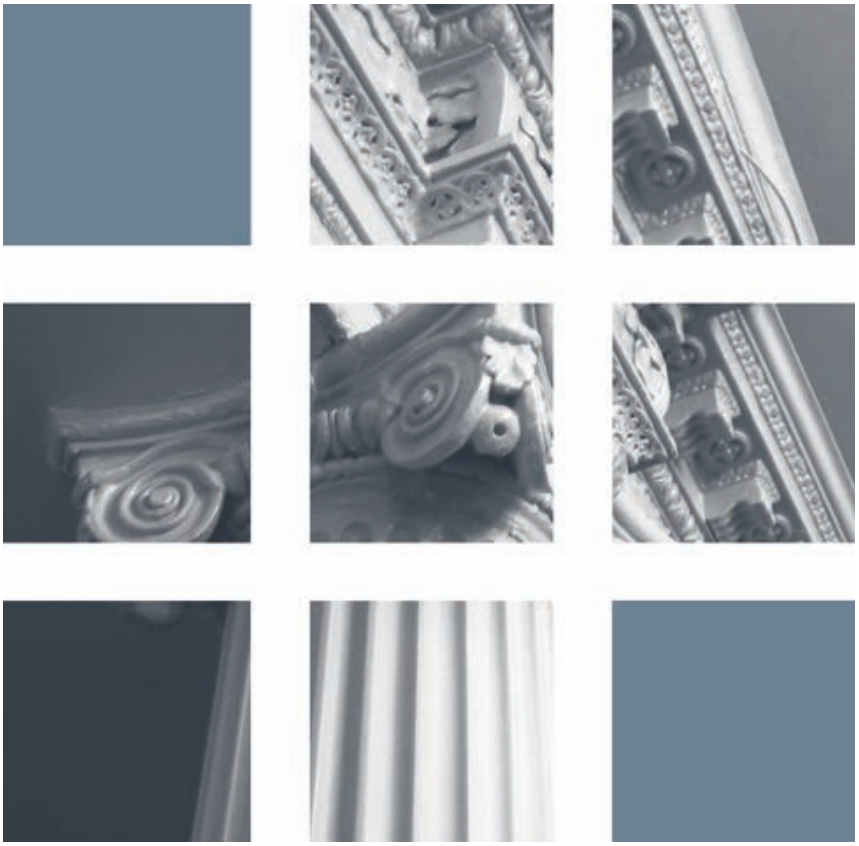
Overview of the Cigarette Restitution Fund (CRF) in Maryland and How CRF Revenues Have Been Spent



Department of Legislative Services 2010

An Overview of the Cigarette Restitution Fund (CRF) in Maryland and How CRF Revenues Have Been Spent

Department of Legislative Services
Office of Policy Analysis
Annapolis, Maryland

December 2010

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DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF THE EXECUTIVE DIRECTOR
MARYLAND GENERAL ASSEMBLY

Karl S. Aro
Executive Director

Warren G. Deschenaux
Director

December 2010

The Honorable Thomas V. Mike Miller, Jr., President of the Senate
The Honorable Michael E. Busch, Speaker of the House of Delegates
Honorable Members of the Maryland General Assembly

Ladies and Gentlemen:

The attached report, titled *An Overview of the Cigarette Restitution Fund (CRF) in Maryland and How CRF Revenues Have Been Spent*, provides an overview of revenue collection into, and expenditures from, the CRF since its inception. The report analyzes revenue trends, both broad and detailed trends in how the funding has been spent, contrasts Maryland's expenditure experience to that of other states, as well as offers some insight into future issues around CRF funding.

The goal in providing you this report is to provide historical context into how current spending priorities have evolved as well as clarify ongoing funding and legal issues. We hope you find it both informative and useful.

This report was prepared by Erin R. Hopwood, Simon G. Powell, and Kathleen K. Wunderlich. Lauren A. Bigelow provided administrative support. Your questions and comments are welcomed.

Sincerely,

Warren G. Deschenaux
Director

WGD/SGP/lab

Contents

An Overview of the Cigarette Restitution Fund (CRF) in Maryland and How CRF Revenues Have Been Spent

Introduction

The Cigarette Restitution Fund (CRF) was established by Chapters 172 and 173 of 1999 and is supported by payments made under the Master Settlement Agreement (MSA)[1]. Through MSA, the settling manufacturers will pay the litigating parties – 46 states (4 states, Florida, Minnesota, Texas, and Mississippi, had previously settled litigation), 5 territories, and the District of Columbia – approximately $206 billion over the next 25 years and beyond, as well as conform to a number of restrictions on marketing to youth and the general public.

The history of the tobacco litigation involving the states is well-documented and is not included in this paper. Rather, the purpose of this paper is to analyze how Maryland has spent the funding received into the CRF.

CRF Revenues

The distribution of MSA funds among the states is determined by formula, with Maryland receiving 2.26% of MSA monies which are adjusted for inflation, volume, and prior settlements. In addition, between 2008 and 2017, the State will collect 3.3% of monies from the Strategic Contribution Fund, distributed according to each state's contribution toward resolution of the state lawsuits against the major tobacco manufacturers. Other contributions include an award from the National Arbitration Panel Award, as well as interest. Further, since the CRF is a nonlapsing special fund, unexpended program funding is also retained in the fund and does not revert to the general fund.[2]

Exhibit 1 details CRF revenues, distinguishing between:

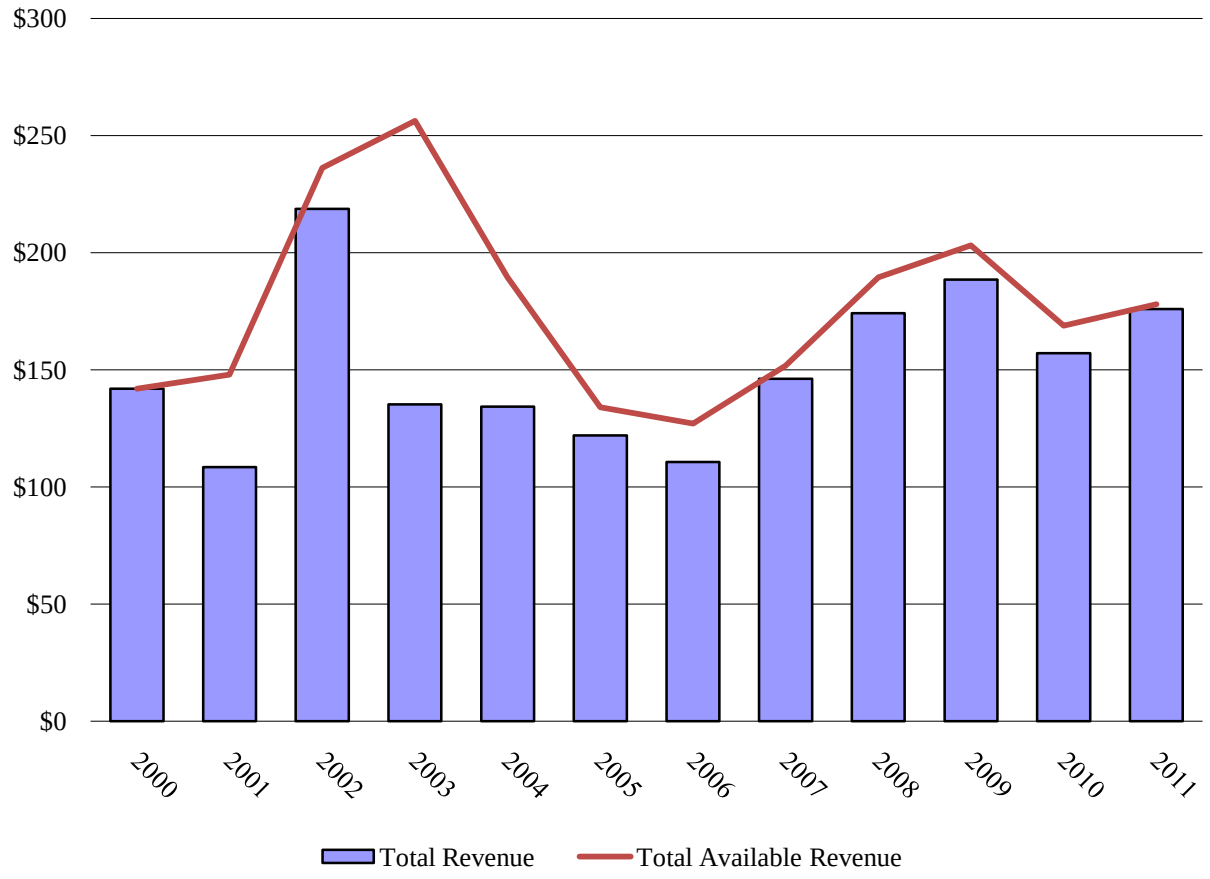
- **Total revenue** which is MSA settlement and other payments and awards adjusted for legal settlement fees and escrowing requirements associated with the nonparticipating manufacturers (NPM) dispute.

- **Total available revenue** which includes unspent fund balances carried over into the subsequent year and prior year recoveries of previously appropriated unexpended funds.

[1] Chapters 501 and 502 of 2007 added language to the CRF statute providing that monies collected from the implementation of the Clean Indoor Air Act be credited to the fund. No material collections have been made from this fund source.

[2] A more detailed breakdown of CRF revenues as well as CRF-supported program expenditures for fiscal 2000 through 2011 is provided in Appendix 1.

Exhibit 1
Cigarette Restitution Fund Revenues
Fiscal 2000-2011
($ in Millions)



Source: Department of Legislative Services; Department of Budget and Management

As shown in the exhibit:

- In the early years of the CRF, revenue patterns were somewhat uncertain. Explanations for this included the timing of the initial payments and the timing of legal settlement escrow payments. As a result, total available revenues jumped dramatically after fiscal 2001 because of available fund balances.

- Between fiscal 2003 and 2005, CRF revenues were reasonably stable, although fund balances as well as other budgeting actions allowed for significantly higher total available revenues in fiscal 2003 and 2004 compared to actual revenues.

- Between fiscal 2006 and 2008, a variety of factors caused some marked changes in revenue. Beginning in fiscal 2006, escrowing associated with the NPM dispute lowered total revenues. Fiscal 2006 revenues were reduced by just over $18 million. Those escrow payments continue through the current period and will remain in effect until the NPM dispute is resolved. In fiscal 2007, legal settlement payments ended, providing an increase in available revenues. Beginning in fiscal 2008, Strategic Contribution Fund revenues added almost $30 million in revenues.

- In the most recent years, MSA revenues are beginning to slowly decline. While total revenue did increase in fiscal 2009 due to an agreement between participating manufacturers and the states to release some of the NPM escrow payments in exchange for getting all of the states into arbitration on the NPM issue, MSA payments have actually fallen from just below $150 million in fiscal 2008 to an anticipated under $140 million in fiscal 2011.

CRF Expenditures: An Overview

The use of the CRF is restricted by statute in a variety of ways. For example:

- at least 50.0% of the funds must be appropriated to fund the Tobacco Use Prevention and Cessation Program, the Cancer Prevention, Education, Screening, and Treatment Program, eight health-related priorities including tobacco control and cessation, cancer prevention, treatment and research, and substance abuse treatment and prevention, and tobacco production alternatives;

- mandated appropriations to the Tobacco Use Prevention and Cessation Program, and the Cancer Prevention, Education, Screening, and Treatment Program;

- at least 30.0% of the funds must be appropriated to Medicaid;

- at least 0.15% of the fund is dedicated to enforcement of Title 16, Subtitle 5 of the Business Regulation Article (Escrow Requirements for Nonparticipating Tobacco Product Manufacturers) by the Office of the Attorney General (OAG); and

- the Governor is required to appropriate at least the lesser of $100 million, or 90.0%, of the estimated funds available in the annual budget.

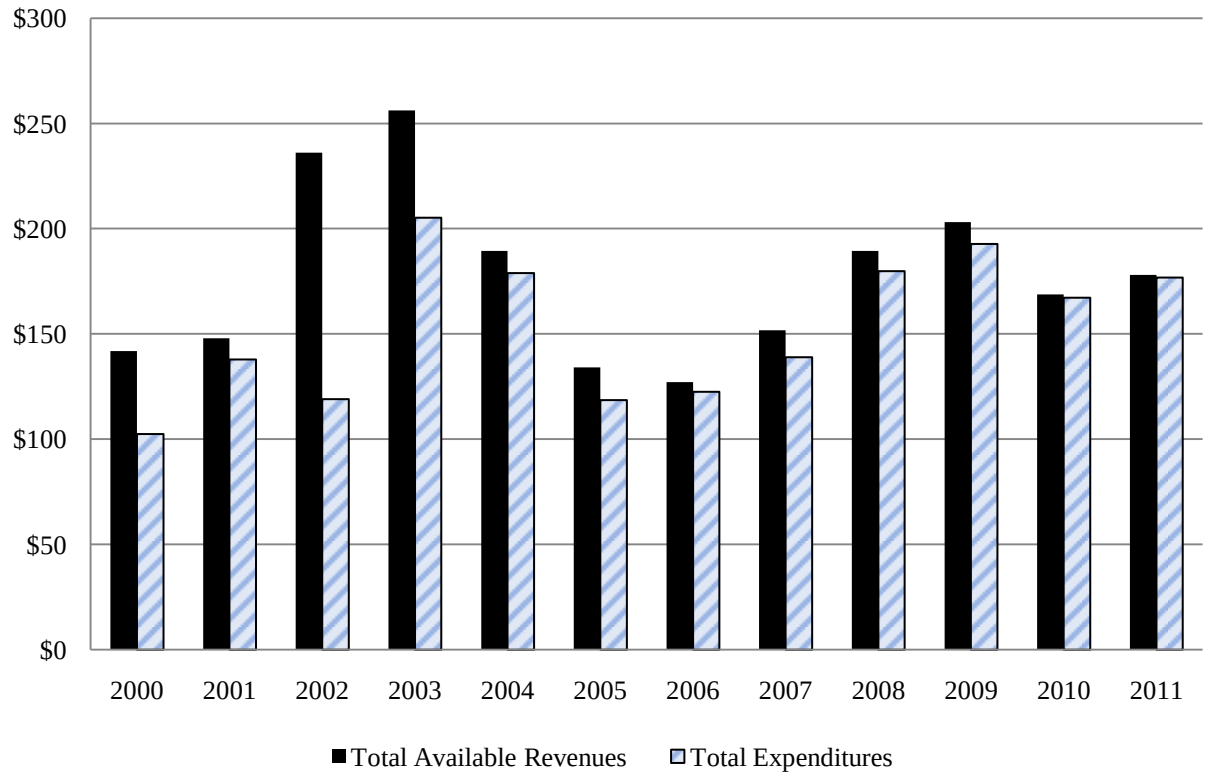
These guidelines were primarily part of Chapters 172 and 173 which originally created the CRF, although the Medicaid requirements were added later.[3]

[3] Chapter 440 of 2002 added a temporary four-year earmark of 25% for Medicaid (fiscal 2003 through 2006). Subsequently, Chapter 444 of 2005 amended the language to that in statute today, removing the four-year window and raising the minimum appropriation to Medicaid of 30%.

In creating the CRF, and in earmarking CRF revenues for specific purposes, Maryland's actions were consistent with the majority of other states in that MSA payments were considered a discrete funding source and attention was paid as to how these revenues should be used. According to the General Accountability Office, at least 30 states established a legislative framework similar to Maryland's as to fund use. In at least 6 other states, voter referenda established dedicated funding and use requirements.

Exhibit 2 provides total CRF expenditures for fiscal 2000 to 2011 (more specific detail is provided below and in Appendix 1). The exhibit compares total available revenues to total expenditures. The main point to be made from this exhibit is that after the initial few years when there was fluctuation in revenues, the Administration has primarily looked to fully utilize CRF revenues each year.

Exhibit 2
Cigarette Restitution Fund
Total Available Revenues and Expenditures
Fiscal 2000-2011
($ in Millions)



Source: Department of Legislative Services; Department of Budget and Management

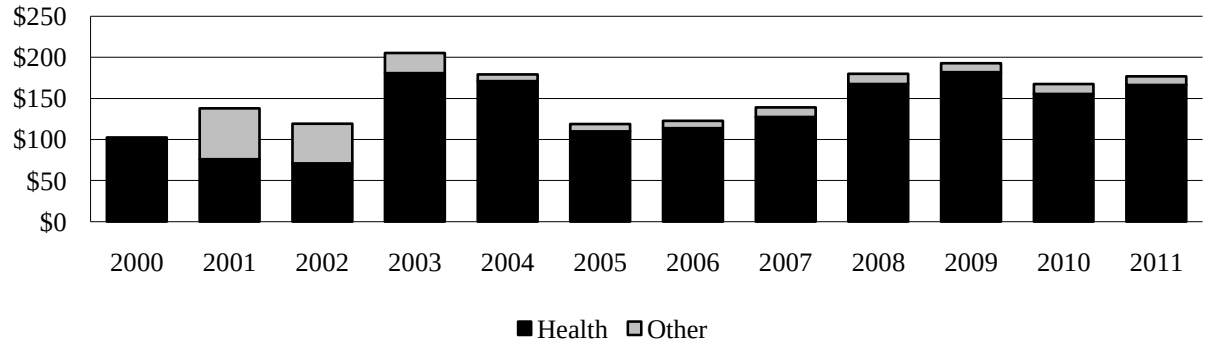
More significant is how the funds have been used. As noted earlier, the legislature enunciated a clear preference for using CRF funds for health-related purposes, specifically noting eight health-related activities, as well as requiring 80% of available funds to be appropriated for primarily health-related activities. While statute does allow the funds to be used for "any other public purpose," as shown in **Exhibit 3,** expenditures have primarily focused on health-related expenditures. Other than fiscal 2001 and 2002, health-related expenditures have never fallen below 88% of total expenditures. Even in fiscal 2001 and 2002, when education-related priorities (for example, K-12 and higher education technology upgrades, teacher mentoring programs, and the Baltimore City Partnership) received funding of almost $48 million and $37 million, respectively, non health-related expenditures accounted for only 40-45% of total expenditures.

Aside from fiscal 2001 and 2002, other than the mandated modest amount of funding for the Office of Attorney General's tobacco-related enforcement activities, the non health-related expenditures have been focused in two areas:

- tobacco-related crop conversion activities (varying between $5.0 million to $8.3 million in the years between fiscal 2002 and 2011), which is also part of the statutory framework; and

- aid to nonpublic schools (varying between $2.8 million and $4.9 million over the same period), which is not a specific part of the statutory framework.

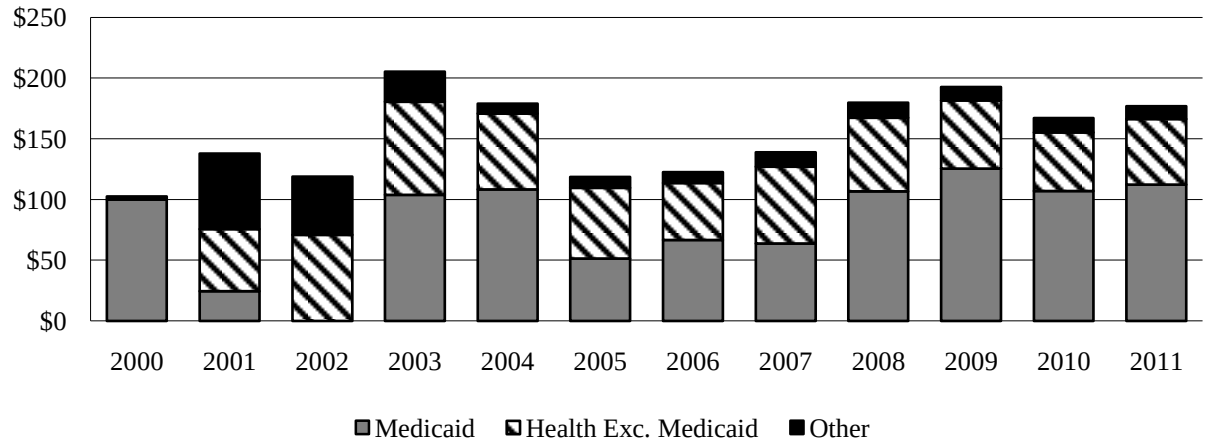
Exhibit 3
Cigarette Restitution Fund Expenditures
Health versus Non-health Expenditures
Fiscal 2000-2011
($ in Millions)



Source: Department of Legislative Services; Department of Budget and Management

In terms of health-related spending, as shown in **Exhibit 4**, after the initial years, Medicaid funding has never fallen below 43% and tends to rise in terms of both dollars and as a percentage of expenditures in times of budget strain. For example, in the last four fiscal years, Medicaid spending accounts for 60 to 65% of CRF expenditures. In fiscal 2008 and 2009, the availability of Strategic Contribution Fund payments meant that this increase in Medicaid funding could be accommodated without cuts in other programming. However, in fiscal 2010 and 2011 (and anticipated in fiscal 2012), in order to maintain a high level of Medicaid funding as well fund the Breast and Cervical Cancer Program with CRF dollars rather than general funds, significant reductions were made in various budget reconciliation and financing legislation to the mandated appropriations for the Tobacco Use Prevention and Cessation Program, and the Cancer Prevention, Education, Screening, and Treatment Program.

Exhibit 4
Cigarette Restitution Fund Expenditures
Various Detail
Fiscal 2000-2011
($ in Millions)



Source: Department of Legislative Services; Department of Budget and Management

CRF Expenditures: Fiscal 2011 Programming and Performance Measurement

The funds received through the CRF are spread over five major health program areas including three major non health-related program areas. Those include:

- tobacco use prevention and cessation;

- cancer prevention, screening, and treatment;
- breast and cervical cancer diagnosis and treatment program;
- substance abuse treatment;
- medicaid provider reimbursements;
- crop conversion;
- education; and
- legal expenses.

Exhibit 5 shows the distribution of funding across the program areas by percent of total CRF appropriation for fiscal 2011. Medicaid payments account for the majority of the funding each year. In fiscal 2011, 63.4% of the total funding from the CRF was dedicated to Medicaid.

The program areas that receive CRF funding can be generally grouped into three main usage categories: fund swap, program enhancement, and new programming. For purposes of this report, legal expenses are not categorized, as this represents funds used to enforce the tobacco settlement.

Exhibit 5
Cigarette Restitution Fund – Funding by Program Area
Fiscal 2011
($ in Thousands)

	FY 11	% of Total
Health		
Tobacco Use Prevention and Cessation	$3,403	1.9%
Cancer Prevention and Treatment	13,759	7.8%
Breast and Cervical Cancer Program	15,200	8.6%
Management – Cancer and Tobacco Programs	680	0.4%
Substance Abuse	21,079	11.9%
Medicaid	112,200	63.4%
Subtotal	**$166,321**	**94.1%**
Non-health		
Crop Conversion	$5,039	2.8%
Education	4,490	2.5%
Legal Expenses	991	0.6%
Subtotal	**$10,520**	**5.9%**
Total	**$176,841**	**100.0%**

Source: Department of Health and Mental Hygiene, Department of Legislative Services

Fund Swaps

Two program areas that receive CRF funding do so as a way to reduce the general fund liability for the State. Those include the Medicaid program and the Breast and Cervical Cancer Diagnosis and Treatment Program (BCCDTP).

Medicaid

Medical assistance (Title XIX of the Social Security Act) is a joint federal and state program that provides assistance to indigent and medically indigent individuals. The federal government covers 50% of Medicaid costs. Medical assistance eligibility is limited to children, pregnant women, elderly or disabled individuals, and low-income parents. To qualify for benefits, applicants must pass certain income and asset tests.

Cigarette Restitution funds have been used to supplant general funds to operate the program since fiscal 2000. In fiscal 2011, $112.2 million of special funds from the CRF were used in the program.

Medicaid enrollment in Maryland has increased significantly due to expanded eligibility and poor economic conditions in the State. Additionally, national health care reform will result in a further increase to the Medicaid enrollment in Maryland. As a result, CRF funds dedicated to the Medicaid program will be expected to exceed the 30% minimum set forth in statute.

Breast and Cervical Cancer Diagnosis and Treatment Program

BCCDTP funds breast and cervical cancer diagnostic and treatment services for uninsured, low-income (below 250% of the federal poverty level) women age 40 and older that are not Medicaid eligible. The BCCDTP covers the following services:

- breast and cervical cancer diagnostic procedures including ultrasound, biopsy, colposcopy, surgical consultations, etc.;
- breast and cervical cancer treatment procedures including cryotherapy, laser hysterectomy, lumpectomy, mastectomy, radiation therapy, and chemotherapy;
- physical therapy, occupational therapy, and a home-health nurse, when required because of breast or cervical cancer;
- medications required for the treatment of breast or cervical cancer;
- medical equipment when required because of breast or cervical cancer including breast prosthesis, bras, and wigs;
- breast reconstruction; and

- other costs related to diagnosis and treatment (laboratory tests, x-rays, and hospital care).

Although the BCCDTP received CRF funding in fiscal 2005 in the amount of $2.5 million, the program did not receive any other CRF funds until fiscal 2010. The program operated with general funds only between fiscal 2006 and 2009. Revenue decline forced the State to reduce its general fund expenditures in many program areas, including the BCCDTP. Beginning in fiscal 2010, special funds from the CRF were used in place of the general funds to cover program expenses.

Program Enhancement

Substance Abuse

In fiscal 2011, the Alcohol and Drug Abuse Administration (ADAA) received just over $21 million in CRF funds for drug treatment programming. This amount has been relatively constant since fiscal 2001 when the ADAA budget contained $18.5 million in special funds from the CRF to expand treatment services. The funds were used primarily for funding treatment at the local levels to address gaps in service. Emphasis was placed on jurisdictions that had waiting lists and that served priority populations, including women with dependent children, criminal and juvenile justice, adolescents, and families. ADAA also used the funds to increase grants to cover salaries for addictions personnel for State employees in the local health departments as well as private providers. Finally, the CRF funds were used for information technology upgrades.

Between fiscal 2001 and 2002, the first year that ADAA received CRF funds, 7,765 new treatment slots were created in the following areas: outpatient (4,382); correctional (1,027); detoxification (859); methadone (841); halfway house (350); and residential (306) slots. The use of special funds from the CRF has continued through fiscal 2011 to maintain these treatment services at the local level.

New Programming

Cancer Prevention, Screening, and Treatment

The cancer prevention, screening, and treatment program areas aim to reduce death and disability due to cancer in Maryland through implementation of local public health and statewide academic health center initiatives. The programs have successfully targeted and reduced the incidence of tobacco-related cancers in Maryland. There are four main components of the cancer prevention, screening, and treatment programs: local public health; statewide programs; surveillance and evaluation; and the academic research centers.

The local public health component accounts for 70% of the total funding under the cancer prevention, screening, and treatment programs. The funds dedicated to this purpose are distributed to local county public health departments, as well as Baltimore City, and are used to

develop clinical guidelines for targeted cancers, to provide for cancer prevention, education, and screening within each county, and to conduct regional training.

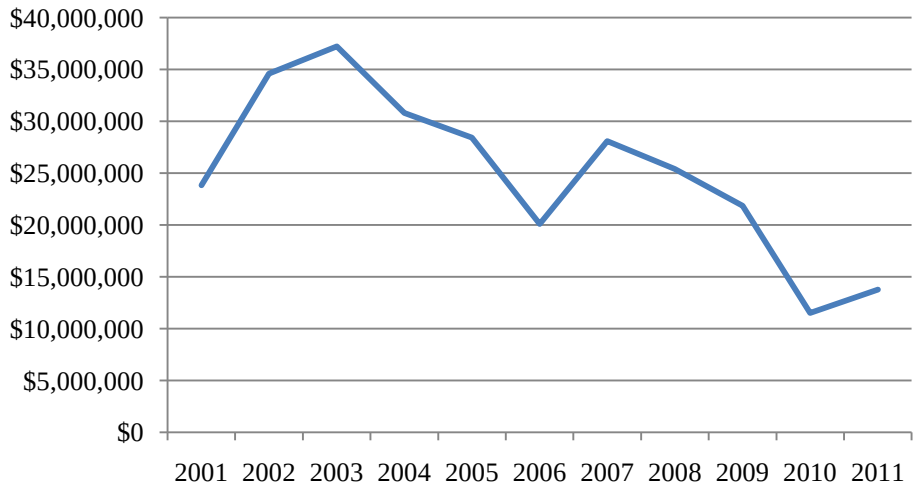
Statewide programs funded under this program target skin cancer prevention and promote sun protection activities. Surveillance and evaluation activities include collecting standardized data on cancer-related activities in each jurisdiction, publishing the annual cancer report, and collecting, analyzing, interpreting and disseminating cancer data from the State. Collectively, these activities account for 14% of the total funding under the cancer prevention, screening, and treatment programs.

The University of Maryland and the Johns Hopkins University receive funding from the CRF under the Statewide Academic Health Center to fund translational cancer research, the Maryland Statewide Health Network, tobacco-related diseases research, and to facilitate faster connection of cancer research findings to practice. Statewide Academic Health Centers receive 17% of the total funds allocated under the cancer prevention, screening, and treatment programs.

Funding

In fiscal 2011, the cancer prevention programs received $13.8 million of CRF funds, representing 7.8% of the total allocation. Although the cancer program still receives a significant amount of CRF funds, the amount has dropped by over 50% since fiscal 2005 due to the transfer of funds to the breast and cervical cancer program and Medicaid. **Exhibit 6** shows the funding level for the cancer prevention, screening, and treatment program since fiscal 2001.

Exhibit 6
Funding for Cancer Prevention, Screening, and Treatment
Fiscal 2001-2011

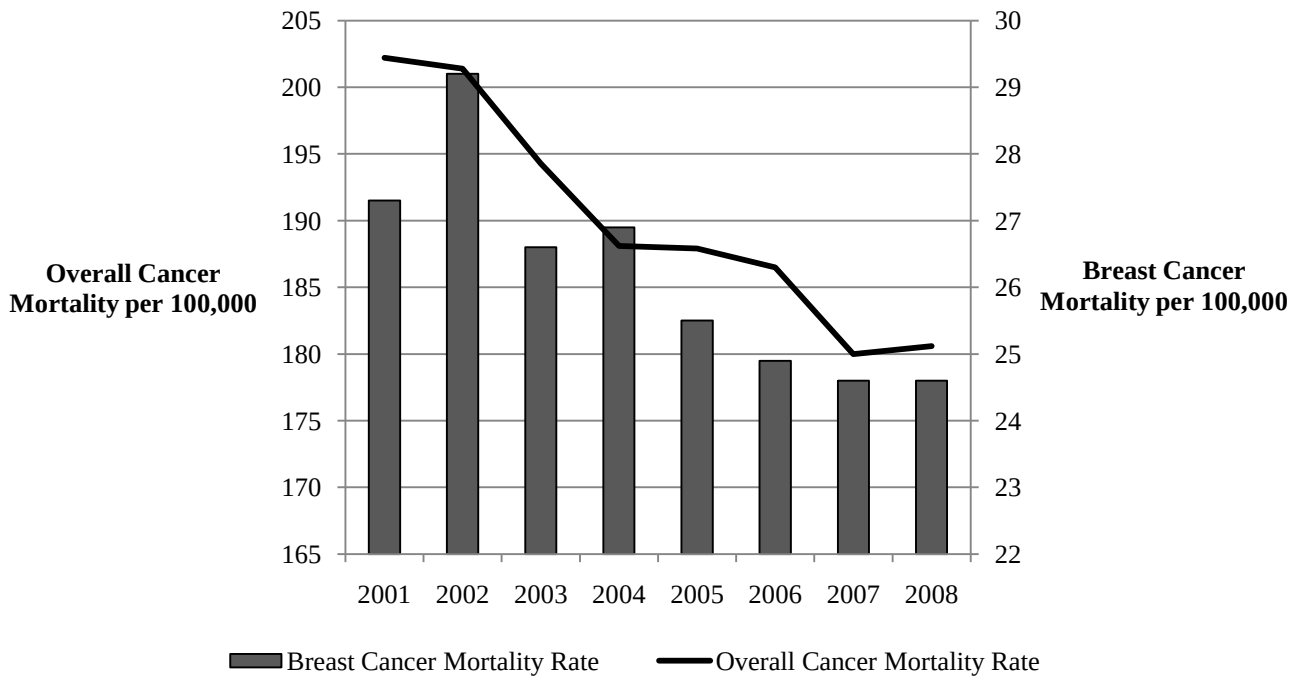


Source: Department of Health and Mental Hygiene

Outcome Measures

One of the main functions of the Cancer Prevention, Education, Screening, and Treatment Program is to fund community-based programs that prevent, detect, and treat cancer. The mission of the program is to reduce the burden of cancer among Maryland residents by reducing overall cancer mortality in the State. **Exhibit 7** shows the program has successfully reduced the overall cancer mortality rate. The exhibit also shows that there has been a significant drop in breast cancer mortality as well. The cancer programs within the CRF program target colorectal cancer, prostate cancer, and cancers associated with tobacco use.

Exhibit 7
Cancer Mortality Rates
Calendar 2001-2008



Source: Department of Health and Mental Hygiene

Tobacco Cessation

The tobacco use, prevention, and cessation program aims to reduce the use of tobacco products and the burden of tobacco-related morbidity and mortality in the State. The components of the program include local public health, surveillance and evaluation, and counter marketing/media.

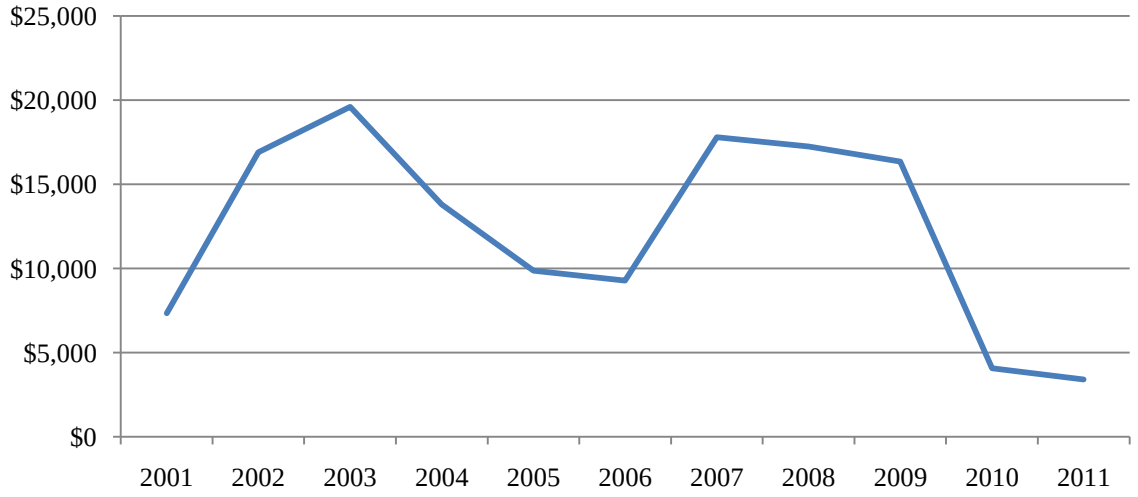
The local public health component accounts for 80% of the total funding for the tobacco use, prevention, and cessation program. Funding is distributed to each jurisdiction within the State and is used to establish community coalitions, fund awareness, prevention and cessation activities, and conduct regional training.

The surveillance and evaluation activities account for 13% of the total funding under tobacco use, prevention, and cessation. The funding is used for collecting, analyzing and disseminating tobacco data and distributing best practices to local programs. Although funding for countermarketing and statewide public health activities have been significantly reduced in recent years, the program still runs the Maryland Quitline and a CRF-sponsored website www.SmokingStopsHere.com.

Funding

Funding for tobacco use prevention and cessation activities has varied widely since fiscal 2001. **Exhibit 8** shows funding for the program between fiscal 2001 and 2011. As mentioned earlier in this report, Maryland law requires the Governor to include a certain amount of money each year for tobacco cessation and use prevention activities. During the 2009 and 2010 sessions, the General Assembly acted to reduce the required amount due to budget constraints.

Exhibit 8
Funding for Tobacco Use Prevention and Cessation
Fiscal 2001-2011
($ in Thousands)

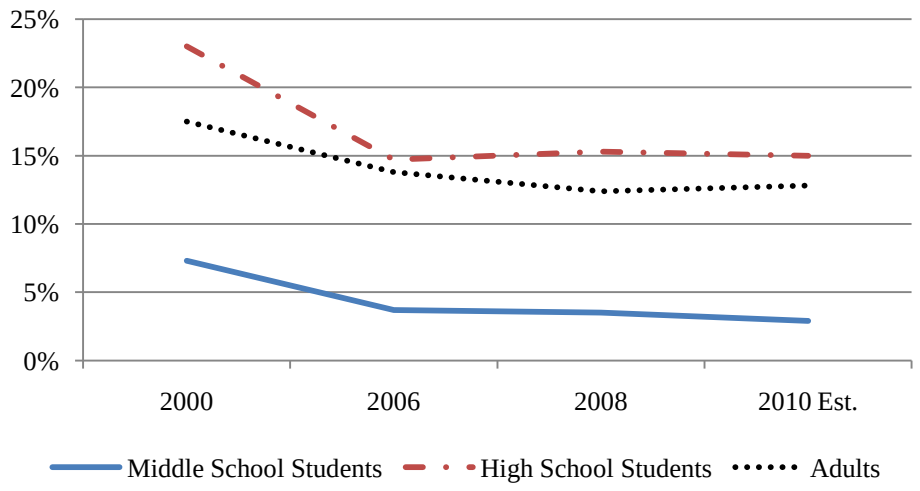


Source: Department of Budget and Management

Outcome Measures

One of the program's goals is to reduce the proportion of Maryland youth and adults who currently smoke cigarettes. **Exhibit 9** shows tobacco usage rates for Maryland middle school students, high school students, and adults. As the graph demonstrates, there was a decrease in usage between calendar 2000 and 2006. However, since that time, usage rates have stayed relatively consistent. In the case of high school students, the usage rate went up between calendar 2006 and 2008. One reason for the stagnation of usage rates may be the elimination of funding from tobacco programs including countermarketing and media initiatives which fund anti-smoking campaigns targeted to school-aged children.

Exhibit 9
Tobacco Usage Rates
Calendar 2000-2010



Source: Department of Health and Mental Hygiene

Crop Conversion

One purpose of the CRF is to fund the implementation of the Southern Maryland Regional Strategy Action Plan for Agriculture adopted by the Tri-County Council (TCC) for Southern Maryland with an emphasis on alternative crop uses for agricultural land now used for growing tobacco. Funds are appropriated to the Maryland Department of Agriculture (MDA), which then issues grants to TCC. TCC is a nonprofit, quasi-governmental body that works with the Southern Maryland Agricultural Development Commission to develop programs to stabilize the region's agricultural economy as Maryland growers' transition away from tobacco production.

TCC's Strategy Action Plan has three main components: the tobacco buyout (first priority), agricultural land preservation (second priority), and infrastructure/agricultural development (third priority).

- The tobacco buyout component is a voluntary program that provides funds to (1) support all eligible Maryland tobacco growers who choose to give up tobacco production forever while remaining in agricultural production; and (2) restrict the land from tobacco production for 10 years, should the land transfer to new ownership. A total of 854 farmers and 7.65 million pounds of tobacco are enrolled in the program and out of production.

- The agricultural land preservation component seeks to provide an incentive to tobacco farmers to place land in agricultural preservation, enhance participation in existing preservation programs, and assist in the acquisition of land for farmers' markets. The 10-year agricultural land preservation goal established in 2001 is to protect 35,000 acres.

- The infrastructure/agricultural development program seeks to foster profitable natural resource-based economic development for Southern Maryland by helping farmers and related businesses to diversify and develop and/or expand market-driven agricultural enterprises in the region through economic development and education.

Outcome Measures

The performance data associated with TCC's efforts to help farmers transition to other agricultural opportunities, suggest a performance plateau for both farmers benefiting from farmers' market promotion enhancement and agri-businesses enhanced/developed.

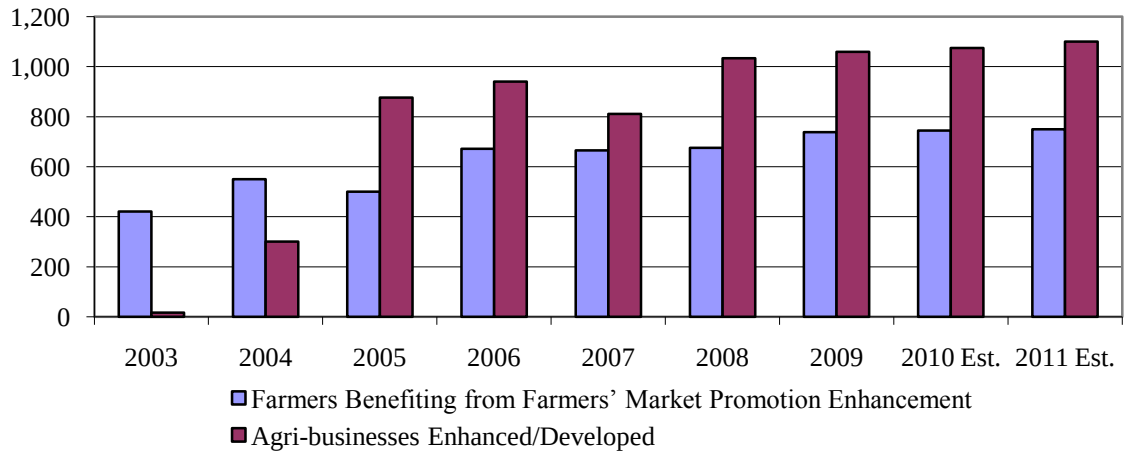
As shown in **Exhibit 10**, the number of agri-businesses benefiting from TCC's marketing efforts only increased by 25 between fiscal 2008 and 2009, whereas it increased by 223 between fiscal 2007 and 2008. In contrast, the number of farmers benefiting from farmers' market promotions increased by 63 between fiscal 2008 and 2009, while it increased by only 10 between fiscal 2007 and 2008.

Education

The majority of funds dedicated to education support nonpublic schools for the purchase of textbooks or computer hardware and software and other electronically delivered learning materials. In fiscal 2011, $4.4 million was appropriated for this purpose from the CRF. All nonpublic schools are eligible to apply. Those schools where at least 20% of the students are eligible for the free or reduced-price lunch program, receive a distribution of $90 per student. Schools that do not meet those criteria are eligible to receive up to $60 per student.

Since this program is a formula-based aid to nonpublic schools, there is no outcome measure to mention.

Exhibit 10
Tobacco Transition Program
Fiscal 2003-2011



Source: Maryland Department of Agriculture

CRF Expenditures: Maryland and Other States

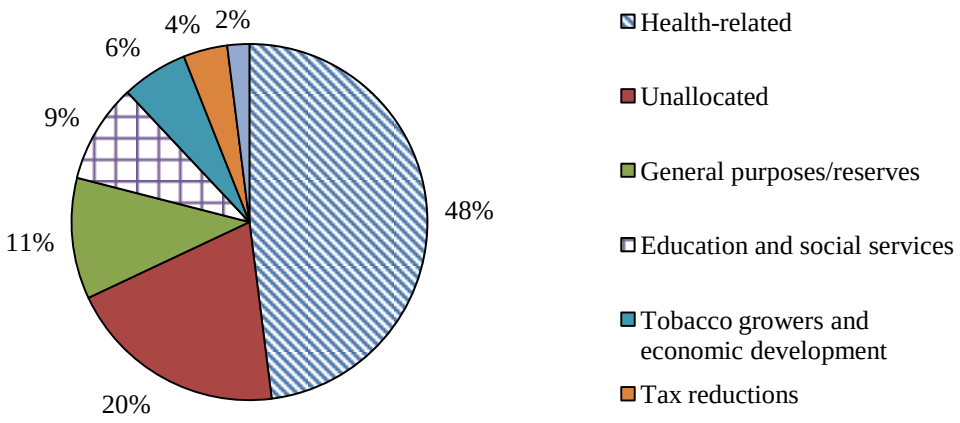
The legislative framework established for CRF expenditures has resulted in a strong and continuing focus on health-related expenditures, even in times of budget constraint. This ongoing focus is somewhat different from other states, where CRF revenues have been used for a wider variety of expenditures. **Exhibits 11** and **12** detail state expenditures immediately after the MSA settlement for state fiscal years 2000 and 2001. Exhibit 11 is aggregated national data, while Exhibit 12 is Maryland-specific data for the same time period. As shown in the exhibits:

- Initially, health-related expenditures were about half of total expenditures both nationally (48%) and in Maryland (52%).

- Unsurprisingly, given the typical issues of program start-up, at the national level, a large percentage of MSA revenues were simply unallocated or placed in reserves, 31%. This was also somewhat the case in Maryland where significant funds were put aside to settle litigation over attorney fees (33%).

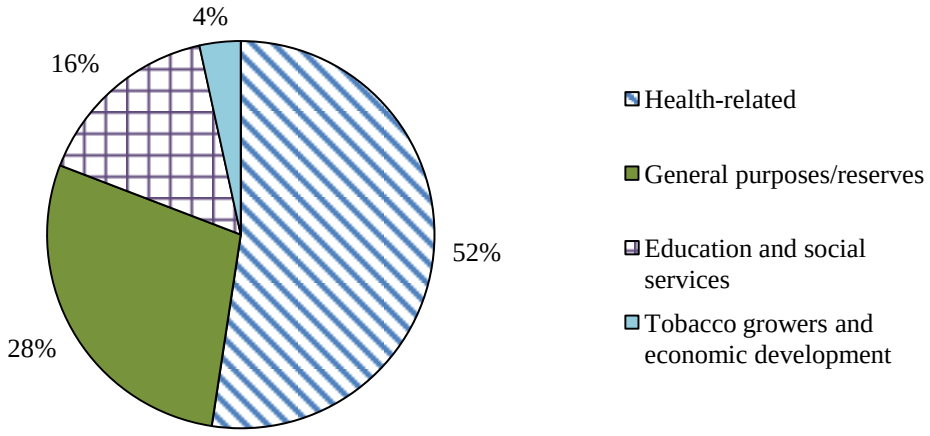
- At both the national (6%) and Maryland (4%) level, a relatively small percentage of funds were used to assist tobacco growers converting to alternative crops.

Exhibit 11
Master Settlement Agreement
Settlement Payment Uses – National Aggregate Data
Combined Fiscal 2000 and 2001



Source: General Accountability Office

Exhibit 12
Master Settlement Agreement
Settlement Payment Uses – Maryland
Combined Fiscal 2000 and 2001



Source: Department of Legislative Services; Department of Budget and Management

Over time, these initial spending patterns have changed somewhat. **Exhibit 13** and **14** detail state expenditures for state fiscal 2010, with Exhibit 13 being aggregated available national data and Exhibit 14 Maryland specific data. From these exhibits two main points emerge:

- Health-related spending nationally has remained at half of total expenditures, whereas in Maryland the growth in health-related spending results in 93% of fiscal 2010 expenditures being health-related.

- Just over one-quarter of MSA payments nationally are used to pay debt service on securitized funds. It is not precisely how revenues generated though securitization have been expended. To be sure, in many states, expenditures based on the securitized funds are health-related. However, some states, for example Wisconsin and Rhode Island, have also used all or significant portions of securitized payments for deficit reduction and general operating expenses.

Securitization

Securitization involves the selling of rights to an expected stream of revenue to investors in return for receiving a lump-sum payment now. Eighteen states have securitized all or a portion of their MSA payments since 2000. A recent estimate puts MSA payments acting as collateral for nearly $56 billion in bonds. The advantages of securitization include:

- accelerated receipt of funds;

- some degree of higher budget certainty as MSA revenues can vary from year to year; and

- a reduction in the potential risk of tobacco company default on future MSA payments (although there is no certainty that bond holders would not be able to recoup investment losses from the government entity that had originally securitized the MSA payments, clearly undermining this advantage).

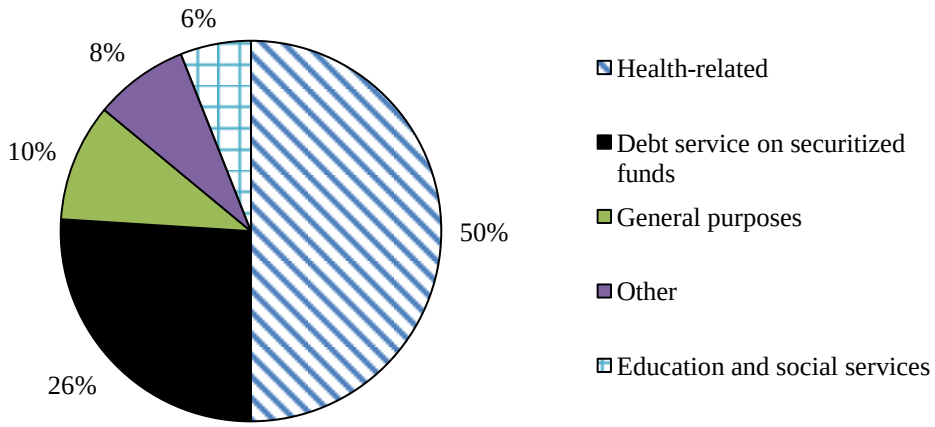
However, these potential advantages are offset by the costs of securitization:

- the up-front lump sum may offer advantages for jurisdictions needing a large pool of funding in the short-term, but it obviously reduces future payments; and

- interest and transactional costs.

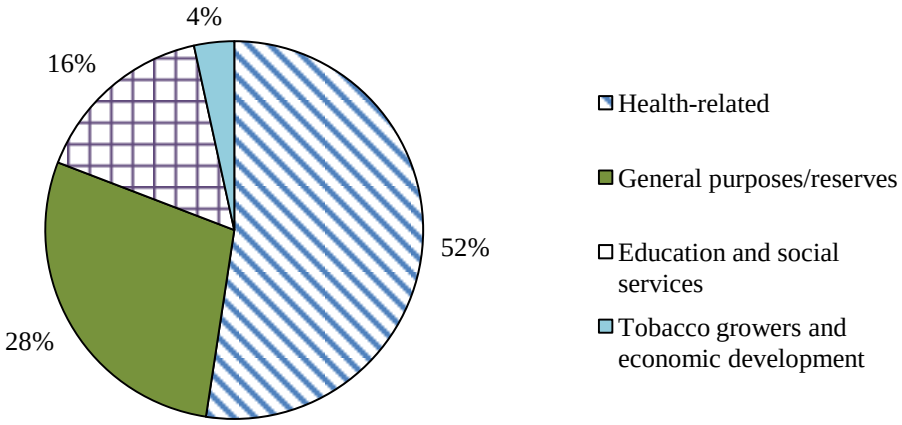
There has been little interest in Maryland to securitize its MSA payments. In the 2008 session, House Bill 1597 proposed to establish a Maryland Tobacco Settlement Securitization Authority to issue bonds secured by MSA revenues. The bill was unsuccessful, although the chairs of the House Appropriations and Health and Government Operations committees wrote a letter to the Treasurer asking that office to further study the issue. The Treasurer's Office ultimately advised against the idea. Given the recent declines in MSA revenues and concerns about the financing of tobacco settlement bonds as a result, there is little to suggest that this idea should be reconsidered.

Exhibit 13
Master Settlement Agreement
Settlement Payment Uses – National Aggregate Data
Fiscal 2010



Source: The Finance Project

Exhibit 14
Master Settlement Agreement
Settlement Payment Uses – Maryland
Fiscal 2010



Source: Department of Legislative Services; Department of Budget and Management

Campaign for Tobacco Free Kids – Tobacco Prevention Programs

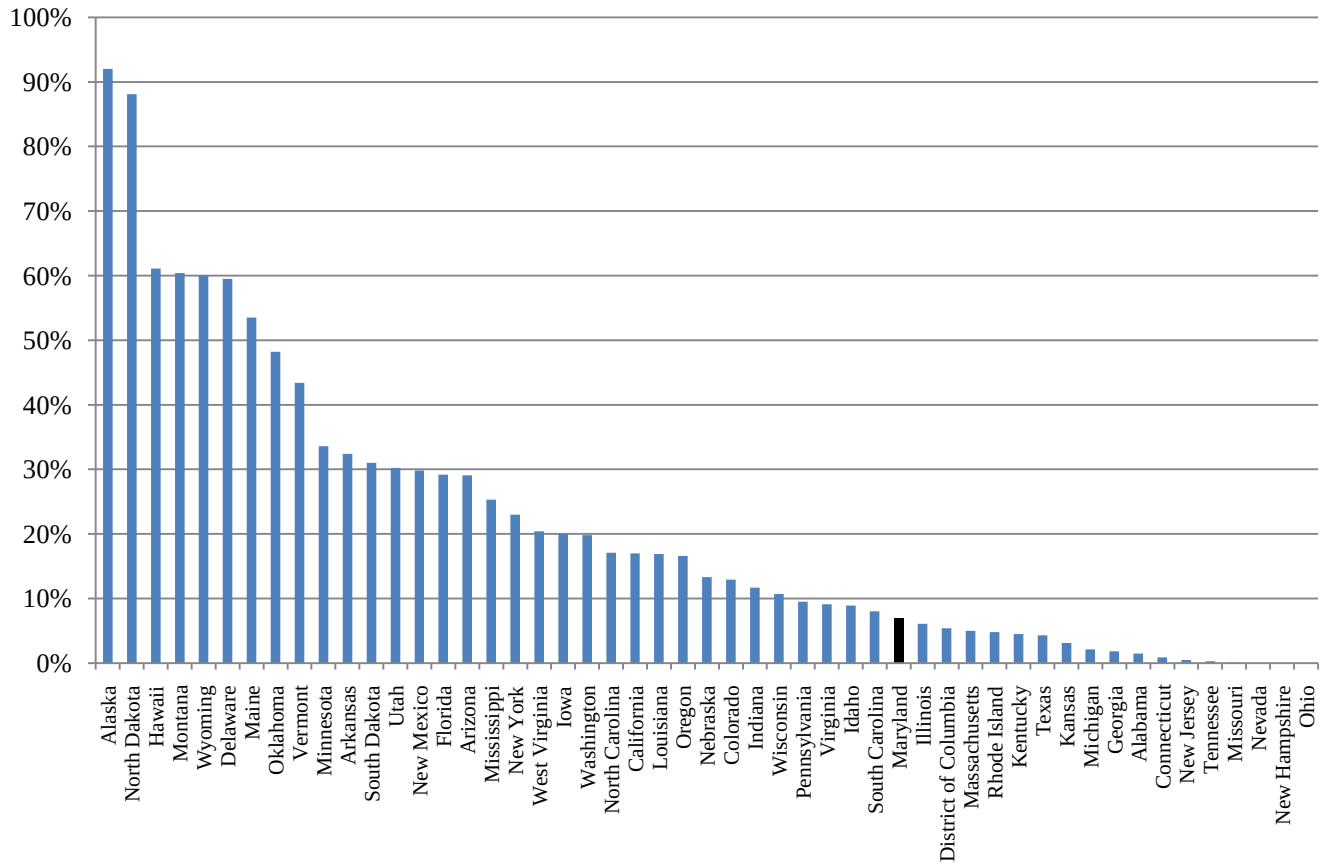
Although MSA funds are unrestricted, interest groups such as the Campaign for Tobacco Free Kids follow the states' use of MSA funds for specific purposes. In its November 2010 report, "A Broken Promise to our Children: The 1998 State Tobacco Settlement 12 Years Later: A Report on the States' Allocation of Tobacco Settlement Dollars," the Campaign for Tobacco Free Kids assessed and ranked the states based on whether they were funding tobacco prevention programs at levels recommended by the Centers for Disease Control (CDC). CDC first recommended funding levels for comprehensive tobacco control programs in 1999. Since that time, CDC has updated its recommendations to include the following program elements: (1) state and community interventions that incorporate a variety of activities including chronic disease and tobacco-related disparity elimination initiatives and interventions specifically aimed at influencing youth; (2) health communications interventions; (3) cessation interventions; (4) surveillance and evaluation; and (5) administration and management. For each element, CDC established upper and lower spending limits and a recommended spending amount.

The report found that states have cut funding for tobacco prevention and cessation programs to the lowest level since 1999. The report found that only 2 states, North Dakota and Alaska, currently fund tobacco preventions program at the CDC-recommended level. Only 5 other states are funding tobacco prevention programs at even half the CDC recommended levels, while 33 states and the District of Columbia are providing less than a quarter of the CDC-recommended amounts. Nevada, New Hampshire, and Ohio provide no state funding for tobacco prevention programs.

Like other states, Maryland has cut funding for tobacco cessation programs since receiving settlement funds in 1999. In fiscal 2011, the Campaign for Tobacco Free Kids reported that Maryland spent $4.3 million on tobacco cessation (which is less than 10% of CDC-recommended levels for tobacco cessation) and ranked thirty-fourth among states for spending recommended amounts on tobacco cessation.[4] In fiscal 2000, Maryland spent $30.0 million on tobacco cessation, which was 99% of CDC-recommended levels. **Exhibit 15** shows how states ranked in fiscal 2011 for spending CDC-recommended levels on tobacco prevention and cessation programs.

[4] The Campaign for Tobacco Free Kids does not include federal funding in its estimate of spending. This particular accounting explains the variation between the amount used by the campaign in its material compared to the figure noted elsewhere in this document for tobacco cessation and prevention activities.

Exhibit 15
Relative Spending on Tobacco Prevention and Cessation Programs
Fiscal 2011
(% of CDC-recommended Levels)



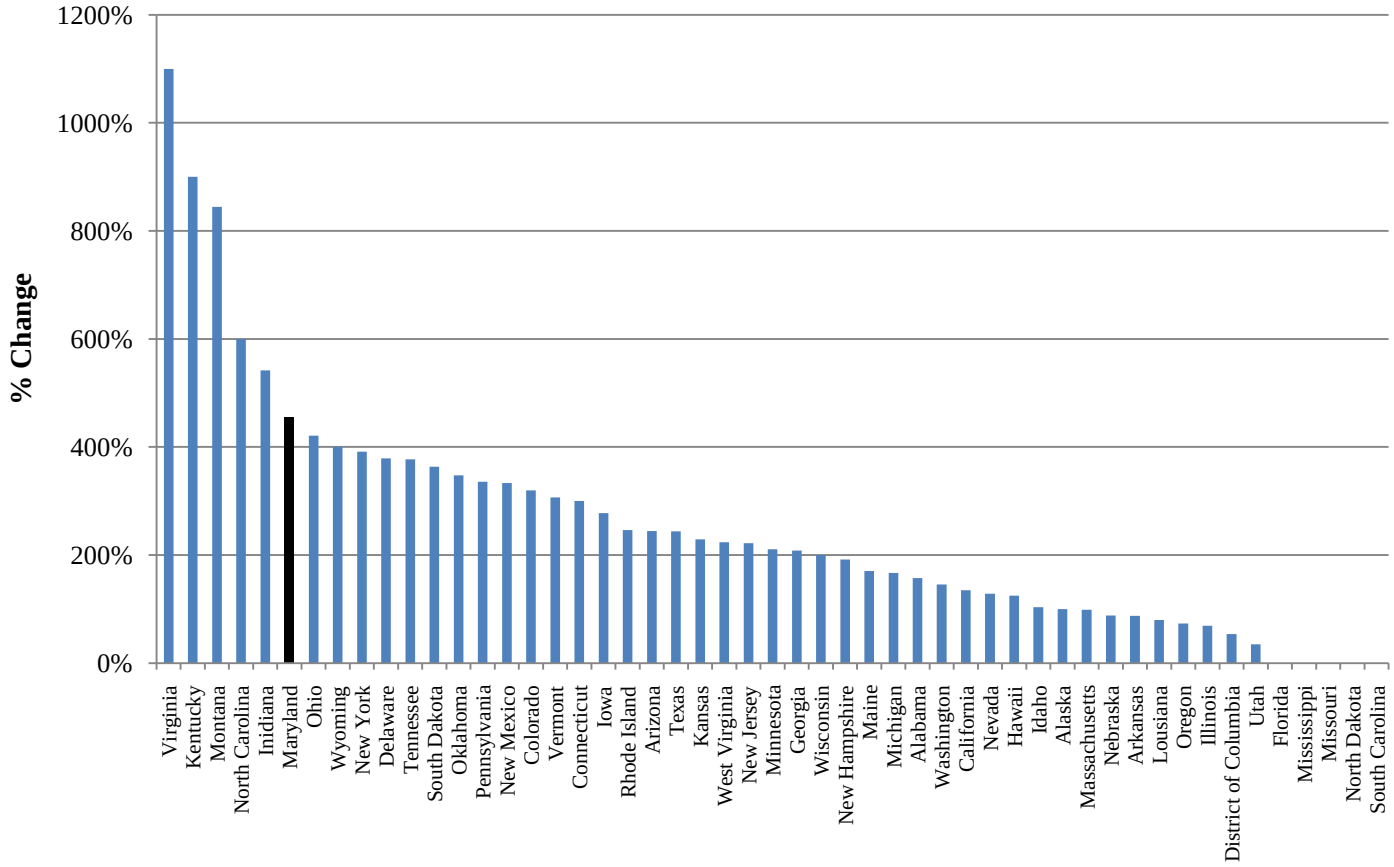
CDC: Centers for Disease Control

Source: Campaign for Tobacco Free Kids

Cigarette Excise Taxes

If the State's financial commitment to tobacco prevention and cessation programs has dwindled in recent years, the State has significantly raised cigarette excise taxes. Most commentators believe that raising the cost of cigarettes and other tobacco products has a significant impact in deterring smoking, especially among youth. As shown in **Exhibit 16**, between 1998 and 2008, Maryland increased its excise tax on cigarettes by over 400%, the sixth highest relative change in that period.

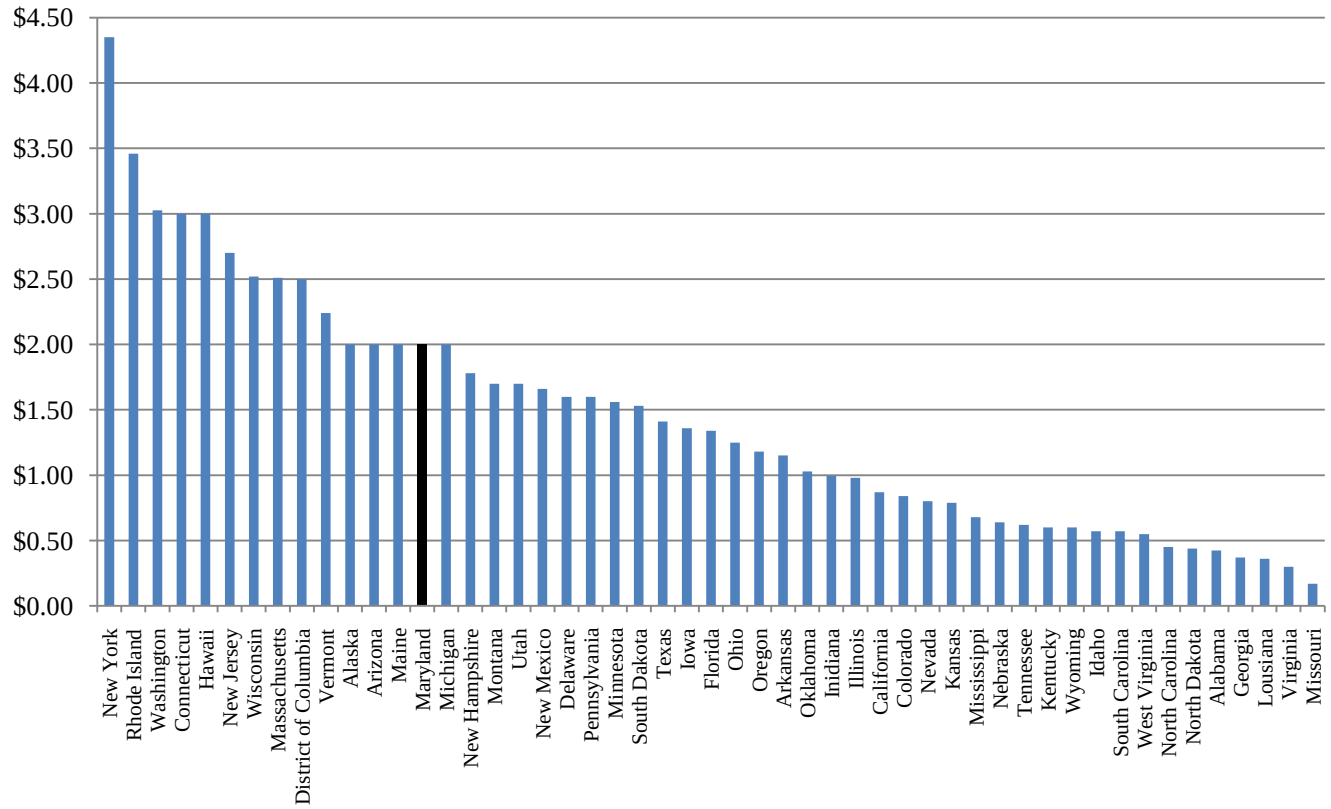
Exhibit 16
Percentage Increase in State Cigarette Excise Rates
1998-2008



Source: *Tobacco Regulation through Litigation: The Master Settlement Agreement*, W.K. Viscusi and J. Hersch, September, 2009

Just as important, unlike Virginia, Kentucky, and North Carolina for example, which had even higher rates of change, as shown in **Exhibit 17** the impact of these changes was to place Maryland's excise tax on cigarettes as the eleventh highest in the country. Although, as also shown in this exhibit, at $2 per pack, Maryland's rate is still less than half that of New York.

Exhibit 17
State Cigarette Excise Rates Effective July 1, 2010
($ Per Pack)



Source: National Conference of State Legislatures

What Is Ahead for the CRF?

Two issues will continue to shape spending in fiscal 2012 and in the near future: the impact of ongoing budget constraints and pending litigation.

CRF and Spending in Fiscal 2012: Ongoing Budget Constraint on Tobacco Cessation and Cancer Prevention Programs

The cancer and tobacco programs are required to be included in the Governor's budget at specified dollar amounts. According to Title 13, subtitles 10 and 11, of the Health General Article, the programs are to be included in the Governor's budget as follows:

- tobacco use prevention and cessation programs: $6.0 million in fiscal 2011 and 2012; $10.0 million in fiscal 2013 and each fiscal year thereafter.

- cancer prevention, screening, and treatment programs: $2.4 million in fiscal 2011 and 2012; $13 million in fiscal 2013 and each fiscal year thereafter.

The funding level for these programs has fluctuated over the last few years due to budget cuts. The Budget Reconciliation and Financing Act of 2010 was used to make temporary and permanent changes to the mandated funding levels. **Exhibit 18** shows that the mandated level was reduced in fiscal 2011 and 2012 for both the tobacco and cancer programs. Although the law increases the amount in fiscal 2013 and beyond, it is still well below the amount mandated in fiscal 2009.

Exhibit 18
Temporary and Permanent Reductions to Mandated Funding Levels of the CRF Program
Fiscal 2009-2013
($ in Millions)

	2009	2010	2011	2012	2013 and beyond	% Change from 2009 to 2011	% Change from 2009 to 2013 Permanent Level
Tobacco Use Prevention and Cessation	**$21.0**	**$7.0**	**$6.0**	**$6.0**	**$10.0**	**-71.4%**	**-52.4%**
Total Statewide Academic Health Centers	**$15.4**	**$9.9**	**$2.4**	**$2.4**	**$13.0**	**-84.4%**	**-15.6%**
Cancer Research Grants	$10.4	$6.7	$2.4	$2.4	$13.0	-76.9%	25.0%
Tobacco-related Disease Research Grants	2.0	1.3	0.0	0.0	0.0	-100.0%	-100.0%
Statewide Network Grants	3.0	1.9	0.0	0.0	0.0	-100.0%	-100.0%

Source: Department of Legislative Services

The recent cuts in the tobacco prevention and statewide academic health center grants have raised questions about the competition for resources between these programs and Medicaid. As noted earlier, the initial 1999 legislation establishing the CRF and the funding priorities did not include any specific earmark for Medicaid. One reason for this was the concern that Medicaid funding would crowd out other priorities. While on balance, as noted earlier in Exhibits 11 through 14, Maryland has retained a health-centered focus for CRF expenditures, the concerns about Medicaid have to some extent come to pass.

However, it should be noted that:

- the MSA agreement reimburses states for previously incurred and ongoing costs borne by the states for tobacco-related illnesses, primarily in the Medicaid program;

- Although there is no specific data available for Maryland, CDC estimates that 11% of all Medicaid expenditures are for tobacco-related illnesses. In fiscal 2011 in Maryland, this would amount to a State share of spending equivalent to an estimated $328 million, significantly below the actual CRF support for Medicaid.

Legal Challenges to the Master Settlement Agreement

Legal actions by manufacturers participating in MSA continue to influence the amount of tobacco settlement revenues available to the states. These manufacturers contend that manufacturers not participating in the agreement have increased market share by exploiting legal loopholes to reduce their escrow payments to the states, giving those manufacturers a competitive advantage in the pricing of their products.

MSA authorizes participating manufacturers that lose a certain share of the market to withhold three times the amount of their losses. This withholding is known as NPM adjustment. The agreement allows participating manufacturers to pursue this adjustment on an annual basis. In April 2005, the participating manufacturers gave notice to the State Attorneys General that they were pursuing an NPM adjustment with respect to a loss of market share in sales year 2003 (impacting revenue in fiscal 2007). A similar adjustment has been sought for subsequent sales years.

According to MSA, the litigants must meet a three-prong test in order to reduce their MSA payments:

- there must be a demonstrated market share loss by participating manufacturers;

- if a market share is demonstrated, participation in MSA must be ruled as a significant factor contributing to that loss; and

- a state must be found to be not diligently enforcing its qualifying statute in that specific sales year. The qualifying statute is a model statute that was included in MSA and intended

to level the playing field with respect to price between participating and nonparticipating tobacco manufacturers by requiring nonparticipating manufacturers to either join MSA or make refundable deposits into an escrow account based on the number of cigarettes they sell in the state. Maryland formally adopted its qualifying statute in Chapter 169 of 1999, subsequently amended in 2001 and 2004.

There is no doubt that manufacturers participating in MSA have lost market share since MSA was signed. Market share loss (off of the base established in MSA) in sales year 2003 for example, was calculated at 6.2%. In March 2006, an arbitrator ruled that MSA was a significant factor contributing to the participating manufacturers' 2003 loss of market share, thus allowing a 2003 NPM adjustment. The March 2006 ruling entitled the tobacco manufacturers to reduce their 2006 Master Settlement payment by approximately $1.1 billion, or 18.0%, of which Maryland's share is approximately $26.0 million. Of this amount, $15.7 million (representing the payments from RJ Reynolds and Lorillard) was placed into escrow pending the resolution of this litigation. Philip Morris and several other participating manufacturers ultimately chose to continue to make its payments under MSA and those payments are reflected in State CRF revenues but are nonetheless subject to dispute.

At this point, it is the third part of the process outlined above that is being litigated: Was the State diligently enforcing its qualifying statute? The potential consequences of this litigation are significant. If one state wins diligent enforcement, that state's share of the NPM adjustment will be deducted from those states that are found not to have diligently enforced. Consequently, if Maryland is found not to have diligently enforced its qualifying statute, it is possible that Maryland's share of the 2003 adjustment could exceed $26.0 million, rising up to the value of the State's full 2006 Master Settlement payment or approximately $158.2 million. The actual amount would depend on how many other states are found not to have diligently enforced their qualifying statute. A similar process will occur for subsequent sales years.

Resolving this issue has involved several rounds of legal battles in Maryland but is now in national arbitration. The Office of the Attorney General notes that arbitration on sales year 2003 began during calendar 2010. At this stage, the hearings are dealing with preliminary legal and jurisdictional issues. Rulings are unlikely for another year or perhaps longer. At this point, this ongoing delay calls into question assumptions made in terms of the fiscal 2011 CRF revenues that the State would be receiving $12 million from prior year escrowing associated with the NPM litigation. Based on prior years, this is likely simply to add to the deficiency anticipated for Medicaid in the 2011 session.

Appendix 1
Cigarette Restitution Fund Budget Estimates
($ in Millions)

	FY 00	FY 01	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10 Working	FY 11 Adj. Appropriation
Beginning Fund Balance	$0.0	$39.4	$10.0	$117.1	$51.0	$10.5	$15.4	$4.5	$12.9	$9.6	10.3	1.5
Settlement Payments	185.0	141.7	164.2	164.0	143.8	144.1	150.6	154.5	148.7	150.3	135.0	139.1
NPM and other shortfalls in payments [1]							-18.4	-16.1	-11.9	-11.6	-12.7	-12.0
Awards from disputed account										12.2	0.0	12.0
Other Adjustments [2]	4.1	4.8	4.5	-3.5	20.4	8.0	8.2	7.7	37.3	37.6	34.8	36.9
Subtotal	**$189.1**	**$186.0**	**$178.7**	**$277.6**	**$215.2**	**$162.5**	**$155.9**	**$150.7**	**$187.0**	**$198.1**	**$167.4**	**$177.5**
Reserve for legal fees/legal settlement	-47.2	-38.1	49.9	-25.3	-30.0	-30.0	-29.9					
Prior Year Recoveries	0.0	0.0	7.5	3.9	4.3	1.5	1.0	1.1	2.4	4.9	1.4	0.5
Total Available Revenue	**$141.9**	**$147.9**	**$236.1**	**$256.2**	**$189.4**	**$134.0**	**$127.1**	**$151.8**	**$189.4**	**$203.0**	**$168.8**	**$178.0**
Health												
Tobacco		7.3	16.9	19.6	13.8	9.9	9.3	17.8	17.2	16.3	4.1	3.4
Cancer		23.8	34.6	37.2	30.8	28.4	20.1	28.1	25.4	21.8	11.5	13.8
Substance Abuse		18.5	18.5	18.5	17.1	17.1	17.1	17.1	17.1	17.1	17.1	21.1
Medicaid	100.0	24.6		104.0	108.3	51.5	66.8	63.7	106.7	125.4	107.0	112.2
Administration				0.4	0.5	0.4	0.3	0.5	0.9	0.9	1.0	0.7
Breast and Cervical Cancer					0.3	2.5					14.6	15.2
Other [3]		1.5	1.0	1.0								
Subtotal	**$100.0**	**$75.7**	**$71.0**	**$180.7**	**$170.8**	**$109.8**	**$113.5**	**$127.1**	**$167.4**	**$181.6**	**$155.2**	**$166.3**
Other												
Aid to Nonpublic Schools		5.0	4.9	3.6	2.9	2.9	2.8	3.9	3.6	3.6	4.4	4.4
Crop Conversion	2.5	9.0	6.3	6.3	5.1	5.7	6.0	7.6	8.3	7.0	7.0	5.0
Attorney General		0.4	0.1			0.2	0.2	0.2	0.4	0.4	0.4	1.0
Transfer to General Fund				3.8								
Subtotal	**$2.5**	**$62.1**	**$48.0**	**$24.6**	**$8.1**	**$8.8**	**$9.0**	**$11.8**	**$12.4**	**$11.1**	**$12.0**	**$10.5**
Total Expenses	**$102.5**	**$137.9**	**$119.0**	**$205.3**	**$178.9**	**$118.6**	**$122.6**	**$138.9**	**$179.8**	**$192.7**	**$167.2**	**$176.8**
Ending Fund Balance	**$39.4**	**$10.0**	**$117.1**	**$51.0**	**$10.5**	**$15.4**	**$4.5**	**$12.9**	**$9.6**	**$10.3**	**$1.5**	**$1.2**

NPM: nonparticipating manufacturer

[1] The NPM adjustment represents the bulk of this total adjustment.
[2] Other adjustments include interest (initial years only), the strategic contribution payments and the National Arbitration Panel Award.
[3] Includes grants to the Maryland Health Care Foundation.
[4] Other education funding included technology upgrades in K-12 and higher education, the Judy Hoyer program, teacher mentoring, and the Baltimore City partnership.

Note: Numbers may not sum to total due to rounding. Totals reflect fiscal 2010 deficiencies and fiscal 2011 contingent reductions. Fiscal 2010 actuals are most recent estimates of actual revenues and expenditures.