,000	$4,156,000	$1,242,000	$1,343,000	$17,478,000	$2.6	26%





West Virginia

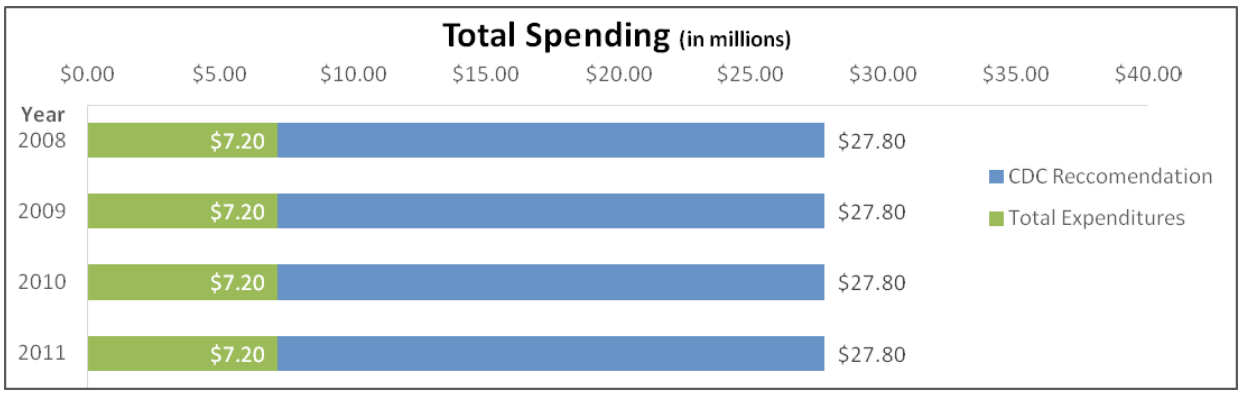
West Virginia's Bureau for Public Health, in the year 2000, established the Division of Tobacco Prevention. Funds appropriated from West Virginia's Master Settlement Agreement payments finance the Division of Tobacco. At that time, West Virginia's approximate $55 million in annual settlement payments were governed by a 1999 law that divided the settlement funds evenly into two funds: the West Virginia Medical Trust Fund and the West Virginia Tobacco Settlement Fund. Monies in the Tobacco Settlement Fund were for Medicaid and other public health programs and initiatives. Tobacco control and prevention funding also came from this fund. In fiscal year 2006, money was redirected from the Medical Trust Fund and it was renamed the Revenue Shortfall Reserve Fund-Part B. West Virginia securitized their MSA funds in 2007, and from fiscal year 2008 forward, MSA receipts are directed to the payment of debt. With this, all future tobacco control and prevention funding depends upon the state legislature's willingness to allocate funds in its annual budget process (The Finance Project, 2011). West Virginia does have a cigarette tax, with its last increase occurring in 2003, from $0.17 to $0.55 per pack.

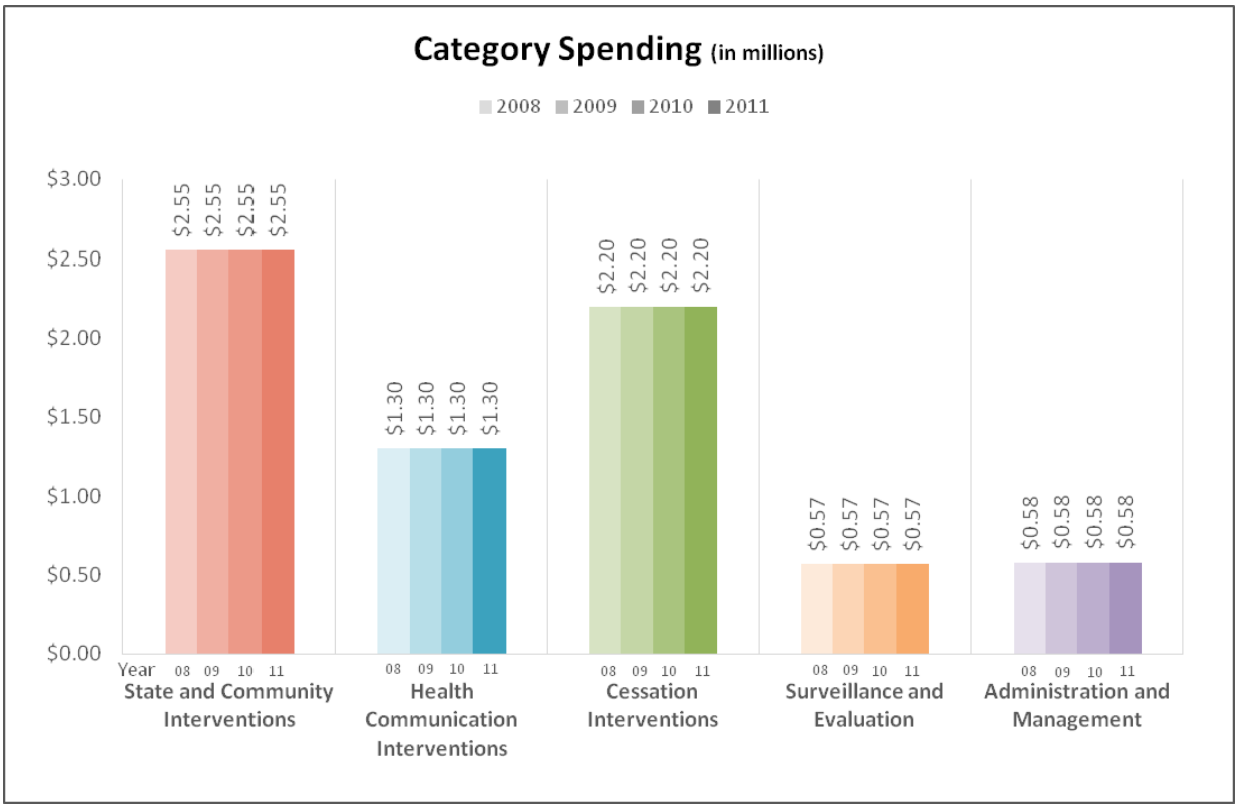
West Virginia spent $7.2 million on tobacco control expenditures in the 2008 fiscal year, reaching 26% of the CDC's recommended level. Of these expenditures, the state spent 35% on state and community interventions, 18% on health communications, 31% on cessation interventions, 8% on surveillance and evaluation, and 8% on administration and management. The subsequent fiscal year, 2009, West Virginia's monetary total reached 26% of the CDC's recommendation for tobacco control, or $7.2 million. In 2009, approximately 35% of tobacco control expenditures supported state and community interventions, 18% supported health communications, 31% supported cessation interventions, 8% supported surveillance and evaluation, and 8% supported administration and management. West Virginia's investment in 2010 amounted to $7.2 million, achieving 15% of the CDC's recommended spending level. Of this investment on tobacco control, Virginia used 35% for state and community interventions, 18% for health communications, 31% for cessation interventions, 8% for surveillance and evaluation, and 8% for administration and management. In 2011, West Virginia increased funding for tobacco control programs to $7.2 million, thus increasing to 26% of the CDC's suggested spending total. Of the $7.2 million, West Virginia funded state and community interventions with 35%, health communications with 18%, cessation interventions with 31%, surveillance and evaluation with 8%, and administration and management with 8%.

West Virginia

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$2,550,000	$1,300,000	$2,200,000	$570,000	$580,000	$7,200,000	$4.0	26%
FY2009	$2,550,000	$1,300,000	$2,200,000	$570,000	$580,000	$7,200,000	$4.0	26%
FY2010	$2,550,000	$1,300,000	$2,200,000	$570,000	$580,000	$7,200,000	$3.9	26%
FY2011	$2,550,000	$1,300,000	$2,200,000	$570,000	$580,000	$7,200,000	$3.9	26%





Wisconsin

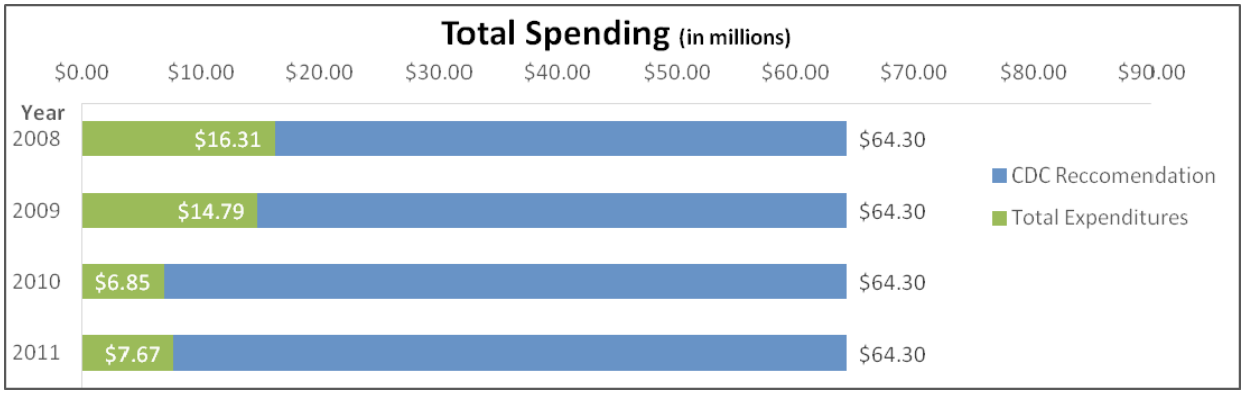
Wisconsin's tobacco control efforts began in 1991 with the implementation of the ASSIST project. The ASSIST project was conducted in 17 states simultaneously at that time and was funded by the National Cancer Institute. Using grant money from the CDC and money from its Master Settlement Agreement, the Tobacco Prevention and Control Program (TPCP) replaced the ASSIST program in 2000. At the time, tobacco control funds were mostly channeled towards local intervention efforts and helped establish over 40 local coalitions in Wisconsin that provided tobacco control services (WDHS, 2010). Since 2002, Wisconsin TPCP no longer received the funding from Wisconsin's MSA payments because the rights to those payments were sold to balance the state budget. TPCP has relied on annual state budget appropriations for its funding ever since. TPCP continues to conduct comprehensive tobacco control interventions utilizing the established local coalitions, supporting policy changes, eliminating tobacco-related disparities, and performing regular surveillance of tobacco use trends. Wisconsin does have a cigarette tax, which was increased in 2009 from $1.77 to $2.52 per pack (ALA, 2012).

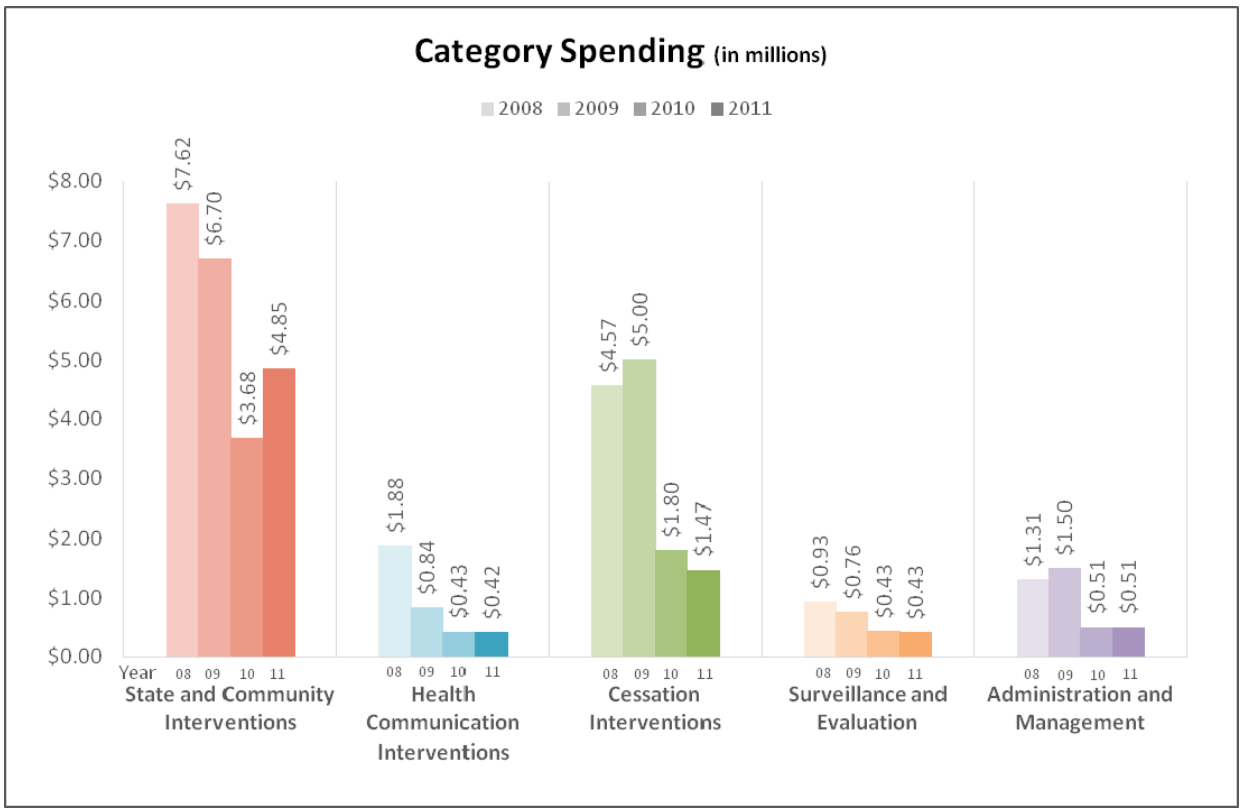
In order to reach 25% of the CDC's recommended level for tobacco control expenditures, Wisconsin spent $16.31 million in fiscal year 2008. Of this $16.31 million, the state expended 47% on state and community interventions, 11% on health communications, 28% on cessation interventions, 6% on surveillance and evaluation, and 8% on administration and management. Wisconsin decreased its investment to 23% of the CDC's recommendation for tobacco control, or $14.79 million, for the 2009 fiscal year. With this amount, state and community interventions received 45%, health communications received 6%, cessation interventions received 34%, surveillance and evaluation received 5%, and 10% administration and management received 10%. The following fiscal year, Wisconsin invested $6.85 million, 11% of the CDC's recommended spending level. Of this investment on tobacco control, 54% went to state and community interventions, 6% went to health communications, 26% went to for cessation interventions, 7% went to surveillance and evaluation, and 7% went to administration and management. In the following fiscal year, 2011, Wisconsin increased spending to $7.67 million, reaching 12% of the CDC's suggested investment level on tobacco control. Of the $7.67 million, Wisconsin spent 63% on state and community interventions, 5% on health communications, 19% on cessation interventions, 6% on surveillance and evaluation, and 7% on administration and management.

Wisconsin

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$7,618,000	$1,877,000	$4,574,000	$931,000	$1,310,000	$16,310,000	$2.9	25%
FY2009	$6,695,000	$835,000	$5,000,000	$763,000	$1,500,000	$14,793,000	$2.6	23%
FY2010	$3,683,000	$430,000	$1,800,000	$433,000	$505,000	$6,851,000	$1.2	11%
FY2011	$4,848,000	$420,000	$1,472,000	$425,000	$505,000	$7,670,000	$1.4	12%





Wyoming

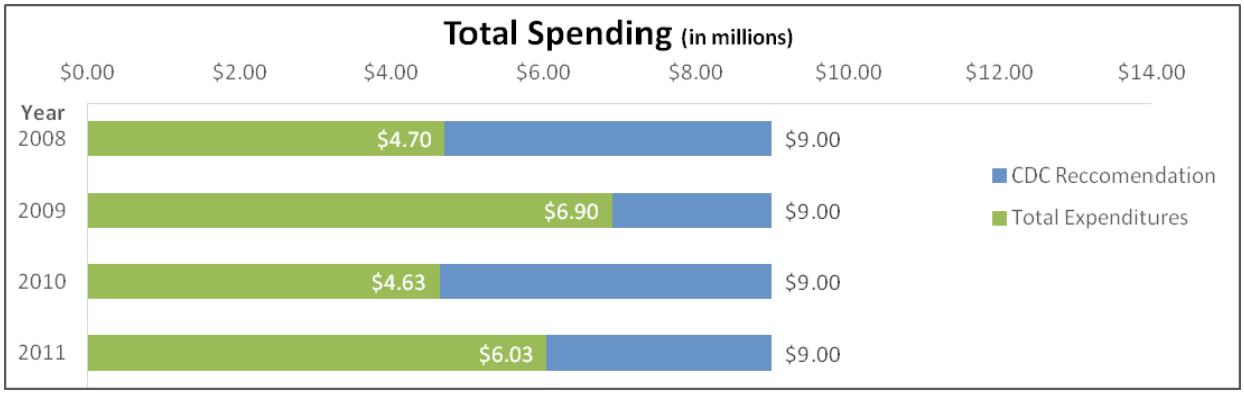
Wyoming's Tobacco Prevention and Control Program (TPCP) began in 1999 within Wyoming's Department of Health (WDH). It implements several tobacco control and prevention initiatives. One of its main initiatives is the establishment of the Tobacco Free Wyoming Community Programs, which runs local tobacco prevention services in 22 counties and the Wind River Indian Reservation (WCCCC, 2006). Wyoming's tobacco prevention initiatives receive funding through the state appropriation from Wyoming's Master Settlement Agreement payments (The Finance Project, 2011). In 1999, Wyoming created the Wyoming Tobacco Settlement Trust Fund to receive annual payments from the Master Settlement Agreement through March 2002. The interest and all MSA payments received after March 2002 went to the Trust Fund Income Account. The money in this account can be spent on efforts in tobacco use and prevention through school and community-based programs. It can also be used to establish and implement programs to prevent and limit alcohol and substance abuse. This money must be appropriated by the state legislature (ALA, 2012).

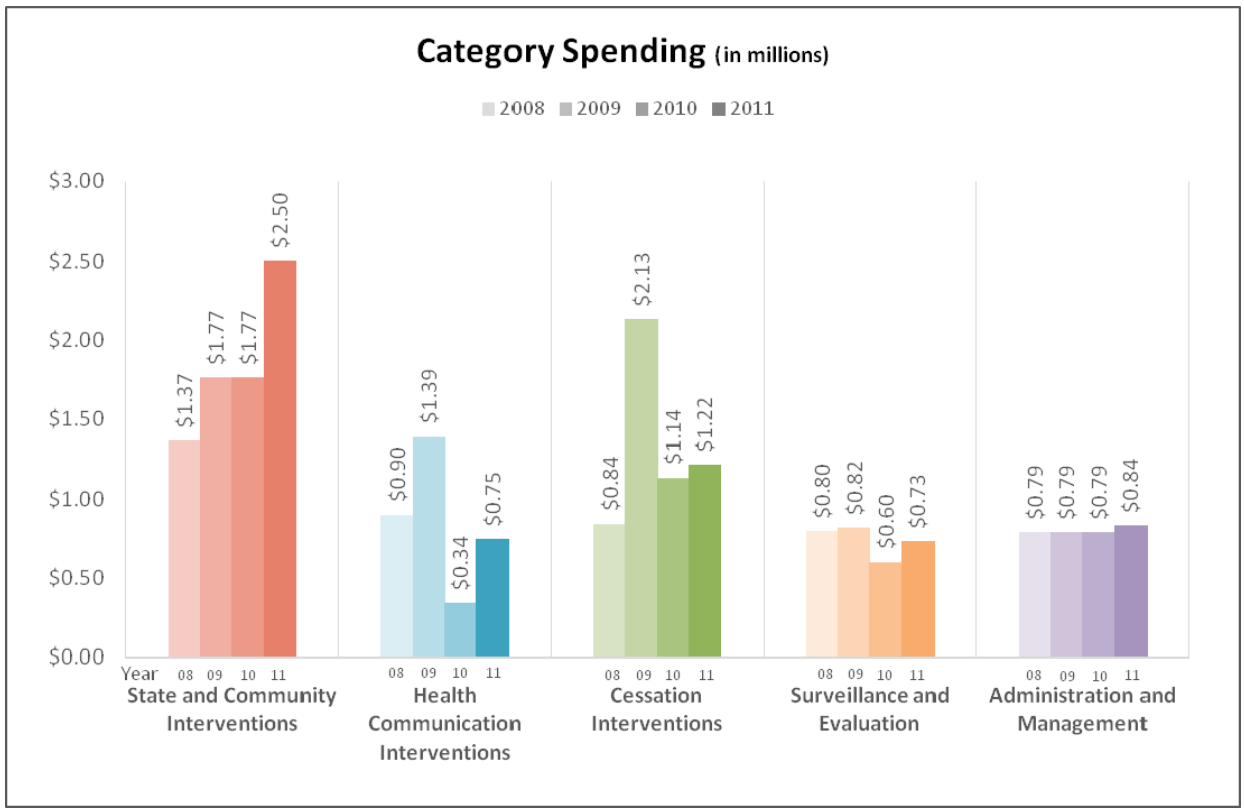
For the 2008 fiscal year, Wyoming spent $4.7 million on tobacco control expenditures, fulfilling 52% of the CDC's suggested spending level. Of these expenditures, the state spent 29% on state and community interventions, 19% on health communications, 18% on cessation interventions, 17% on surveillance and evaluation, and 17% on administration and management. For Wyoming's 2009 fiscal year, tobacco control program funding reached 77% of the CDC's recommendations, or $6.9 million. With this increase in funding, Wyoming used 26% of tobacco control expenditures for state and community interventions, 20% for health communications, 31% for cessation interventions, 12% for surveillance and evaluation, and 11% for administration and management. Wyoming's total for the 2010 fiscal year was $4.63 million, decreasing to 52% of what the CDC suggested Wyoming spend. Of this total provided for tobacco control, 38% was for state and community interventions, 7% was for health communications, 25% was for cessation interventions, 13% was for surveillance and evaluation, and 17% was for administration and management. In the following fiscal year, 2011, Wyoming spent $6.03 million, reaching 67% of the CDC's recommended investment level on tobacco control. Of the $6.03 million, Wyoming funded state and community interventions with 42%, health communications with 12%, cessation interventions with 20%, surveillance and evaluation with 12%, and administration and management with 14% of the state's $6.03 million.

Wyoming

Tobacco Control Spending Profile FY2008 - FY2011

	State and Community Interventions	Health Communication Interventions	Cessation Interventions	Surveillance and Evaluation	Administration and Management	Total		
						Dollars	$ Per Capita	% of CDC
FY2008	$1,365,000	$900,000	$844,000	$800,000	$791,000	$4,700,000	$8.8	52%
FY2009	$1,765,000	$1,390,000	$2,134,000	$820,000	$791,000	$6,900,000	$12.7	77%
FY2010	$1,765,000	$340,000	$1,135,000	$602,000	$791,000	$4,633,000	$8.3	52%
FY2011	$2,504,000	$745,000	$1,219,000	$731,000	$835,000	$6,034,000	$10.7	67%





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