S. HRG. 106–1146

EFFECTIVE TOBACCO REDUCTION PROGRAMS AND THE USE OF TOBACCO REVENUES FROM THE SETTLEMENTS, FOR THIS PURPOSE

HEARING

BEFORE THE

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

OCTOBER 5, 2000

Printed for the use of the Committee on Commerce, Science, and Transportation

U.S. GOVERNMENT PRINTING OFFICE

86–959 PDF WASHINGTON : 2004

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

SENATE COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

JOHN MCCAIN, Arizona, *Chairman*

TED STEVENS, Alaska
CONRAD BURNS, Montana
SLADE GORTON, Washington
TRENT LOTT, Mississippi
KAY BAILEY HUTCHISON, Texas
OLYMPIA J. SNOWE, Maine
JOHN ASHCROFT, Missouri
BILL FRIST, Tennessee
SPENCER ABRAHAM, Michigan
SAM BROWNBACK, Kansas

ERNEST F. HOLLINGS, South Carolina
DANIEL K. INOUYE, Hawaii
JOHN D. ROCKEFELLER IV, West Virginia
JOHN F. KERRY, Massachusetts
JOHN B. BREAUX, Louisiana
RICHARD H. BRYAN, Nevada
BYRON L. DORGAN, North Dakota
RON WYDEN, Oregon
MAX CLELAND, Georgia

MARK BUSE, *Republican Staff Director*
ANN CHOINIERE, *Republican General Counsel*
KEVIN D. KAYES, *Democratic Staff Director*
MOSES BOYD, *Democratic Chief Counsel*

CONTENTS

WITNESSES

EFFECTIVE TOBACCO REDUCTION PROGRAMS AND THE USE OF TOBACCO REVENUES FROM THE SETTLEMENTS, FOR THIS PURPOSE

THURSDAY, OCTOBER 5, 2000

U.S. SENATE,
COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION,
Washington, DC.

The Committee met, pursuant to notice, at 9:30 a.m. in Room SR–253, Russell Senate Office Building, Hon. John McCain, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. JOHN MCCAIN, U.S. SENATOR FROM ARIZONA

The CHAIRMAN. Good morning. I want to thank the witnesses for their presence. I would like to discuss this issue a bit before we call our witnesses.

In November 1998, 46 states settled lawsuits they had filed against tobacco companies. Over the next 25 years, the settlement will pay an additional $206 billion to the states involved. Four other states that have reached separate settlements with the tobacco industry will receive an estimated $40 billion. That's Florida, Minnesota, Mississippi, and Texas.

At the onset of the litigation, one of the most recurring and dominant refrains by state officials pursuing the litigation was the critical need to reduce the use of tobacco products by children. The settlement funds are now arriving in state coffers at a time when most state economies are at their greatest. State governments in the United States reported a total surplus of $35 billion in 1999. The settlement agreement placed no restrictions on the use of the funds.

While many states are still in the process of determining the use of the funds, questions are being raised by public health advocates and Members of this Committee about the amount of funding that is being devoted to tobacco use prevention and reduction programs. Matt Myers, of the Campaign for Tobacco-free Kids, who we had the great privilege of working with as we attempted to pass legislation through the Congress of the United States, and has been an advocate of children for many years, has stated that of the 30 states that dealt with the tobacco settlement money in 1999, only eight provided enough new funding for truly comprehensive tobacco prevention and cessation programs.

Much of this funding is being used for other purposes. For example, it has been reported that the mayor of Los Angeles intends to use $100 million of the city's tobacco settlement payment to address lawsuits involving police corruption.

Today, we will examine a series of recommendations by the Surgeon General and the U.S. Centers for Disease Control (CDC) about effective programs to reduce tobacco use. This Committee will also review the uses to which the states have devoted settlement dollars.

Beginning in 1998, payments from tobacco companies have been credited to an escrow account. Each state's annual allotment from the account is based on a complex formula that accounts for its historical health spending. The total annual payments will be adjusted based on a number of factors, including the consumer price index and the amount by which domestic tobacco sales declined. As a result, a great deal of uncertainty exists about the precise amount of funding the states will receive.

Under the terms of the agreement, states must enact certain legislation and take other actions to receive their settlement payments in full. States must enact a model statute, as drafted in the Master Settlement Agreement (MSA), or the payments could be reduced. Forty-four states have enacted model statutes to date.

Next, states must achieve state-specific finality under the agreement by having their state courts approve the master settlement, and all parties must be released from liability except for criminal liability. To date, 44 of the 46 states that were part of the MSA have achieved state-specific finality.

The Surgeon General and the CDC describe tobacco use as, quote, the single most preventable cause of death and disease in our society. Annually, tobacco use causes more than 433,000 deaths, and costs the Nation between $50 and $73 billion in medical expenses alone. Their recommended goals for comprehensive tobacco control programs focus on preventing the initiation of tobacco use by young children, promoting quitting among young people and adults, eliminating nonsmokers' exposure to environmental tobacco smoke, and identifying and eliminating the disparities relating to tobacco use among different population groups.

Commenting on the funding necessary to establish comprehensive tobacco control programs, the CDC says the amount necessary will, of course, vary from state to state. However, it recommends a range of $5 to $20 per person to implement all of the components of a comprehensive tobacco control program.

The CDC has reported that no state—no state—is currently implementing all of its recommended program components fully. The most comprehensive review of the states' use of tobacco funds has been done by the National Conference of State Legislatures (NCSL). Similar work has been done by the American Cancer Society and the Campaign for Tobacco-Free Kids.

According to NCSL, as of July this year 44 state legislatures have appropriated nearly $8 billion in tobacco settlement funds to be placed in endowments, trust funds, and general revenue accounts to fund tobacco prevention, health care, and education activities. Six remaining states, Arizona, Missouri, Oklahoma, Oregon, and Pennsylvania have yet to decide how to spend the funds.

As a group, states are spending a little more than half of their money on either health care programs or tobacco prevention programs. A mere 9.2 percent of the funds is being used for tobacco prevention programs. The vast majority of the funding is being used for health care services. However, the NCSL report demonstrates that individual states are using the settlement funding for a variety of purposes.

New Hampshire spent all of its fiscal year 2000 funds to correct flaws in its education formula.

Georgia established the one Georgia trust fund and appropriated $62 million of the $144.2 million it received to attract business to rural regions of the state.

The Commonwealth of Virginia has allocated $18 million of the $179 million it received for fiscal year 2001 to tobacco prevention programs. $89.5 million has been used to indemnify tobacco growers from the effects of the MSA and revitalize tobacco-growing communities.

Nevada will use 10 percent of the funding for tobacco prevention, but some of the money will be used to aid public broadcasting television stations develop DVD television.

Illinois will spend $26.4 million on tobacco prevention programs. However, $315 million of the $437.4 million allocated to the state for fiscal year 2001 will be used for either a property tax rebate or an earned income tax credit.

I want to say a word about legal fees. In some states, legal fees represent more than a quarter of the total settlement award, far outweighing the amount of funding used for tobacco prevention and reduction programs. Of the State of Mississippi's estimated $4.1 billion settlement, attorney's fees will eat up $1.4 billion, or 34.1 percent of the funds. Michael Horowitz of the Hudson Institute estimates that the tobacco settlement will provide $500 million per year to 200 to 300 lawyers.

I want to repeat that. The tobacco settlement, according to Michael Horowitz of the Hudson Institute, will provide $500 million per year to 200 to 300 lawyers, most probably in perpetuity.

The state Attorneys General accounted for these statistics by stating that the payments to attorneys are from a separate and distinct account being paid by the tobacco companies. I think that is a disingenuous argument.

As part of the MSA, the tobacco-free arbitration panel was established to oversee payments to the plaintiffs' counsel. The inmates were guarding the asylum. However, some attorneys have refused to submit their fee requests to the panel, and they insist on payment according to contingency fee agreements.

One example of this is Maryland attorney Peter Angelos. Mr. Angelos has previously insisted on full payment on the original 25 percent contingency fee contract. This would potentially result in Angelos' receiving a payment of $1 billion from Maryland's $4 billion settlement award.

A dispute has resulted over this payment in Maryland, with leaders of the state legislature claiming that a subsequent reduction of half of that fee was agreed to by Angelos due to the fact that Maryland State tort law was changed in order to assist Angelos in winning the case.

Three firms representing the state of Wisconsin billed the tobacco companies $75 million for the case's 26,284 hours of work. Even though this sum was a substantial reduction from the firms' original request for $847 million (20 percent of the $4.2 billion to be awarded Wisconsin) the reduced sum still represents a fee of $2,853 per hour, not bad compensation.

I would like to thank the witnesses for being here today, and I'd like to ask Dr. David Satcher, who is the Assistant Secretary of Health and the Surgeon General of the United States, to please come forward as our first witness.

I am sorry. I would welcome you, and how do you pronounce your name, Mr. Pechacek—but I would like to first ask for opening statements. Senator Wyden.

STATEMENT OF HON. RON WYDEN,
U.S. SENATOR FROM OREGON

Senator WYDEN. I am going to be very brief, and I am going to have to be in and out this morning because we have other hearings at this time as well. First, Mr. Chairman, I want to thank you for holding this hearing and for all of your efforts since I have been in the United States Senate on this matter of protecting children in particular.

It is very clear that we have significant problems with respect to protecting America's youngsters. You have consistently worked with me and others who have been active on this cause, and I want you to know that we very much appreciate your leadership on this issue.

The CHAIRMAN. Thank you very much, Senator Wyden.

Senator WYDEN. Mr. Chairman, it has been almost 7 years now since the tobacco executives told me when they were under oath that nicotine is not addictive, and it is very clear since that time that while some progress has been made on some fronts there is still a long, long way to go to protect America's youngsters.

In 1998, the Senate debated whether to require the states to spend a portion of the tobacco settlement funds on health care. Although it sounded at the time like a significant amount of money was being discussed for 39 states and the District of Columbia, the 20 percent of total settlement dollars earmarked for health programs actually turned out to be less than what the CEO's of RJR and Phillip Morris made in compensation in just 1 year.

Mr. Chairman, you, in your opening statement, outlined—and I think it is very important that it be part of the record—some of the flaws in the settlement, some of the problems that we have seen since its enactment with respect to how those critically used funds have been siphoned off.

I want to make it clear, I am not against CEO's being compensated for their work, but when you have so many states in this country spending less on protecting youngsters than the executives of just a couple of these companies, and then you add on to it the holes in the settlement that you pointed out in your opening statement, it is very clear to me that there is significant work to be done to reform this program.

And so I am very pleased that you are holding this hearing. I hope the Congress will come back next year and look at a way to

reform this program to get it back on track so it is doing what is essential for the public health, and that is to ensure that an adequate portion of these resources is actually spent on smoking prevention and cessation with a special focus on young people.

So I look forward to working with you, Mr. Chairman. I am very appreciative that you are holding this hearing.

The CHAIRMAN. I thank you, Senator Wyden, and I would like to make an additional comment. I think Dr. Satcher will testify in states where there have been vigorous anti-youth smoking programs, combined with the increase in the cost of a pack of cigarettes, we have seen positive results, and I think Matt Myers will also agree with this, that in states where they have not been doing that we have not seen the reduction in youth smoking, so there is a direct connection that frankly was derided by some at the time we were working on the tobacco bill.

Senator Burns, welcome.

STATEMENT OF HON. CONRAD BURNS,
U.S. SENATOR FROM MONTANA

Senator BURNS. Thank you very much, Mr. Chairman. Thank you for holding this hearing, and I will be very, very short. When we got notification of this hearing we contacted our Attorney General's Office in Montana to see how we were doing up there and how the funds were being spent, and I am very happy to report that our programs are in place, the models are in place.

And just visiting with some of the public health folks across the State of Montana, of all the programs like helping people to quit smoking and the health problems and second-hand smoke and all these programs, prevention is probably—and especially with children—has probably been the most successful to this date. The Tobacco-Free Kids are to be congratulated for their work in this area and education also as far as tobacco is concerned.

So I just want to report to you that we are doing well in Montana, and I am also glad to hear your report this morning. I was really concerned that our lawyer friends were not going to be justly compensated.

[Laughter.]

The CHAIRMAN. Thank you very much. I know of your abiding concern for them.

Senator BURNS. I have a great concern. I am afraid they will just have many hungry days.

The CHAIRMAN. Could I mention to our witnesses, I think we are going to have a vote at 10 o'clock, which means we are going to have to break, and then I would imagine, if the past few days has been true, that there will be an objection lodged to the hearing continuing past 11:30, so we will try to expedite our opening statements, and I will try to restrain myself as well.

Welcome, Dr. Satcher, and thank you for the wonderful work you do in a broad variety of areas. We are proud of your service to our country.

STATEMENT OF DR. DAVID SATCHER, ASSISTANT SECRETARY FOR HEALTH AND SURGEON GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY TERRY PECHACEK, ASSOCIATE DIRECTOR FOR SCIENCE, OFFICE ON SMOKING AND HEALTH, CENTERS FOR DISEASE CONTROL AND PREVENTION

Dr. SATCHER. Thank you, Chairman McCain, Members of the Committee. I am David Satcher, Surgeon General and Assistant Secretary for Health, and I am pleased to appear before you and to present testimony on our newest tobacco-related Surgeon General's report, which was entitled, Reducing Tobacco Use.

I am accompanied by Mr. Pechacek, Associate Director for Science in CDC's Office on Smoking and Health. He was also associate scientific editor of the new report.

I do want to express my appreciation, Mr. Chairman, particularly at what I know is a very busy time in this legislative season for your holding this hearing and for your continuing concern and leadership on tobacco control. Let me just say that this was the 52nd report from the Office of the Surgeon General. It was the 29th report on tobacco use. It is the first ever to provide an in-depth analysis of various methods to reduce tobacco use.

Our report shows we have the tools, the knowledge, and the resources to cut smoking rates in half by the end of this decade, and that is the goal of Healthy People 2010. The question is, do we have the will? Although our knowledge of tobacco control remains imperfect, we know more than enough to take on the tobacco control challenges of the 21st Century. Our findings tell us that our lack of greater progress in tobacco control is a result of our failure to implement proven strategies rather than a lack of knowledge about what to do.

I think the sobering reality is that smoking remains a leading cause of preventable death and disease in the United States today. More than 400,000 adults die prematurely from tobacco-related diseases each year. Today, nearly a quarter of U.S. adults and about a third of U.S. teenagers continue to smoke, and we believe efforts should focus on promoting quitting among adults and youth smokers, preventing young people from ever starting to smoke, protecting citizens from second-hand smoke, and eliminating racial and ethnic disparities in tobacco-related diseases.

This last goal, eliminating disparities, poses a great national challenge. We are wholeheartedly committed to expanding our research efforts and designing even more effective programs that address the unique cultural, ethnic, social, and socioeconomic needs of different populations.

At the beginning of September I participated in a World Federal of Public Health Associations meeting in China. I reported at that meeting that today more than 4 million people die each year from smoking in the world. By 2030, that number will rise to 10 million, 70 percent of whom will be from developing countries. The United States is committed to working side-by-side with other nations and international organizations such as WHO to create a broad framework to curb the global epidemic of tobacco-related disease.

Later this month, the WHO will meet to begin the first stage of a negotiation on a framework convention on tobacco control. Al-

though the report was developed primarily to guide decisions about effective tobacco control programs in this country, the report's findings have clear global applications. I want to now share briefly with you some of the major conclusions of the new tobacco report.

The report suggests the most serious challenge to our efforts to prevent tobacco use is the pervasive ongoing tobacco advertising and promotion campaigns by the tobacco industry. The industry spent $6.7 billion to market tobacco in the United States in 1998, more than $18 million a day. This marketing campaign takes place despite overwhelming evidence of the adverse health effects of tobacco use.

The regulation of tobacco sales and promotion is required to protect young people from influences to take up smoking, and in which many of them become addicted before they are actually old enough to legally purchase tobacco, and that is the bad news.

The good news in the report concludes that our major methods of reducing tobacco use are effective particularly when used as part of a comprehensive control program, and I will mention four of those strategies. The first are school programs. The report finds that educational strategies can postpone or prevent smoking onset in 20 to 40 percent of adolescents. School-based programs are most effective when combined with mass media programs and the community-based efforts involving parents and other community resources.

Unfortunately, less than 5 percent of schools nationwide are fully implementing the CDC school health guidelines. The report concludes second that pharmacologic treatment of nicotine addiction, combined with behavioral support, will help 20 to 25 percent of users to quit smoking for good. In fact, we now know that if physicians would just ask their patients to quit smoking, 5 to 10 percent of their patients would in fact quit, and that would represent a two to fourfold increase in the quit rate.

If you go further and add to that programs of pharmacological treatment and counseling, 20 to 25 percent of users would quit, and that is a tenfold increase in the quit rate that we have in this country.

These findings are critical, because 70 percent of smokers actually want to quit, and yet only 2.5 percent are now able to succeed in any given year. Addiction is, in fact, a chronic disease.

The Public Health Service recently issued a clinical practice guideline that highlights effective treatment methods for nicotine addiction. The broad application of this guideline could produce some more rapid short-term impact on the statistics.

The report concludes that clean air regulations and restrictions of minors' access to tobacco use help to change social norms with regard to smoking, and may reduce smoking rates directly. The report is clear that optimal protection of nonsmokers and smokers requires a smoke-free environment. However, despite the existence of numerous laws and policies in support of smoke-free schools, work site, and public places, only California today meets the Healthy People 2010 objective to eliminate exposure to second-hand smoke by the banning of indoor smoking or limiting it to separately ventilated areas.

I want to point out, Mr. Chairman, that almost 30,000 children per year are estimated to have the onset of asthma because of exposure to second-hand smoke.

The report also concludes that economic approaches to tobacco control are good public health policy. It is estimated that a 10-percent increase in price can lead to an overall reduction in smoking of 3 to 5 percent, and as high as 7 percent in teenagers.

The report also notes that the need to improve tobacco warning labels in the United States is great. The report shows that consumers receive very little information regarding the ingredients, additives, and potential toxicity of tobacco products.

I want to conclude by highlighting that the most effective approach to controlling tobacco use is the comprehensive approach, one that combines education, clinical, regulatory, and economic strategies in an integrated program. Comprehensive state-wide tobacco control programs funded by excise taxes on tobacco products and settlement funds from the tobacco industry have emerged as the model for future effort to reduce tobacco use. They have been very effective where used.

Mr. Chairman, let me return to where I began. We know what works. We have the public health tools necessary to cut tobacco use by 50 percent over the next decade. Every death from tobacco use is a preventable death. I hope that this report will serve as a blueprint for coordinated national tobacco control efforts to reduce the devastation of tobacco-related diseases and death in our Nation.

It is time to exercise our collective will to put this blueprint into action. It is not an exaggeration to suggest that tobacco control represents the most important public health intervention since the development of the polio vaccine. The challenge for us is one of will. Do we have the will to take advantage of this golden opportunity?

Thank you, Mr. Chairman.

[The prepared statement of Dr. Satcher follows:]

PREPARED STATEMENT OF DR. DAVID SATCHER, ASSISTANT SECRETARY FOR HEALTH AND SURGEON GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY TERRY PECHACEK, ASSOCIATE DIRECTOR FOR SCIENCE, OFFICE ON SMOKING AND HEALTH, CENTERS FOR DISEASE CONTROL AND PREVENTION

Good morning, Mr. Chairman and Members of the Commerce Committee. I am Dr. David Satcher, Surgeon General and Assistant Secretary of Health for the U.S. Department of Health and Human Services. I am pleased to appear before you and present testimony on our newest tobacco-related Surgeon General's Report, *Reducing Tobacco Use*. I am accompanied by Dr. Terry Pechacek, Associate Director for Science in the Office on Smoking and Health at the Centers for Disease Control and Prevention (CDC).

Mr. Chairman, I want to express my appreciation, particularly at what I know is a very busy time in the legislative session, for your holding this hearing and for the concern and leadership in tobacco control issues that you and this Committee have shown.

This is the 29th report on tobacco issued by the Surgeon General. It is the first-ever to provide an in-depth analysis of the various methods to reduce tobacco use. Our report shows that we have the tools, the knowledge and the resources to cut smoking rates in half by the end of the decade. The question is: Do we have the will?

In my testimony, I will refer to three important documents that contain information that can be used to shape the future of tobacco control. First is the Surgeon General's report I just mentioned. This report provides a blueprint for achieving the ambitious health objectives for the nation, which are laid out in Healthy People 2010—the second important document, which contains 17 tobacco-related objectives. Finally, CDC has made this information more concrete with the *Best Practices for*

Comprehensive Tobacco Control Programs, which was prepared to help states assess options for comprehensive tobacco control programs and to evaluate their local funding priorities. If you don't already have copies of these important documents, all three are available on-line and I have a few copies with me today.

Overview

As I am sure you are aware, the need to address the public health consequences of tobacco use is urgent. Tobacco use is responsible for more than 430,000 deaths each year, or one in every five deaths. It is the single most preventable cause of death and disease in our nation, and it is well documented that smoking can cause chronic lung disease, coronary heart disease, and stroke, as well as cancer of the lung, larynx, esophagus, mouth, and bladder. Smokeless tobacco and cigars also have deadly consequences including cancer of the lung, esophagus, and mouth. In addition to this enormous health burden, the economic burden of tobacco use is more than $50 billion in medical expenditures and another $50 billion in indirect costs annually. The harmful effects of smoking do not end with the smoker—environmental tobacco smoke causes an estimated 3,000 deaths from lung cancer each year, and causes up to 300,000 episodes of lower respiratory tract infections in children each year.

Surveillance data reported in today's issue of CDC's *Morbidity and Mortality Weekly Report* indicate that the prevalence of cigarette use among adults has changed very little during the 1990s—about one-quarter of adults reporting current cigarette use. Among adolescents, smoking prevalence rates steadily increased from 1991–1997, but preliminary new data show that the rates have peaked and are starting to decline. However, if tobacco-use patterns do not decline more rapidly than current trends indicate, an estimated five million persons who were less than 18 years of age in 1995 will die prematurely from a smoking related disease.

Reducing Tobacco Use: A Report of the Surgeon General

The good news related to tobacco is that although our knowledge of tobacco control remains imperfect, we know more than enough to act now. The Surgeon General's Report on *Reducing Tobacco Use* is the first-ever report that provides an in-depth analysis of tobacco intervention strategies. This reports offers a science-based blueprint for achieving our Healthy People 2010 health objectives to cut adult and teen smoking rates in half. One of the key conclusions of our Surgeon General's report is that existing state tobacco control programs have provided evidence of the efficacy of a comprehensive approach to reducing tobacco use.

This type of comprehensive approach—one that combines educational, clinical, regulatory, economic, and social strategies—has emerged as the guiding principle for future efforts to reduce tobacco use. Evidence shows that multifaceted state tobacco control programs are effective in reducing tobacco use in part because they bring about a shift in social norms and reduce the broad cultural acceptability of tobacco use. Comprehensive approaches combine community interventions, counter-marketing, and program policy and regulation.

The goal of a comprehensive tobacco control program is to reduce disease, disability, and death related to tobacco use by: (1) promoting quitting among adult and youth smokers; (2) preventing young people from ever starting to smoke; (3) implementing public health policies to protect citizens from secondhand smoke; and (4) eliminating racial and ethnic disparities in tobacco-related diseases.

To assist states in achieving these goals, the CDC has prepared guidelines to help states determine funding priorities and to plan and carry out effective comprehensive tobacco prevention and control programs. In CDC's *Best Practices for Comprehensive Tobacco Control Programs,* CDC recommends that states establish tobacco prevention and control programs that are **comprehensive, sustainable,** and **accountable.**

The guidelines draw on best practices determined by evidence-based analyses of excise tax-funded programs in California, Massachusetts, Oregon and Maine and in the four states that individually settled lawsuits with tobacco companies (i.e., Florida, Minnesota, Mississippi, and Texas).

Evidence from California, Massachusetts, and Oregon—and more recent results from Arizona and Maine—indicate that increasing the price of cigarettes reduces tobacco consumption rates. In addition, evaluations have shown that an adequately funded, comprehensive tobacco prevention and control program can result in even more dramatic reductions when coupled with price increases. Data from California provide the best example of this. The state excise tax was increased from $0.10 to $0.35 in January 1989 to fund the new tobacco control program. There was an initial and rapid reduction in consumption as a result of the January 1989 price increase. If price were the only factor in contributing to the declines in California, we

would expect the rates to drop initially and then follow the similar pattern of slow decline experienced by the rest of the country. However, as a result of the tobacco control program implemented in California, the rates of tobacco use in California continued to decline two to three times faster than in the rest of the country throughout the 1990s. Between 1988 and 1999, per capita cigarette use in California has declined by almost fifty percent while in the rest of the country, rates have declined by only about twenty percent.

CDC is conducting an in-depth analysis of state tobacco control programs for all 50 states. Evaluation data from the statewide comprehensive tobacco control programs indicate that there is a dose-response relationship between investment in tobacco prevention and control and reductions in tobacco use in the state.

"Best Practices"—Program Components

CDC recommends that states establish tobacco control programs that contain the following nine elements:

- Community Programs to Reduce Tobacco Use
- Community Programs to Reduce the Burden of Tobacco-Related Diseases
- School Programs
- Enforcement
- Statewide Programs
- Counter-Marketing
- Cessation Programs
- Surveillance and Evaluation
- Administration and Management

The Surgeon General's report provides further discussion on the specific strategies that might be adopted in each of these areas, and reviews the scientific literature about their efficacy, so I will limit my remarks to describing the programmatic components included in the CDC guidelines and briefly touch on the extent to which they are currently being implemented by states.

Community Programs to Reduce Tobacco Use

To achieve the individual behavior change that supports the non-use of tobacco requires whole communities to change the way tobacco is promoted, sold, and used while changing the knowledge, attitudes, and practices of young people, tobacco-users, and nonusers. Effective community programs involve people in their homes, work sites, schools, places of worship and entertainment, civic organizations, and other public places. To achieve lasting changes, programs in local governments, voluntary and civic organizations, and community-based organizations require funds to hire staff, provide operating expenses, purchase educational materials, provide education and training programs, support communication campaigns, organize the community to debate the issues, establish local plans of actions, and draw other leaders into tobacco control activities. While most states are supporting community programs, these programs are not yet reaching the entire state population. Evaluation reports from the states of California, Massachusetts, and Oregon indicate that very encouraging progress has been made by local communities in these states to protect nonsmokers from environmental tobacco smoke, limit youth access to tobacco products, and restrict local tobacco advertising.

Community Programs to Reduce the Burden of Tobacco-Related Diseases

Another element of community programs reflects the fact that tobacco use increases the risk of development of a number of diseases. Even if current tobacco use stopped, the residual burden of disease among past users would cause disease for decades in the future. Community programs can focus attention directly on these diseases, both to prevent them and detect them early. Comprehensive, state-based tobacco prevention and control programs can address diseases for which tobacco use is a major cause, such as cancer, cardiovascular disease, stroke, oral cancers, and asthma.

School Programs

The recent Surgeon General's Report, *Reducing Tobacco Use,* concluded that educational strategies, conducted in conjunction with community- and media-based activities, can postpone or prevent smoking onset in 20 to 40 percent of adolescents. Because most people who start smoking are younger than age 18, school-based programs that prevent the onset of smoking are a crucial part of a comprehensive tobacco prevention program. Several studies have shown that school-based tobacco prevention programs, which identify the social influences that promote tobacco use among youth and teach skills to resist such influences, can significantly reduce or delay adolescent smoking. Because many students begin using tobacco before high

school and impressions about tobacco use are formed even earlier, tobacco use prevention education must be provided in elementary school and continued through middle and high school grades.

To address this need, CDC collaborates with more than 30 professional and voluntary organizations to assist schools and agencies in developing model policies and guidelines. States are using these to implement effective school health programs. However, less than 5 percent of schools nationwide are implementing the major components of CDC's *School Health Guidelines to Prevent Tobacco Use and Addiction.* Of the states that are working to follow the guidelines, such as Maryland and Oregon, they struggle to reach all school age children. Furthermore, despite Oregon's intensive efforts to implement the guidelines, they reach only 30 percent of the school districts.

Enforcement

The Surgeon General's report concluded that enforcement of tobacco control policies enhances their efficacy both by deterring violations and by sending a message to the public that the community believes the policies are important. The primary areas addressed by local and state policies that require enforcement strategies are restrictions on minors' access to tobacco and restrictions on indoor smoking in public places. As other policy changes (e.g., local restrictions on advertising and promotion) are adopted, they also will need to be enforced. The state of Florida is implementing an enforcement program consistent with CDC's *Best Practices.*

Statewide Programs

Also consistent with the Surgeon General's report, funding to support statewide programs is a major element of CDC's recommended comprehensive approach to the prevention and reduction of tobacco use. Statewide projects can increase the capacity of local programs by providing technical assistance on evaluating programs, promoting media advocacy, implementing of smokefree policies, and reducing minors' access to tobacco. Supporting organizations that have statewide access to diverse communities can help eliminate the disparities in tobacco use among the state's various racial and ethnic groups. Statewide and regional grants to organizations representing cities, business and professional groups, law enforcement, and youth groups inform and involve their membership about tobacco control issues and encourage their participation in local efforts. Arizona, California, Maine, Massachusetts and Oregon currently have statewide programs that serve as "best practice" models to reach diverse communities.

Counter-Marketing

One of the major conclusions of the Surgeon General's report is that efforts to prevent the onset or continuance of tobacco use face the pervasive and countervailing influence of tobacco promotion by the tobacco industry. During the last decade, the industry has spent more than $20 billion in imagery advertising and promotions to create a "friendly familiarity" for tobacco products and an environment in which smoking is seen as glamorous, social, and normal. This is of particular concern since studies show that children buy the most heavily advertised brands and are three times more affected by advertising than adults.

To counter this influence, tobacco control programs should undertake counter-marketing activities that can promote smoking cessation and decrease the likelihood of initiation. In addition, counter-marketing messages can have a powerful influence on public support for tobacco control intervention and set a supportive climate for school and community efforts. Counter-marketing attempts to counter pro-tobacco influences and increase pro-health messages and influences throughout a state, region, or community. Counter-marketing consists of a wide range of efforts, including paid television, radio, billboard, and print counter-advertising at the state and local level; media advocacy and other public relations techniques using such tactics as press releases and local events and pro-health promotional activities; and efforts to reduce or replace tobacco industry sponsorship and promotions.

Some states are initiating significant counter-marketing efforts. Multifaceted prevention programs, such as the Minnesota Heart Health Program and the University of Vermont School and Mass Media Project, have shown that comprehensive efforts that combine media, school-based, and community-based activities can postpone or prevent smoking in 20 percent to 40 percent of adolescents. Although the relative effectiveness of specific message concepts and strategies is widely debated, research from all available sources shows that counter-marketing must have sufficient reach, frequency, and duration to be successful. The Vermont youth campaign, for example, exposed 50 percent of the target population to each TV and radio spot about six times each year over a 4-year period. This level of exposure is possible only through paid media placement.

The Florida TRUTH campaign has achieved high levels of exposure among target aged youth that their evaluation reports suggest are related to the their impressive declines in rates of youth tobacco use. The award-winning Massachusetts counter-marketing campaign has focused on prevention of initiation, promotion of cessation, and protection of non-smokers and reports both high levels of exposure to its multiple message themes as well as direct impacts on adult attempts to quit and prevention of youth initiation rates.

Cessation Programs

You may be aware that the Public Health Service (PHS) has recently published evidence-based clinical practice guidelines on cessation. Tobacco dependence is a chronic condition that often requires repeated intervention. The PHS Guideline, "Treating Tobacco Use and Dependence," provides recommendations which are both clinically effective and cost-effective relative to other medical and disease prevention interventions.

Cessation is a particularly important component of tobacco control programs, because programs that successfully assist young and adult smokers in quitting can produce a quicker and probably larger short-term public health benefit than any other component of a comprehensive tobacco control program. Smokers who quit smoking before age 50 cut in half their risk of dying in the next 15 years. In addition, the cost savings from reduced tobacco use resulting from the implementation of moderately-priced, effective smoking cessation interventions would more than pay for these interventions within 3 to 4 years. Unfortunately, no state currently has fully implemented the best practices recommendations in this area. However, the states of California, Oregon, Arizona and Massachusetts have developed innovative approaches to increase access to evidence-based treatments for nicotine addiction. We encourage other states to follow their lead.

Surveillance and Evaluation

The Surgeon General's report stressed the importance of expanding the science base in support of comprehensive tobacco control programs. Hence, a statewide programs must have a sound surveillance and evaluation system both to monitor fiscal accountability for state policy makers as well as to increase the efficiency and effectiveness of program activities. For this reason, the establishment of surveillance and evaluation systems must have first priority in the planning process. With technical assistance from CDC, California, Massachusetts, Oregon, Arizona, Maine, and Florida have established comprehensive surveillance and evaluation systems based upon CDC's *Best Practices'* recommendations.

Administration and Management

An essential component of an effective tobacco control program is a strong management structure. Experience California, Massachusetts and Oregon has shown the importance of having all of the program components coordinated and well-managed. A comprehensive program involves multiple state agencies (e.g., health, education, and law enforcement) and multiple levels of local government, as well as numerous health-related coalitions, voluntary and community groups. Coordination of these groups requires high quality program administration and management. Many states have difficulty maintaining a comprehensive tobacco control program and rely on federal support to maintain key management and administrative personnel.

Conclusion

Only three years ago, tobacco control spending in almost all states averaged pennies and nickels per capita. Now all states have a sound core funding, and current allocations in those states with expanded programs range from $2.50 to more than $10 per capita. While these funding sources and levels have contributed to the development of a basic capacity within states to conduct tobacco prevention and control programs, no state is currently implementing all the components recommended in CDC's *Best Practices.* Approximate annual costs to implement all of the recommended program components have been estimated to range from $7 to $20 per capita in smaller states (population under 3 million), $6 to $17 per capita in medium-sized states (population 3 to 7 million) and $5 to $16 per capita in larger states (population over 7 million).

While the focus of today's discussion is on state efforts to address tobacco use, a comprehensive national tobacco control effort requires strategies that go beyond state programs. A comprehensive national effort should involve the application of a mix of educational, clinical, regulatory, economic and social strategies. In each of these areas, some of the program and policy changes that are needed can be addressed most effectively at the national level. That is why the Administration has sought FDA authority to restrict advertising and sales of tobacco products to chil-

dren, and taken actions such as establishing smoke-free workplaces to protect the health of federal employees and visitors to federal buildings. Even as we have encourage states to use their settlement funds to help support tobacco prevention programs in states and local communities, we also have increased federal support for those programs.

Progress is being made, but a great deal remains to be done. States such as California, Massachusetts, Arizona, Oregon, Maine, and Florida are demonstrating that significant reductions in tobacco use rates among young people and adults are possible. However, our Healthy People 2010 objectives, including cutting in half the rates of tobacco use among young people and adults, will require a sustained and comprehensive effort at both the federal and state level. The Surgeon General report and CDC's *Best Practices* provide the blueprint for what needs to be implemented. Prevalence of cigarette use among adults in this nation has changed very little during the 1990s. Each year, more than 1 million young people continue to become regular smokers and more than 400,000 adults die from tobacco-related diseases. We know what strategies are effective in controlling tobacco use. What we need now is a stronger, sustained effort by government at all levels to implement these proven tobacco control strategies. Tobacco use will remain the leading cause of preventable illness and death in this nation and a growing number of other countries until tobacco prevention and control efforts are commensurate with the harm caused by tobacco use. We look forward to working with you and our other partners, some of whom will be addressing you shortly, to address this urgent public health issue.

The CHAIRMAN. Thank you, Dr. Satcher.

We referred earlier to the fact that there are a number of states, and we will get into it perhaps with the next panel, that simply have not lived up to the commitments they made at the time that the tobacco agreement settlement was made, I might add, an agreement between lawyers.

Are you concerned about some states not spending enough of their tobacco settlement proceeds on tobacco cessation prevention programs, and are there certain states you know of that have exemplary approaches. In other words, maybe you could give me both sides of this, or parts of this equation.

Dr. SATCHER. We are very concerned that so few states are using the settlement funds to implement programs to prevent the initiation of smoking by teenagers, programs to help with the cessation of smoking, and programs to help strengthen regulations to protect the environment. As I pointed out, 30,000 children a year have the onset of asthma because of being exposed to cigarette smoke. We do have very clear evidence that these programs make a difference, and they were the basis for this report.

California has had a 50-percent reduction in smoking over the last 10 years between 1988 and 1999, and——

The CHAIRMAN. Can I interrupt? They began these programs even before the settlement.

Dr. SATCHER. They use excise taxes. California raised the excise tax from, I believe, 10 to 30 cents. Massachusetts did a similar thing and has had a dramatic reduction in the initiation of smoking. More recently, Florida, using a new program called TRUTH, has reduced the initiation of smoking by teenagers from almost 20 percent per year, and this was a range from middle school to high school, down to about 8.9 percent, 40-percent or more reduction. So we have a lot of evidence, including Arizona in recent years between 1996 and 1999.

We really have not had much reduction in smoking nationally. There has been more than a 20 percent reduction in some states, again because of initiating programs consistent with the settlement agreement, and so we have a lot of evidence that where states have

initiated programs consistent with these recommendations we are seeing results. We are saving a lot of lives.

The CHAIRMAN. Would it be possible, Dr. Satcher, and if you're reluctant to do this I can understand, but if you could inform this Committee, and perhaps in the next report point out where states are successfully carrying out the commitment that they have made, and I put in quotes the commitments they made at the top of the settlement and the results, and the states that are not, and the lack of results?

I think frankly the only way we are going to get the governors and the legislatures to use this pot of gold they found at the end of the rainbow for the purposes that they committed to as a part of the settlement—I do not think any Americans would have supported a tobacco settlement that went for tax rebates. That is not what this is all about. It is an affront, I think, to many Americans to hear these kinds of commitments, and I have got a bunch of quotes from the Campaign for Tobacco-Free Kids, the American Cancer Society, the American Heart Association and the American Lung Association, which are really kind of chilling.

Governor after Governor, Attorney General after Attorney General, said "this is it, we will devote all this money to these programs", and they did not—and they did not in many, many cases. But as you pointed out, in some cases they did. Massachusetts and California being perhaps the best examples, at least of the ones that I have seen. There are other success stories, but there are many failures, and so would it be possible for you to get into that a little bit for us?

Dr. SATCHER. You are going to hear that from the next panel, and they are better prepared right now than I am to talk about those states. CDC is, in fact, doing a very comprehensive study of the states, and that will be finished in January of 2001. I usually like to wait for the CDC in terms of what we say at our level.

The CHAIRMAN. Perhaps, Dr. Satcher, after they issue that report in January we could have another hearing and you could prepare yourself at that time.

Dr. SATCHER. I would be delighted.

The CHAIRMAN. We are not talking about a scholastic argument here. We are talking about kids dying because the assets available are not being used to address the problem, which was the promise when the agreement was made. That is a bit disturbing, and I understand why it might contribute to the cynicism of people about their government.

Dr. SATCHER. I agree 100 percent. What the CDC has told us, and it makes sense, is that different states are taking different strategies for accessing this money and using it. Some states are saying, give us a lump sum right now as opposed to the amount we would get over 25 years, and so they will get a lump sum of money which is much smaller than what the total sum would be, and therefore how they budget this money in these various areas is a little bit more difficult for us to evaluate until we look at it in more depth.

But let me just say clearly, and I mentioned that Arizona, California, Massachusetts, Maine, and Oregon are states that are, in fact, according to what we know right now, implementing programs

of the kind that we recommend. Some of them have had excise taxes working for them even before the settlement fund, but they are implementing the programs recommended by CDC.

The CHAIRMAN. And there is not a doubt in your mind that these programs work?

Dr. SATCHER. Our data show that if you begin educating children in elementary school and you continue your programs telling them the harmful effects of tobacco you reduce the initiation of smoking between 20 and 40 percent in the states where we looked. I mean, that is a lot of lives. That is almost a 1/2 million children a year that will not begin to smoke in this country.

Five million children in this country today under 18 years of age will die from smoking if things continue as they are going now, and so that is how serious this problem is. But by the same token, that is how relevant and how critical this opportunity is that we have, if states use the tobacco settlement funds.

I mean, even if you want to make the economic argument, we spend between 50 and $100 billion a year dealing with either medical care for smoking-related diseases or the indirect cost from smoking, so in the long run it even makes sense in terms of an investment. But the problem is that we are going to find ourselves years from now with people continuing to die from smoking because we did not implement these programs that we know can work.

And I just want to say one other thing, because I am concerned about children especially. I agree with David Kessler when he said that smoking is a pediatric disease, because children begin to smoke and before they are 18 years of age they are addicted, and addiction is a disease. It is not easy to quit smoking once you are addicted. Some people can quit easier than others, but for most people it is not easy. 70 percent of smokers would like to quit this year. Less than 3 percent will quit.

The other thing I am concerned about with children is the fact that almost 30,000 children a year have the onset of asthma by being exposed to environmental tobacco smoke, and so there are a lot of, quote, innocent victims being affected by this. I think to a great extent smokers in a way are also innocent victims if they are addicted when they are children and they have trouble shaking this addiction. But there are also 3,000 nonsmokers a year who die from lung cancer and we estimate that between 40,000 and 60,000 nonsmokers die from heart disease because they are exposed to smoking environments.

So we know that the recommendations that we have made can make a tremendous difference in this country.

The CHAIRMAN. Well, doctor, I hope you stay involved in this issue. I know you have been, and you have been the most persuasive spokesperson, not only because of your own personal credentials, but the fact that you are the Surgeon General of the United States of America, and we are very grateful for that, and I would like for you to next year help us get into this issue of how this money is being spent.

If there is no dispute that there is a direct relation between the antitobacco use programs and the reduction in the use of tobacco, i.e., as you so eloquently illustrate, saving thousands and thou-

sands of lives, then it seems to me we ought to put the states' feet in the fire to comply with the agreement that they made.

The whole reason, rationale, as I understood, for the settlement was not to provide another windfall of money for the states, but to achieve a goal of reducing smoking, particularly among children, the use of tobacco particularly.

My friend Joe Garagiola is very interested in me saying the use of tobacco rather than just saying smoking. He has been an strong advocate against the use of chewing tobacco.

Again, I want to return to the states who seem to be saying here we have got a whole bunch of money, we can give a tax rebate, and I think it is really a betrayal, almost, when they use this money for other purposes than for what the stated intentions were, and again, we have got this report that I just referred to earlier, the statements made by the Governors and the Attorneys General.

When the settlement was made all were committed to programs which would reduce the use of tobacco, and unfortunately that has not been the case, some more egregious than others, so I hope you will stay involved in that part of the issue as well, because I think the thing that will bring these states, the Governors and legislatures around very frankly is a lot of visibility.

Dr. SATCHER. Well, we plan to stay involved, and also we have tried to be available to states that have asked for our support, and I am willing to travel to any state that would like our help in assisting to develop these programs. This is critical and so we are willing to do that.

The CHAIRMAN. Thank you. Did you have a comment, sir?

Mr. PECHACEK. Just to reinforce the point that a key component of the Center for Disease Control's program is technical assistance to the states. In response to this issue, our guidelines are released not in any way to mandate. This is in response to the states. We are providing the budgetary guidelines to help states fulfill these types of commitments and to develop effective programs, so that is a key portion of our overall program.

The CHAIRMAN. Well, I also—to state the obvious there are some great success stories out there. California is one of them, Massachusetts is another one, and there are other states that are great success stories, and I would recommend that the states that are not achieving these reductions should probably look to what is being accomplished in other states and how they did it, as well as your guidelines.

Dr. SATCHER. Mr. Chairman, in part that is what CDC's Best Practices outline does. CDC has looked at these successful states, and they have pulled together the Best Practices, so any state that wants to know what has worked in other states can find them in this document, Best Practices, or in the Surgeon General's report, Reducing Tobacco Use.

The CHAIRMAN. Thank you. We look forward to seeing you in January or February, Dr. Satcher. Obviously, I hope to see you before. I hope you will continue the great work that you are doing, and we look forward to working very closely with you. Thank you very much.

Dr. SATCHER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Since we have this vote on, we will take a brief break before we call the next panel, and I will be back in 5 to 10 minutes, as quickly as I can get over and back.

[Recess.]

The CHAIRMAN. The Committee will reconvene. Our next panel is Betty D. Montgomery, Attorney General of Ohio, Mr. Francis L. Coolidge, immediate past chairman, national board of directors, American Cancer Society, Mr. Matt Myers, president, Campaign for Tobacco-Free Kids, and Mr. John Hurson, delegate from the Maryland General Assembly. I believe Mr. Hurson is also Majority Leader, is that correct?

Mr. HURSON. That is correct.

The CHAIRMAN. Congratulations, or should I say condolences?

[Laughter.]

The CHAIRMAN. We want to begin with Attorney General Montgomery. Thank you for being here.

STATEMENT OF BETTY D. MONTGOMERY, ATTORNEY GENERAL OF OHIO, OFFICE OF THE ATTORNEY GENERAL, STATE OFFICE TOWER

Ms. MONTGOMERY. Thank you, Mr. Chairman. It is a pleasure to be here. It is a pleasure to be able to be here at such a momentous time in our history, where we have had the largest civil settlement in the world, and we have an opportunity to make a real difference in the public health in this country.

Ohio began the analysis on this lawsuit back in March 1996. A year later we announced our intention to sue, and as we did our investigations, as you certainly know, we found a pattern of corrupt activity regarding anticompetitive behavior. We found violations of consumer laws. We found misrepresentations regarding addiction, and the like. You have heard all that testimony.

Most importantly for us and all the Attorneys General was the unsettling discovery that there was a pattern of direct marketing to minors, with their marketing campaigns, so that as you know we ultimately, as Attorneys General, 46 states, 5 Commonwealths and Territories, and the District of Columbia, reached an agreement with the tobacco companies regarding this lawsuit.

This lawsuit was heard around the world. The settlement was equally striking because of the work, frankly, of the state Attorneys General, and we now have banned certain kinds of activities. We have no more billboards. We have tobacco advertisements in teen publications banned. Multimillion conspiracies to hide the truth about smoking have been exposed, and we pray that all of these things are a thing of the past as we move forward.

You know, there are four additional states that settled outside of the master settlement agreement. I am very pleased to report to you, Senator McCain, that Ohio under the master settlement agreement received the fourth largest settlement under the master settlement agreement, which would total about, over $10 billion by the time we are done in the next 25 years.

I have been humbled by the fact that Ohio has at this point been held as a model for allocating tobacco settlement dollars for the public health purpose. I have to tell you I attribute that to the fact that from the very beginning we worked very closely with the pub-

lic health community before we filed the lawsuit, during the lawsuit, at the time of the settlement of the lawsuit, and now, as we are planning our structure on how we are going to spend those dollars the public health community has been a vital and equal partner in that expenditure and that planning.

In fact, in June of 2000 the Campaign for Tobacco-Free Kids quarterly legislative newsletter was kind enough to compliment Ohio for our work, and I appreciate that. That was a bit of a surprise. As a result of the newsletter and previous national and regional seminars our office has been contacted by an awful lot of states and legislators to see what model those states can use to successfully spend tobacco money to fund smoking cessation and prevention programs, as well as other public health priorities.

Senator McCain, I am a creature of the General Assembly. I have a great respect for the collective wisdom of the legislative body to make decisions, and we were very fortunate in Ohio to have both the House and the Senate, under the leadership of Senator Finan and Speaker Davidson, as well as Governor Taft, collectively believe that the money should be focused on intervention and prevention programs.

As a result, our General Assembly has set up priorities and created a blueprint by up-fronting our settlement dollars for public health-related trust funds. In fact, at least 43 percent of our dollars are spent and are sequestered for public health moneys, for public health issues over the next 12 years directly. It is very hard to bind a legislature, but we had to do everything we can to bind the future legislatures to that commitment.

We credit our success, as I said, to the public health community. These groups included the American Lung Association, the Heart Association, the Cancer Association. Obviously, the Campaign for Tobacco-Free Ohio, the Ohio Department of Health, the Ohio Department of Human Services, and the Ohio Hospital Association.

Prior to earmarking the dollars, we frequently met, and I asked them at some point as we were going through this process to create for me a blueprint, what is it ideally you think you need in terms of expenditures of dollars, come back to me with the blueprint so we can use that as we work through our lawsuit and as we work through the General Assembly.

When the settlement first appeared possible back in 1998, I met personally with the public health community and, in fact, the blueprint that they prepared, known now as the state-wide tobacco use prevention plan, was ultimately used as a guideline for us in subsequent hearings, both in planning hearings as well as legislative hearings. The plan utilized the foundation concept with governing boards. It specifically focused on tobacco prevention and cessation programs, and provided for grants to be awarded on a competitive basis while encouraging public-private partnerships.

After developing these recommendations, we created the Tobacco Settlement Task Force, which consisted of 15 members, and we took testimony from 60 different witnesses. We had over a dozen hearings in which we listened to all of the ideas about what Ohio should be doing with its dollars. We had sort of a pre-legislative meeting and put together, then, a plan, which we then presented to the General Assembly. The recommendations included ear-

marking created individual funds for on health programs, smoking prevention, biomedical research, school facilities, education technology, relief for farmers, and for some law enforcement involvement.

Again, strong leadership by good people in the state who were listened to made all the difference in the world. It was not without legislative wrangling, as you might expect, Senator McCain. We had the same kind of issues we have heard you speak about today. We had the debates about tax relief. We had the debates about where these dollars should or should not be spent, even though we had a very strong recommendation from critical members of the legislature.

I will not tell you that it was an easy process, but at the end of the day I think we can say that at this stage we are very pleased with the product. Hopefully, now the future leaders of this state will have the responsibility of determining the uses and allocations, but we think the blueprint is a strong enough blueprint that it will be hard for them to depart from it.

Every 6 years the General Assembly will assign a committee consisting of Senators and state representatives, including the minority parties, to reexamine the use of tobacco moneys under the master settlement agreement. This is to ensure, quite frankly, that the dollars are being spent the way they were intended to address public health issues.

All the money that Ohio will receive from tobacco will be divided into eight trust funds. The trust fund, the Tobacco Use Prevention and Control Foundation will include about $1.26 billion, or over 25 percent of the total dollars we expect to get, and that foundation is the heart and soul of our tobacco intervention programs and cessation programs made up of members of the public health community, made up of members of the General Assembly, and public elected officials.

The CHAIRMAN. Ms. Montgomery, I apologize for asking you to shorten because of arcane rules of the Senate we do not have a lot of time because we will be shut down.

Ms. MONTGOMERY. Anyway, we have a number of trust funds. We will submit the testimony on that. One of the other things we have done which is rather unique is also focus dollars in biomedical research, particularly directly related to tobacco-related diseases and the like.

Mr. Chairman, knowing you have other members here to speak, and having been a member of the General Assembly myself, I recognize there are other priorities here. I would ask to submit the testimony as well as, I have some testimony from Christine Gregoire, without whom we would not be sitting here today talking about this. As Attorney General of Washington she asked, and I would probably request that we could submit the letter that she sent to me for the Committee to look at.

[The prepared statement of Ms. Montgomery follows:]

PREPARED STATEMENT OF BETTY D. MONTGOMERY, ATTORNEY GENERAL OF OHIO, OFFICE OF THE ATTORNEY GENERAL, STATE OFFICE TOWER

Mr. Chairman, Members of the Committee, thank you for providing me with the opportunity to provide testimony to you today on how Ohio has allocated our tobacco settlement dollars.

In March of 1996, our office began a careful analysis of potential litigation claims against the tobacco industry. A year later, we announced our intention to sue.

Here are just two examples of what we found. Our evidence indicated that the industry had engaged in a pattern of corrupt activity by illegally building anti-competitive alliances aimed at deceiving the general public about the dangers of smoking.

We also discovered multiple violations of Ohio consumer protection laws, such as the industry deceiving the public about nicotine addition and their persistent public reference to doubt in the connection between smoking and many diseases of heart and lungs.

However, the primary purpose for filing our lawsuit was that we had evidence that the industry was specifically targeting minors with their marketing campaigns.

As you know, on November 23, 1998, the attorneys general of forty-six states, five commonwealths and territories, and the District of Columbia reached an agreement with the major tobacco companies, which represented approximately 97.5 percent of the U.S. tobacco sales. At least 23 additional manufacturers have since then signed on to the agreement and we continue to work with tobacco producers interested in joining. Worth an estimated $206 billion over the next twenty-six years, the settlement will provide payments to states based on a formula developed by the attorneys general.

This was the lawsuit heard 'round the world.' The settlement was equally as striking. Because of the work of state attorneys general, gone forever are cigarette vending machines, tobacco advertisement in teen publications, and multi-million dollar conspiracies to hide the truth about smoking.

Four additional states—Florida, Minnesota, Mississippi, and Texas—individually settled with the tobacco industry for more than $40 billion additional dollars. Ohio received the six largest settlement in the country, which will total $10.1 billion over 25 years and payments will continue in perpetuity.

Ohio is held up nationally as one of the model states for allocating tobacco settlement funds for public health purposes. In fact, in June of 2000, the Campaign For Tobacco Free Kids quarterly legislative newsletter started to highlight state achievements in earmarking tobacco dollars for public health purposes. That first issue highlighted Ohio's achievements. Here's what they said:

"*This is a victory for everyone who worked hard to see this law enacted, a model for the nation and most importantly, a win for kids. Way to go Ohio!*"

As a result of this newsletter and previous national and regional seminars, our office has been contacted by legislators and public health advocates from a number of states to explain how Ohio successfully used tobacco money to fund smoking cessation and prevention programs as well as other public health priorities. Our general assembly has made a strong commitment to public health priorities by up fronting our settlement dollars for public health-related trust funds. In fact, almost $2.3 billion or 47% of our dollars that we will receive over the next 12 years will be dedicated to public health issues.

We credit our success in to our regular pre-Master Settlement Agreement (MSA) discussions with the public health community. These groups included the American Lung Association, the American Heart Association, the American Cancer Association, the Campaign for Tobacco Free Ohio, the Ohio Department of Health, the Ohio Department of Human Services, and the Ohio Hospital Association.

Prior to the creation of the MSA, we frequently met with these organizations to keep them informed about our litigation and negotiations. We also asked for their input on various public-health provisions in drafting the settlement agreement.

Although we chose not to have a seat at the negotiating table, Ohio was a lead state in drafting provisions of the MSA, and we were consulted throughout the negotiation process. When we announced our settlement agreement with the tobacco manufacturers, we stood side-by-side with the public health community.

In fact, I am not aware of any other state that announced the agreement with such *strong support* from their local public health community.

When the settlement first appeared possible (back in the summer of 1998), we asked our public health coalition to develop a plan on what Ohio could do to best use those settlement dollars, specifically focusing on public health purposes. This blueprint, known as the Statewide Tobacco Use Prevention Plan, was ultimately used as a guide for earmarking our funds. The plan utilized a foundation concept

with governing boards. It specifically focused on tobacco prevention and cessation programs, and provided for grants to be awarded on a competitive basis, while encouraging public/private partnerships.

After developing these recommendations, I announced with the Governor and legislative leaders the creation of the Tobacco Settlement Task Force. This bi-partisan Task Force was created to review how best Ohio could spend our settlement dollars. The Task Force included 15 members: four from the administration; 10 lawmakers; and myself. We took open testimony from 60 different witnesses, including my office, tobacco control organizations, educators, public health organizations, tobacco growers, the National Council of State Legislatures (NCSL), and other interested parties.

In September of 1999, the Task Force issued recommendations (approved by a 14–1 vote), which called for the creation of seven separate trust funds. The individual funds created would be focused on:

1. Health programs;
2. Smoking prevention;
3. Biomedical research;
4. School facilities;
5. Education technology;
6. Aid to tobacco farming regions of the state; and
7. Law enforcement improvements.

These recommendations were then rolled into state legislation which specifically earmarked the settlement dollars into 8 trust funds addressing these seven stated purposes. Our office continued to play a key role in advising the General Assembly, the leadership, and the Administration on the intent of the MSA and its provisions, and we actively supported passage of the bill.

Our Governor signed the package on March 3, 2000. The bill earmarked settlement dollars through FY 2012, covering a period of 13 years. Future leaders of my state will have the responsibility of determining the uses and allocations of funds received in years after that. Please know, the Ohio General Assembly will be required to make appropriations every two years since the Ohio Constitution prohibits the General Assembly from appropriating for more than a two-year period. Although we have a strong standing to commit these dollars for the purposes outlined in our tobacco spending bill, these appropriations will be scrutinized every two years by the General Assembly. We also recognized that the MSA payments are subject to numerous adjustments and that while the amount of future payments could not be predicted, if we were successful in reducing consumption, the payments would decline. Consequently, we divided most payments among the funds by share, rather than by fixed dollar amount.

Every six years, beginning in January 2012, a committee consisting of three state senators and three state representatives, including minority party representation, will reexamine the use of the tobacco master settlement agreement funds to ensure that the spending of those dollars remains on target *to address public health issues.*

All the money that Ohio will receive from the tobacco industry will be divided into the eight trust funds. Each trust fund will retain all investment earnings accrued by the particular trust fund.

Here is a brief summary of the trust funds established by the Ohio legislature for the purposes of allocating the proceeds from the tobacco settlement. The following trust funds are specific for public health purposes:

A. Tobacco Use Prevention and Control Foundation

1. $1.26 billion, or 25.3 percent of the total through FY 2012.
2. The goals of the 20-member foundation include decrease tobacco use by Ohioans, with the emphasis on decreasing use by youth, minority, and others who may be disproportionately affected by tobacco use.
3. The Foundation shall carry out, or provide funding to other organizations to carry out, research and create programs related to tobacco use prevention and cessation.
4. The Foundation is the trustee of the endowment fund which would use a combination of interest and principle to carry out its responsibilities. We expect/hope to meet the C.D.C. minimum tobacco control guidelines in Ohio, which amounts to $5.48 per capita costs.

B. Ohio's Public Health Priorities Trust Fund

1. $252.9 million through FY 2012, or 5.1percent of the total received through FY 2012.
2. Five areas of use:

a. Not less than 25 percent of the annual appropriations to minority health programs
b. Enforcing (ORC 2927.02) Ohio's underage tobacco use laws
c. Alcohol and drug abuse prevention programs, including programs for adult and juvenile offenders in state institutions and aftercare programs
d. Five percent of the annual appropriations to provide emergency assistance to seniors whose health has been adversely affected by tobacco use and whose income does not exceed 100 percent of the federal poverty guidelines
e. Partial reimbursement, on a county basis, of hospitals, free medical clinics, and similar organizations or programs that provide free, uncompensated care to the general public, and of counties that pay private entities to provide such care using revenue from a property tax levied at least in part for that purpose.

C. Biomedical Research and Technology Transfer Trust Fund and Its Related Commission

1. $493.5 million, or 9.9 percent of the total received through FY 2012.
2. Twenty-five-member unpaid Commission will provide competitive grants to public and private parties in Ohio for "any of a broad range of activities" related to biomedical research and technology transfer.

D. Southern Ohio Agricultural and Community Trust Fund

1. $229.0 million—4.6 percent of the total amount received through FY 2012.
2. To provide economic alternatives for tobacco growers.

E. Law Enforcement Trust Fund

1. $25.0 million in three installments through FY 2001.—0.5percent of the total amount received through FY 2012.
2. Allocated to the Attorney General's Office to make capital improvements for the Ohio Peace Officer Training Academy and Ohio Bureau of Criminal Investigation laboratory facilities, which serve law enforcement agencies across the state.

The remaining trust funds are specific to education purposes:

F. Education Technology Trust Fund

1. Through FY 2012, this trust fund is estimated to receive $218.7 million,—4.4 percent of the total settlement received through FY 2012.
2. Pay costs of new and innovative technology at institutions of primary and secondary education, including chartered nonpublic schools, and public colleges and universities or private nonprofit institutions of higher education.

G. Education Facilities Trust Fund

1. $1.96 billion between fiscal years 2003 and 2012.
2. Support the state's Classroom Facilities Assistance Program.

H. Education Facilities Endowment Fund

1. $65 million through 2012 and specified percentages of the payments from 2013 to 2025.
2. Permanent source of revenue for constructing, renovating, or repairing primary and secondary schools in the state.

In addition to the tobacco trust funds, the legislation also included several other provisions, including:

A. Department of Rehabilitation and Correction Smoking Regulations

1. Smoking is prohibited in the buildings of certain state correctional institutions.
2. The bill also requires DRC to provide smoking and tobacco cessation programs for prisoners at all state correctional institutions, subject to available funding.

B. Income Tax Reduction Fund

1. Any year in which tobacco payments to the state exceed the amounts estimated by the Office of Budget and Management in the final report of the Governor's Tobacco Task Force, the excess is to be credited to the Income Tax Reduction Fund.

2. Used to fund temporary income tax reductions in the subsequent calendar year.

C. Prohibition on Lobbying—Our new law also prohibits using any portion of the Tobacco MSA dollars for political activity or lobbying.

We brought our lawsuit against the tobacco industry because of their unscrupulous business practices of specifically targeting minors. This historic settlement gives us the unique opportunity to start protecting not only our children, but also our communities as a whole.

I am proud to have helped craft this spending plan through a systematic, strategic, and inclusive effort. Our efforts balances the health care needs of Ohioans with a number of other needs that were neglected because we had spent tens of millions of dollars to pay for tobacco-related heath care costs over the past half century.

In Ohio, credit is due many people—including our governor, leaders and members of our legislature, and many committed and involved public health advocates—for crafting our plan.

We have worked together to turn the negative byproducts of the tobacco industry's behavior into positive achievements that have a real impact on all Ohioans.

I'm gratified that this plan is seen as a model for other state leaders who are also seeking to balance their resources and needs in a similar responsible fashion.

Thank you for the opportunity to provide testimony this morning, and I will be happy to answer any questions that you might have.

Thank you.

ATTORNEY GENERAL OF WASHINGTON
Olympia, WA, October 5, 2000

Hon. JOHN MCCAIN,
Chairman,
Senate Committee on Commerce, Science and Transportation,
Washington, DC.
Hon. ERNEST F. HOLLINGS,
Ranking Minority Member,
Senate Committee on Commerce, Science and Transportation,
Washington, DC.

RE: STATES AND TOBACCO SETTLEMENT DOLLARS

Dear Senators McCain and Hollings:

As the Washington State Attorney General and the lead negotiator of the nationwide tobacco settlement, I respectfully ask that you enter this letter into the record. Unfortunately, I am unable to attend the hearings on how states are spending the tobacco settlement money and am therefore submitting this letter in my stead.

As you will recall, following the tobacco settlement I requested a waiver from Congress that would prevent the federal government from seeking a Medicaid recoupment and allow states to keep all the payments from the tobacco settlement. I argued that the states would do the right thing and spend the money on purposes related to the lawsuit. The arguments I made at that time remain just as relevant today.

- Tobacco use is the number one cause of *preventable* death in the United States today. It takes more lives than AIDS. alcohol, cocaine, heroin. car accidents. homicide, suicide, and fires combined.
- Investing in tobacco prevention will save lives. According to the Centers for Disease Control and Prevention (CDC), a successful prevention plan in Washington conservatively could prevent 70,000 premature deaths.
- Investing in tobacco prevention and control saves taxpayer dollars. The CDC estimates that a successful plan in Washington could save Washington taxpayers $2.5 billion in excess health care costs in its first five years.
- Investing in tobacco control has a proven record of success. Investments by pioneering states like California and Massachusetts made years ago are paying huge dividends today. Consider the following results we heard from experts from those states who testified before our Legislature in 1999.

California

- Every year there are 14,000 less heart attacks and 11,000 fewer low-birthweight babies born.

- California's health care system as whole—both private and public—saves approximately $1.2 billion per year.
- State government health care savings are nearly $600 million annually.

Massachusetts

- Since 1992, per capita tobacco consumption has decreased 31 percent—over three times the national average.
- Youth smoking rates have remained flat while the national rates skyrocketed.
- By targeting pregnant women who smoke, the percentage of maternal smoking in 1996 was about half of what it was in 1990.
- Because maternal smoking can lead to low birthweight babies, Massachusetts estimates it saves $35 million annually—nearly enough to pay the cost of the entire program.
- Investing in tobacco prevention and control is the right thing to do. To protect the integrity of the settlement, money from the tobacco settlement should be treated as restitution and should be used only for purposes related to the lawsuits. A key element of state lawsuits was that the industry targeted children to be its next generation of addicted smokers. We owe it to our kids to find healthy and positive alternatives to smoking.

Washington State is making good on its promise. In 1999, the Governor and Legislature dedicated all of the settlement dollars due our state this biennium into tobacco prevention and control and public health programs. Specifically, of the approximately $300 million in tobacco payments we expect this budget period, the Legislature invested $100 million in a new Tobacco Prevention and Control Account. The money is being used to fund an aggressive, comprehensive, and sustained tobacco prevention and control plan for Washington State.

The remainder is earmarked for health care for low-income families and to expand health insurance for children. The two main beneficiaries are the Basic Health Plan, an income-based health care plan, and the Children's Health Insurance Program (CHIP). The settlement dollars spent on CHIP will pay for health care for an additional 10,000 kids statewide. While I would have liked to see more dollars allocated to tobacco prevention and control, I believe the Legislature's dedication of all the tobacco dollars for these purposes was a big success.

I recognize that Washington is in the minority of states who have used a significant portion of the money for tobacco prevention and public health. Keeping the money for these purposes has been a hard-fought battle. Many state legislators have erroneously considered the tobacco dollars a windfall and used it for a variety of purposes unrelated to public health. I believe this is a mistake—but it is also a mistake that can be rectified each legislative session.

In conclusion, I respectfully request that you consider the examples set by Washington, and other states who have used the money to prevent a new generation of addicted smokers. If we want to save lives, enhance the quality of life for all Americans, and stop these enormous drains on our budgets from excess health care costs, then we must ensure that state tobacco payments are spent in ways consistent with the lawsuits.

Thank you for your leadership on this important health issue. As always, I look forward to continue working with you and offer any assistance that I can.

Sincerely,

CHRISTINE O. GREGOIRE,
Attorney General.

The CHAIRMAN. Without objection. You see, if someone objects there is a time limit as to how long our hearings can proceed, but I do appreciate your testimony, and your complete testimony and that of Christine Gregoire, who is the Attorney General of the State of Washington, will be made a part of the record.

Mr. Coolidge, welcome.

STATEMENT OF FRANCIS L. COOLIDGE, IMMEDIATE PAST, CHAIRMAN, NATIONAL BOARD OF DIRECTORS, AMERICAN CANCER SOCIETY

Mr. COOLIDGE. Thank you. I am Francis Coolidge, immediate past chair——

The CHAIRMAN. You need the microphone.

Mr. COOLIDGE. I am Francis Coolidge, the immediate past chair of the American Cancer Society, and on behalf of the 18 million volunteers and supporters of the society I would like to thank you, Senator, and your Committee colleagues, for inviting me to speak here today.

3 years ago, John Seffrin, our CEO, testified before this Committee about the need for national legislation to protect the health of Americans from the harms of tobacco. Unfortunately, what was true then is still true today. One in three people who die from cancer dies because of tobacco, and despite the master settlement agreement we are still in need of national policies to address the tobacco problem in this country.

The society and our partners in the public health community had great hopes that the MSA would have a positive impact on tobacco control in this country. Unfortunately, the Congress, without your support, waived its rights to any of the MSA money without requiring that the states spend even a single penny of it on tobacco control, and that failure has resulted in a dismal record and wholly inadequate spending by the states to address the problem of tobacco use.

According to the new study report produced by the Campaign for Tobacco-Free Kids, an average of 7.5 percent of the settlement money, less than a dime out of every dollar, is going to tobacco control. Only a handful of states have allocated even the minimum amount of funding for tobacco control recommended by the Centers for Disease Control and Prevention, and not a single state-based tobacco control program conforms to the CDC's best practices guidelines in this respect.

Unless more of the settlement money is devoted to addressing the scourge of tobacco, future generations will continue to needlessly suffer from tobacco-related disease and death. This represents an extremely costly missed opportunity.

Let me illustrate the problem by briefly sharing with you three experiences, in each of which the society has dedicated significant resources. In Maryland, many months of hard work by the Society and others, including Mr. Hurson, resulted in legislation that established long-term funding allocations for tobacco settlement payments, including a first payment for program ramp-up of $46 million for anticancer and tobacco programs, and payments for the next 10 years of approximately $80 million in the same areas.

The Maryland experience, however, as well as the commendable Ohio decision to endow tobacco prevention and cessation programs, is the exception. Take the example of Kansas where, notwithstanding the efforts of the public health community, the state legislature voted to put the first $70 million of settlement funds into deficit reduction, and the state allocated a mere $500,000, an amount well below the $18 million minimum that CDC rec-

ommends for Kansas to invest in a comprehensive tobacco control program.

Lastly, consider Connecticut. That state consistently ranks as the country's wealthiest in terms of average and disposable income, and since 1995 it has enjoyed a budget surplus, and yet during the 2000 legislative session, although Connecticut received approximately $110 million in settlement funds, the state failed to dedicate any funding to state tobacco control efforts. We are deeply concerned, because our experiences such as those in Connecticut and Kansas have been far more common than that in Maryland.

While the states have an important role to play in tobacco control, this is also a national and global issue in which Congress has an absolutely critical role to play. In this respect, Mr. Chairman, the society applauds your leadership in addressing tobacco control from a national perspective. With your indulgence, I will briefly touch on four of the essential policies that can only be effectively implemented at the federal level.

First, we must have strong, effective, meaningful regulation of tobacco products by the Food & Drug Administration. The Nation's deadliest consumer product cannot continue to be totally unregulated.

Second, federal funding for tobacco control and prevention programs is another priority. CDC, as you know, plays a unique role in advising and assisting all states in their tobacco control efforts, and this work leverages state dollars and effectively weaves the several state programs into a national one. Unless CDC's national tobacco control program is adequately funded this year, state programs will fall short of their potential.

Third, the government's coverage of cessation benefits and services now falls far short of recommendations made by the Surgeon General and other leading public health experts. The Medicare, Medicaid, and MCH Smoking Cessation Promotion Act, sponsored by Senators Brownback and Durbin, would help work to reduce and prevent cancer-related illness and death among key at-risk populations and the Society supports its enactment.

And finally, the federal government has an obligation to its taxpayers to hold tobacco companies accountable for their well-documented wrongdoings. Right now, the Department of Justice is pursuing civil RICO charges against those companies. We urge Congress to provide the DOJ funding to pursue these claims in fiscal year 2001 and beyond, as necessary.

The ACS looks forward to working with you and your colleagues to address these and many of the other issues I have outlined today in my written testimony. We stand ready to join with you to protect our children from tobacco use and to help those currently addicted to quit. With this federal-state, public-private partnership, we will surely save both lives and money through a significant reduction in tobacco-related disease.

Mr. Chairman and Members of this Committee, please know the American Cancer Society sincerely appreciates the opportunity to present our views and thanks you for taking the time out of your schedule at this busy time of year to hold a hearing on this most important public health issue. I will be pleased to answer any questions you may have.

[The prepared statement of Mr. Coolidge follows:]

PREPARED STATEMENT OF FRANCIS L. COOLIDGE, IMMEDIATE PAST, CHAIRMAN, NATIONAL BOARD OF DIRECTORS, AMERICAN CANCER SOCIETY

On behalf of the more than 18 million volunteers and supporters of the American Cancer Society (ACS), I thank you, Mr. Chairman, and your colleagues on the Senate Commerce, Science and Transportation Committee for inviting me to present testimony regarding the status of state-based tobacco control efforts after the Master Settlement Agreement (MSA) and the recent Surgeon General's Report on Reducing Tobacco Use.

I am Francis L. Coolidge, Immediate Past Chairman of the Board of the American Cancer Society. The Society is a co-chair, along with the American Heart Association, of the ENACT (Effective National Action to Control Tobacco) coalition—a public health coalition of more than 50 national organizations dedicated to reducing the death and disease caused by tobacco use. Today, I am representing the American Cancer Society, but I bring to this discussion a broad public health perspective and an understanding of the goals of the public health community in terms of tobacco control and prevention efforts at the local, state, and federal levels.

The American Cancer Society is the nationwide, community-based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives and diminishing suffering from cancer, through research, education, advocacy and service. Despite the significant recent gains we have seen in decreasing overall cancer incidence and mortality rates, approximately 1.2 million Americans still will be diagnosed with cancer this year and more than 550,000 will lose their battle with the disease. As you know, tobacco use is responsible for nearly one in five deaths in the United States—a needless and tragically preventable loss of more than 430,000 American lives each year. Tobacco kills more Americans than AIDS, drugs, alcohol, car accidents, homicides, suicides, and fires combined. A lesser-known but no less grim fact is that more than 30 percent of all cancer deaths is attributable to smoking and tobacco use.

The American Cancer Society has established challenge goals for the year 2015—goals that we are pursuing with the cooperation and collaboration of the public, private, and non-profit sectors. Collectively, we hope to reduce age-adjusted cancer mortality by 50 percent, decrease age-adjusted cancer incidence by 25 percent, and markedly improve the quality of life for all people touched by cancer. We know from data and scientific evidence that one of the key steps to achieving an accelerated reduction in cancer incidence and mortality is tobacco control—especially when it comes to children—through meaningful regulation and effective cessation programs that will help those currently addicted to quit.

Mr. Chairman, three years ago next week, the Chief Executive Officer of the American Cancer Society, Dr. John R. Seffrin, testified before your Committee about the need for national legislation to protect the health of American citizens from the harms of tobacco. Unfortunately, what was true three years ago, is still true today—one in three people who dies of cancer dies because of tobacco. These are deaths that could be prevented if our nation seriously and comprehensively addressed tobacco and made a long-term investment in a sustained campaign to prevent tobacco-related disease and death. Even the Supreme Court determined earlier this year that tobacco is "perhaps the single most significant threat to the public health in the United States."

As you know, some minority and ethnic groups and the medically underserved suffer from a disproportionate burden of cancer. Similarly, large differences in tobacco use exist in the United States. For example, in 1997, smoking prevalence was 37.9 percent among American Indian/Alaska Native men, 32.1 percent among African American men, and 27.6 percent among white men. Taking these data into account, it is therefore not surprising that there are marked differences in tobacco-related cancer deaths among different groups within the population. This year, it is expected that the rate of lung and bronchus cancer death for whites will be 49.3 per 100,000 while for African Americans it will be 60.5 per 100,000. No single factor determines the patterns of tobacco use among racial and ethnic groups. Data collected throughout the 1990s found that teen smoking increased by 80 percent among African-Americans; among Hispanics, 34 percent; among Native Americans, 26 percent; and among Asian-Americans, 17 percent. Clearly this cause for alarm. We know that these trends result from complex interactions among many factors including socioeconomic status, acculturation, targeted advertising, price of tobacco products, stress, and varying capacities of communities to mount effective tobacco-control initiatives.

ACS has prioritized the reduction and elimination of the unequal burden of cancer as a top nationwide priority. As part of meeting this challenge, the Society is working at all levels of the organization to advance policies and programs that work to reduce health disparities among minority and ethnic populations and the undeserved. Also, ACS urges policy makers to take action to ensure that disparities in tobacco use and the associated adverse health outcomes are addressed.

Mr. Chairman, on behalf of the Society's nationwide volunteers and staff, again thank you for your ongoing leadership on tobacco issues and for providing us this opportunity to discuss with you and your colleagues the state-based tobacco control efforts in the post-settlement environment.

Public Health Community Vision of Tobacco-Control in the Post-MSA Environment

The American Cancer Society and our partners in the public health community had great hopes that the MSA could have a positive impact on tobacco control in our nation, especially at the state and local levels. As you know, in 1999, ACS joined with our public health partners in calling for the entire amount of the state settlement money to be returned to the states, as long as Congress required a 20 to 25 percent set-aside for state and local tobacco control efforts. This allocation is the amount that the Centers for Disease Control and Prevention (CDC) and other public health experts say is needed to establish the most effective tobacco control efforts. Unfortunately, the Congress waived its right to any of the settlement money without requiring that the states spend any money on tobacco control.

The failure of Congress to ensure that the states would spend a minimum amount of the new money on initiatives to reduce and prevent the use, access, and appeal of tobacco products unfortunately has resulted in a dismal record and wholesale inadequate spending by the states to address the problem of tobacco use. According to a new report produced by the Campaign for Tobacco-Free Kids and endorsed by the American Cancer Society, on average a mere 7.5 percent of settlement money is going to tobacco control. So, for every dollar paid by the tobacco industry to the states, less than a dime is going to address the problem of tobacco use. Unless more of the settlement money is devoted to addressing the scourge of tobacco, future generations of children and adults will continue to needlessly suffer from tobacco-related disease and death. This represents an extremely costly missed opportunity.

We recognize and appreciate that there are many competing funding priorities at the state level but maintain that unless states begin to spend the CDC recommended amount of money on preventing and reducing tobacco use, both state and federal governments will continue to incur social and economic tobacco-related costs. Tobacco will cost the US economy approximately $100 billion this year alone, and more than $20 billion will come directly out of federal taxpayers' pockets for treating smokers under Medicare, Medicaid, and the Veterans Administration health program. On average, each cigarette pack sold costs Americans more than $3.90 in smoking-related expenses—an amount well in excess of the current average price of a pack of cigarettes. As a nation, we cannot afford to continue to incur the huge human and economic losses due to tobacco use.

The CDC recommends that states establish tobacco control programs that are comprehensive, sustainable, and accountable. ACS and the public health community have long-advocated that a comprehensive approach to tobacco control be implemented at the local, state, and federal level. As part of this advocacy, the Society urges that the needs of special populations be taken into consideration when tobacco control programs are developed and implemented. To be responsible and responsive, tobacco control efforts at the local, state, and national level must address the unequal burden of tobacco-related disease on our nation's minority, ethnic, and medically underserved populations. A guiding principle of these efforts should be the reduction of disparities in tobacco use, tobacco cessation, and health outcomes. ACS supports the best practices outlined by the CDC for comprehensive tobacco control programs and calls on Congress and state governments to ensure that adequate resources are provided so that each state can develop and fully implement a program that contains the following components:

1. **Community-programs to reduce tobacco use**—community involvement is essential to reducing tobacco use and local government entities, community and business leaders, health care providers, community organizations and others can be effective partners and should be engaged in tobacco prevention and cessation activities;
2. **Chronic disease prevention/health promotion programs to reduce the burden of tobacco-related diseases**—this includes cancer registries which help public health professionals determine cancer patterns among diverse populations, monitor cancer trends, target and evaluate cancer prevention and con-

trol programs (including tobacco control efforts), make rational decisions about resource allocation, and advance epidemiological, clinical, and health services research;[1]

3. **School-based health programs to prevent tobacco use and addiction**—the Surgeon General's recent report on Reducing Tobacco Use found that "educational strategies, conducted in conjunction with community and media-based activities, can postpone or prevent smoking onset in 20 to 40 percent of adolescents";
4. **Enforcement of tobacco control policies**—enforcement of tobacco control policies at the local and state level helps ensure their effectiveness by both deterring violators and communicating to the public that these policies are important and a priority of the community;
5. **State-wide programs and projects for greater capacity and reach**—state-wide initiatives that involve the public and private sector can increase the capacity of local programs by providing technical assistance and imparting lessons learned, exchanging contacts in particular communities and organizations, and sharing expertise;
6. **Counter-advertising/counter-marketing to counteract pro-tobacco influences and increase pro-health messages**—the Surgeon General also recently reported that efforts to prevent tobacco use face the "pervasive, countervailing influence of tobacco promotion by the tobacco industry." Current scientific suggests that population-based measures involving a combination of policy and media interventions are the most cost-effective method to decrease tobacco use, particularly among children. Therefore these efforts must be increased;
7. **Tobacco use cessation programs to help the 50 million Americans currently addicted to tobacco to successfully quit**—more than 70 percent of all current tobacco users have indicated a desire to quit and helping them to quit. Helping them to quit can save money and save lives as cessation treatment and therapy is proven to be cost effective;
8. **Surveillance and evaluation to ensure fiscal oversight and effectiveness of programmatic efforts**—monitoring and evaluation of each component of a comprehensive tobacco control program permits policymakers and program staff to adjust and improve activities and ensure that public money is being spent in a responsible and effective manner;
9. **Administration and management for sound program development, implementation, and oversight**—experience from California and Massachusetts suggests that program success partially depends upon sufficient staffing and adequate management infrastructure.

ACS is pleased that a handful of states (California, Massachusetts, Florida, and Oregon) have taken the steps necessary to move their states toward comprehensive tobacco control programs that are beginning to see tangible results. However, despite the availability of new evidence and potential new funding for effective tobacco control efforts, no state is currently implementing all of the CDC recommended program components fully. With only seven states allocating even the minimum amount of funding recommended by the CDC for tobacco control, it is not surprising that there is not one state-based tobacco control program that conforms to the CDC's best practices guidelines for tobacco control.

The American Cancer Society is disappointed with this overall "state of the states" with regard to tobacco control and is extremely concerned about the short-term and long-term health consequences of this failure to invest adequately in preventing and reducing tobacco use among both children and adults.

ACS State-based Efforts to Secure MSA Funding for Tobacco Control

These disappointing results are certainly not for a lack of effort on the part of ACS and our public health partners. Since the MSA was signed, ACS staff and volunteers have worked tirelessly with legislatures in all 50 states to secure adequate appropriation of tobacco settlement funds for comprehensive tobacco control programs. For the past two years, this issue has dominated our public policy agenda across the country. We have educated the public through town hall meetings and

[1] In 1992, *Reader's Digest* claimed, "a network of cancer registries can be our most potent new weapon against cancer." Since then, Congress gave CDC the authority to expand cancer registries to every state. Unfortunately, current funding is inadequate to support this registry network, resulting in the closure of some regional registries. In order to reverse this trend, the American Cancer Society urge Congress to provide $55 million in funding for FY 2001 to expand and improve the collection of information gathered by CDC's state-based cancer registry program.

mass media, organized coalitions with literally hundreds of youth, health, education, and social service organizations to send a singular message to each legislative body, and hired additional staff to press each state to fund a sustainable, comprehensive statewide tobacco control program that meets minimum CDC requirements. Most importantly, we have collaborated with state health departments to develop concrete plans to implement comprehensive community tobacco control programs that meet national standards for effectiveness and demonstrate good stewardship of state dollars.

Yet, for the most part, our calls to action for policy makers to take advantage of this once-in-a-lifetime opportunity to end the scourge of tobacco and to decrease health care costs for generations to come have fallen on deaf ears. While a small number of states have invested tobacco settlement funds at a level sufficient to implement a statewide tobacco control program, the vast majority have woefully under-funded this program area. In his recent report the Surgeon General wrote that ". . . [o]ur lack of greater progress in tobacco control is more the result of failure to implement proven strategies than it is the lack of knowledge of what to do . . . Tobacco use will remain the leading cause of preventable illness and death in this Nation and a growing number of other countries until tobacco prevention and control efforts are commensurate with the harm caused by tobacco use." The American Cancer Society has heeded Dr. Satcher's call to level the playing field and we are working nationwide to help secure funding for comprehensive tobacco control efforts at a level commensurate with the damages tobacco inflicts.

I would like to share three specific state examples where the Society has dedicated significant resources in an effort to ensure that a meaningful portion of settlement dollars is dedicated to an effective tobacco use prevention and cessation program. In Maryland we have a positive example of a state that has made an investment sufficient to reduce tobacco consumption that will ultimately improve long-term health and decrease health care costs. As a second example, we call your attention to Kansas, which has earmarked money for tobacco control, but has done so at a nominal level leaving us little hope of impacting tobacco use rates. Third, in Connecticut, which since 1998 has received more than $250 million in settlement funds, only $5 million has been earmarked for tobacco control, of which only $4 million has been expended.

In Maryland just this April, we saw many months of work come to fruition in the form of legislation that established long-term funding allocations for tobacco settlement payments. The funds will be spent on 20 health and education programs focused on three main issue areas: tobacco prevention, education, and cancer. In the first payment for program ramp-up, $30 million was allocated to anti-cancer programs and $16 million was allocated for tobacco programs. For the next ten years, approximately $80 million annually is earmarked, $50 million for anti-cancer programs and $30 million for tobacco prevention programs, including $10 million for a tobacco prevention media campaign. ACS proudly led the Maryland coalition that achieved this success, funded radio and print ads to educate the general public and legislators about the importance of spending settlement dollars wisely, and provided other resources to help advance this proposal through the legislative process. We are confident that the vision shown by Maryland policymakers this year will reduce suffering, save lives, and control health care costs for generations to come.

The Maryland model, however, is far too rare, and the Society's experiences at the other end of the spectrum, have been far too prevalent. Take for example, Kansas, where the Society joined 44 other organizations, along with Kansas Attorney General (AG) Carla Stovall, to advocate funding for a comprehensive statewide tobacco control effort at the CDC recommended minimum of $18 million annually. Attorney General Stovall has a particularly keen interest in seeing that the money is spent in the spirit of the MSA, as she was the first Republican AG to enter the multi-state suit against the tobacco industry. Despite the multi-faceted citizen-based effort organized by a statewide coalition of which ACS is a member, a lingering budget crisis overshadowed the Kansas legislative session, and consequently a decision was made to put the first $70 million of settlement funds into deficit reduction. The remaining tobacco settlement funding was divided among several issue areas focusing on children and juvenile crime, with only a fraction actually going to tobacco prevention. The mere $500,000 allocation is well below the amount CDC recommends that Kansas invest in a comprehensive tobacco control program.

While the programs established to enhance the lives of children will benefit the future of Kansas, they unfortunately will do nothing to reduce the human and economic toll that tobacco takes on Kansans. Thus, in Kansas, the tobacco use problem will continue unabated unless the state significantly increases the tobacco control appropriations budget line in the next legislative session.

The outcome of the state settlement funding fight in Connecticut has been one of the most disappointing experiences for the Society volunteers and staff working at the state level to secure settlement money for comprehensive tobacco control programs. Connecticut consistently ranks as the country's wealthiest state in terms of average and disposable income, and since 1995 the state has enjoyed a budget surplus. In 1995, ACS partnered with Connecticut Attorney General Richard Blumenthal to form a statewide coalition known as MATCH (Mobilize Against Tobacco for Children's Health). Since then, the MATCH Coalition has grown to include more than 70 statewide agencies, with ACS often serving as the coalition's official voice.

Attorney General Blumenthal, while one of the first state AGs to sue the tobacco industry, was also the very last to sign onto the MSA because he was not convinced that individual state legislatures and governors would spend the money for the purpose the MSA was negotiated—to keep children from becoming addicted to tobacco and to alleviate the financial and social burden caused by tobacco use. To date, Attorney General Blumenthal's fears have been realized—especially in his home state. Despite the fact that the MATCH Coalition, unified with one voice, asked the state legislature and the governor for the CDC recommended minimum of $21 million to carry out a comprehensive tobacco control program, the state failed to meet the challenge. During the 2000 legislative session, although Connecticut received approximately $110 million in settlement funds, the state failed to dedicate any funding toward state tobacco control efforts. In fact, $1 million still remains unspent from the original $5 million allocated to tobacco control in 1999, the only settlement dollars yet to be dedicated to tobacco control in Connecticut.

We are deeply concerned that our experiences in Connecticut and Kansas have been more common than that in Maryland. As detailed in the Campaign for Tobacco Free Kids report released this week, only seven states have invested enough to ensure decreased tobacco use rates, and only eight more have appropriated enough to stand a chance at affecting a real change in tobacco use rates. This nation deserves better. It is a national shame that only 15 states have taken steps to reap long-lasting benefit from the largest health-related legal settlement in history.

The American Cancer Society stands willing and able to help develop and implement effective comprehensive tobacco control programs in each state and county in this country. However, it appears that without a significant shift in the attitudes and priorities of policy makers at all levels of government, the historic opportunity to reverse our nation's largest health burden will be wasted.

Congressional Role in Tobacco Control

While the states have an important role to play in tobacco control, this is also a national and global issue in which Congress has an absolutely critical role to play. In this respect, Mr. Chairman, the American Cancer Society appreciates the leadership role you have played in addressing tobacco control from a national perspective, and we look forward to working with you and your colleagues to pass effective tobacco control legislation. With your indulgence, I will briefly discuss several essential policies that can only be effectively implemented at the federal level.

First, we must have strong, effective, meaningful regulation of tobacco products by the Food and Drug Administration (FDA). The nation's deadliest consumer product cannot continue to be totally unregulated. FDA regulation over tobacco products should be consistent with the agency's regulation of every other product intended for human consumption. Any deviation from agency precedent should be fully justified on public health grounds.

Federal funding for tobacco control and prevention programs is another priority. CDC, for example, plays a unique role in advising and assisting all states and territories in their tobacco control efforts. This federal role leverages state dollars and effectively weaves the state programs into a national program. Unless CDC's National Tobacco Control Program is adequately funded, state programs will fall short of their potential. ACS respectfully requests that Congress allocate this critical public health program $130 million for FY 2001. Other federal agencies, including the National Institutes of Health and the Substance Abuse and Mental Health Services Administration (SAMHSA), also have important roles to play.[2] Federal funding for

[2] This year, the American Cancer Society joined with more than 40 other cancer-related organizations in an unprecedented collaboration as "One Voice Against Cancer" to call upon Congress to appropriate a 15 percent increase for the National Institutes of Health (NIH), $4.1 billion for the National Cancer Institute, and $622 million for the cancer-related programs, including the National Tobacco Control Program, at the CDC.

tobacco control programs remains far below the amounts justified by the magnitude of the problem and the opportunity we have to save lives and reduce suffering.

Congress also has an essential role to play in helping current tobacco users break their addiction. The federal government is the single largest provider and funder of health care services, yet the government's coverage of cessation benefits and services now falls far short of recommendations made by the Surgeon General and other leading health care experts. There is now overwhelming evidence that covering effective cessation is a good investment in both financial and human terms. Recent studies have shown that there are health benefits for individuals who cease their use of tobacco products, irrespective of their age at cessation. As mentioned above, approximately 70 percent of current tobacco users would like to quit and one barrier they experience is lack of insurance coverage for cessation. The "Medicare, Medicaid and MCH Smoking Cessation Promotion Act," sponsored by Senators Brownback and Durbin, would help provide Medicare and Medicaid beneficiaries and pregnant women served by state-based Maternal and Child Health Programs access to important tobacco cessation services and work to reduce and prevent tobacco-related illnesses and deaths among those populations.

The federal government also has an obligation to its taxpayers to hold tobacco companies accountable for their well-documented wrongdoing. Right now, the Department of Justice (DOJ) is pursuing Civil RICO charges against the tobacco companies. The federal judge overseeing the case ruled late last week that the RICO claim has legal merit. Unfortunately, tobacco industry allies in Congress have been trying to block funding for this lawsuit. This would effectively give the tobacco companies immunity for their violation of federal laws, and would deny American taxpayers their day in court. We urge Congress to provide the DOJ funding to pursue the RICO claims in FY 2001 and beyond, as necessary.

Another important tool to hold tobacco companies accountable is to impose prospective penalties on companies based on their share of the illegal youth market. This would reverse the perverse economic incentives now in place and stimulate the companies to compete with one-another to *reduce* their share of the youth market. Unfortunately, this measure has not yet been embraced by Congress.

There is a whole range of international tobacco control issues that also remains the responsibility of Congress, rather than the states. For example, negotiations begin in Geneva next week on a global treaty to promote tobacco control across borders. Congress has a proper role ensuring that the US plays a leading role in encouraging a strong, effective treaty. There are many other ways that Congress can promote tobacco control, multilaterally, bilaterally and unilaterally.

Please note that this is not an exhaustive list of issues that must be addressed by Congress. I have not touched on the need for higher federal tobacco taxes to reduce consumption, especially among children; stronger tobacco product warning labels; safeguards to prevent Internet tobacco merchants from preying on children and violating tax laws; stronger restrictions on tobacco advertising that harms children; and limits on candy-flavored bidi cigarettes and other youth-oriented tobacco products.

As you know, despite the historic settlement with the states, the tobacco industry and its products continue to wreak havoc on the health of our nation. While the public health community and many of our nation's public health and policy leaders had high hopes that the settlement would be the magic bullet to our nation's tobacco woes, it is clear that we continue to have our work cut out for us.

Conclusion

Mr. Chairman, we believe that it is imperative that the states set-aside the CDC recommended amount for comprehensive sustained tobacco control efforts. ACS remains committed to working at the state level to ensure that adequate resources are appropriated to fund both state and local efforts to prevent and reduce tobacco use among both children and adults. Our state-based staff are dedicated to ensuring that a majority of states—sooner rather than later—make significant investments of their settlement money into comprehensive, tobacco control programs that adhere to the best practices as outlined by the CDC.

However, equally important to this effort is the role of Congress in enacting complementary policies and programs. While we recognize we are in the waning days of the 106th Congress, we respectfully call upon Congress to ensure that CDC is provided adequate funding to support both state-based tobacco control and cancer registry efforts which will work to ensure that states have high quality, timely data and technical assistance to bolster their tobacco control efforts. And, as planning begins for the next Congress, we urge you to once again join with the public health community in providing meaningful regulatory authority for the FDA.

ACS looks forward to working with you and your colleagues in the 107th Congress to address many of the other issues I have outlined today in my testimony. We stand ready to work with you to protect our children from tobacco use and to help those currently addicted to quit. With this federal-state, public-private partnership, we will surely save both lives and money from a significant reduction in tobacco-related disease.

Mr. Chairman and Members of the Committee, please know the American Cancer Society sincerely appreciates the opportunity to present our views and thanks you for taking the time of our your schedules at this busy time of year to hold a hearing on this most important public health issue.

I shall be pleased to answer any questions you may have.

The CHAIRMAN. Thank you, Mr. Coolidge.

Mr. Myers, welcome back before the Committee.

STATEMENT OF MATTHEW MYERS, PRESIDENT, CAMPAIGN FOR TOBACCO-FREE KIDS

Mr. MYERS. Mr. Chairman, it is a pleasure to be here. My name is Matthew Myers. I want to start out by thanking you for your leadership. You have made a difference, and we look forward to continuing to work with you on this issue.

The CHAIRMAN. In the interests of straight talk and a complete record, I also failed.

[Laughter.]

Mr. MYERS. We were deterred for a time.

I have three points that I am going to make in my testimony today. First, that too often the states have failed to use the settlement money as it was intended, just as you said, and I would like to provide you some details.

Second, the need for action has never been greater. Despite the hope and promise of the MSA, the evidence shows the tobacco marketing that has the greatest impact on our children has not seen a fundamental change and, if anything, has even increased in the last 2 years.

And last, the need for Congress itself to act has not dissipated. We have not seen a fundamental change in the tobacco industry, and the same reasons that motivated this Congress to move forward 2 years ago are as real today.

Let me try to provide you some concrete numbers, if I may, about how the states are doing. As you know, we have provided the Committee with a brand new report, a score card on how the states are doing, that itemizes them one by one. It is not a pretty picture. Of the 44 states that have acted, only 15 have provided substantial new money. That means more than 50 percent of what the CDC has recommended as a minimum standard. Only five, or a third of those, actually either meet or come close to the CDC's standard, and in several cases these states are not using settlement money.

What we also see is that, in addition to those 15, 14 others have allocated what we call modest amounts of money, between 25 and 50 percent of what the CDC allocated, far too little to make a truly fundamental difference, a change we all think is necessary. And—excuse me, I got that number flipped around. It was 11 are between 25 and 50 percent, and it is 14 who fall under the 25 percent figure.

What that does is paint us a picture of a set of states that are haves and have-nots. It is a pleasure to be on a panel with rep-

resentatives from two of the states that are role models that have taken their commitment seriously and during the process of allocating——

The CHAIRMAN. Do you see any connection, Mr. Myers, between those who have allocated the money and those who have not, and the results as far as reduction of the use of tobacco?

Mr. MYERS. There is a direct connection. As you correctly noted, in the State of Florida, where we have a program that is 2 years old, we see a 40-percent reduction in tobacco use among middle school students and an 18-percent reduction in high school students. In the Commonwealth of Massachusetts, we have seen a 16 percent reduction since 1996 in teenage tobacco use.

Massachusetts is an interesting study, and I do not have this in my written testimony. If you compare Massachusetts to Rhode Island, which is using most of the money to repeal a car tax and virtually none for a comprehensive tobacco prevention program, during the same period of time that Massachusetts saw a 16-percent reduction, Rhode Island saw an actual increase in tobacco use among their children.

We are not talking about experimental programs. We actually know how to reduce tobacco use among kids.

Let me also point out something different, and that people do not often focus on. Massachusetts and California have programs to reduce tobacco use among pregnant women who smoke. Both of them succeeded in reducing tobacco use among that population by between 45 and 50 percent. Just in terms of the number of healthier babies that were born, babies who did not need long-term care, those programs paid for themselves.

My second point to you, sir, is that the need for action is no less today than when you first became involved. The hope had been that the master settlement agreement would bring about a different attitude and a different set of actions by the tobacco companies.

The master settlement itself, even if it was fully implemented in total good faith by the tobacco companies, only addresses less than 25 percent of the marketing dollar of the tobacco companies. But what we have seen is all too typical of the tobacco companies. In the year after the master settlement agreement, tobacco advertising in magazines with high youth readership, more than 15 percent, actually went up, not down. That is a stunning, stunning condemnation of the tobacco industry's good faith.

And when you look at the kind of advertising we are talking about, all you have to do is look at this chart over here. Or let me show you a relatively recent edition of Rolling Stone, where the woman who you probably do not know, because I do not know who she was, but my teenage son told me who she was, the woman who plays Buffy the Vampire Slayer, in this, and look at the kind of advertising we are talking about. Or in this edition, where we have Britney Spears, the teenage heartthrob. In both cases, face to face, Marlboro advertising. Or even a more recent edition, within the last 2 months, what we see, another one of these magazines, and you open it up, and you see the kind of advertising that is just directly targeted to these sorts of kids.

We went to retail stores, and we looked at what happens in retail stores since the master settlement agreement. Again what we found is advertising went up, not down. If you look at this photo that we have over there, all too often, that is the kind of thing we are seeing. That is not the good faith change we hoped to see.

And while billboards came down, the master settlement agreement permits outward-facing signs in convenience stores, and outdoor signs right on convenience store land. Good faith would have been that we would have no longer seen them. The reality is, we see more of them today than we saw before.

The master settlement agreement eliminated the ability of tobacco companies to put their brand name on T-shirts and other goods. We thought that was going to be a great step forward. Have the tobacco companies complied in good faith? Well, to the letter, maybe, yes, but let me show you that advertisement for Kool. You buy a package of Kool, and what is next to it? I would actually like to hand this to you later on, a little pocket radio, which is exactly the sort of thing you would find a young adolescent—this does not appeal to people your age and my age.

The unfortunate reality of what we see is that the tobacco industry responded to the master settlement agreement as they so often have before, as something to get around, and we are also seeing it in ethnic marketing, too. Here is a magazine targeted to Latinos, many Latino youth, and if you open it up it is filled with the same kind of advertising that we see here. Here is a Marlboro ad, and here is a Virginia Slims ad, appealing to, again. And what we are talking about here is by and large in this case a female population that does not smoke, who they are reaching out to.

A long way of saying, sir, we have a long way to go. The master settlement agreement was a good, solid attempt by the Attorneys General, but the states have not lived up to their commitments and the tobacco companies have not really changed, I would like to also focus on one other important area, because the master settlement agreement was designed to force the tobacco companies to tell us the truth about the health effects of smoking.

You held a hearing where you sat here and they weaseled around on addiction. You do not have to go back to 1994. The tobacco companies tell us they have turned over a new leaf, that they are going to tell the truth on these issues. If you go to their web sites and you watch their ads, you would think it is really true, but let me give you a couple of quotes of what they are really saying when people are not looking, what they are really telling people out there.

A good example. Despite acknowledging on their web sites that there is an overwhelming consensus about the health effects of smoking, less than a year ago Phillip Morris, under oath, filed an affidavit in court in New York and they said, and I quote a specific quote exactly, "it has not been scientifically established whether cigarette smoking causes any of these diseases in humans."

On the issue of addiction, which I would have hoped we would have put to bed, let me again quote from the sworn affidavit from Phillip Morris a year after the master settlement agreement, and I quote, "nicotine in cigarettes is not addictive under objective, sci-

entifically verifiable, pharmacologic criteria used to define that term."

Unfortunately, they may be spending hundreds of millions of dollars to tell the American public they have changed, but the facts do not support that conclusion.

Sir, we hope that we can push the states, with your assistance, to live up to their promise. We also think it is essential to recognize that there is truly important unfinished business in this body. The authority for the Food & Drug Administration is a top priority. We need the kind of comprehensive legislation that you have championed.

We should not be giving the tobacco companies breaks through the Foreign Sales Corporation legislation. That does not make any sense whatsoever, and we ought to ensure that the special interests of the tobacco industry do not have Congress intervene to cut off the Department of Justice's lawsuit against the tobacco companies. That lawsuit ought to be decided on its merits, and that is even more important today, now that the judge in the district court has permitted that lawsuit to go forward.

I want to thank you for continuing to champion these issues. We in the public health community offer you our full support, and to work with you and the type of public officials we have up here today to really tackle this problem. As Dr. Satcher said, this is real life and death. If we can reduce by 50 percent the number of kids who smoke, we are talking about saving millions of our children's lives. There is virtually nothing else we can do that can have that kind of public health impact.

Thank you very much.

[The prepared statement of Mr. Myers follows:]

PREPARED STATEMENT OF MATTHEW MYERS, PRESIDENT, CAMPAIGN FOR TOBACCO-FREE KIDS

Good morning Mr. Chairman, and Members of the Committee. My name is Matthew Myers. I am the President of the National Center for Tobacco-Free Kids, a national organization created to protect children from tobacco by raising awareness that tobacco use is a pediatric disease, by changing public policies to limit the marketing and sales of tobacco to children, and by actively countering the special interest influence of the tobacco industry.

Mr. Chairman, I want to thank you for your continued leadership on the issue of tobacco control. Many others and I are very grateful for your willingness to stand up for our kids and take on the tobacco companies. During the past year you have been attacked by allies of the tobacco companies, but you have not backed down, and today's hearing is further evidence of your commitment to protecting our children and reducing the death toll of tobacco.

I also want to thank Senator Hollings for his leadership, particularly his recent efforts to ensure that the Department of Justice is able to move forward with its lawsuit against the tobacco companies. I also want to again express our desire to continue to work with Senator Hollings on efforts to assist tobacco farmers. I believe we can simultaneously protect the public health and help family farmers and their communities reduce their economic dependence on tobacco production. For years, the cigarette companies have tried to blame the plight of the American tobacco farmer on public health initiatives and declining smoking rates. But it has become increasingly clear that the primary cause has been the decisions of the cigarette companies. The tobacco companies have chosen to maximize their profits by relying on less-expensive foreign labor and cheap foreign-grown tobacco while sacrificing the economic well being of the American tobacco farmer.

My testimony today will focus on a few key points:

1. A report being released today by the Campaign for Tobacco-Free Kids, the American Heart Association, the American Cancer Society, and the American

Lung Association demonstrates that too often states are not living up to their promise to spend the tobacco settlement money to reduce tobacco use.

2. The need for comprehensive, effective prevention programs has never been greater because tobacco company promotional expenditures that affect children continue to rise. The Master Settlement Agreement has eliminated or reduced some types of advertising and promotions, but the evidence shows that the tobacco companies are continuing the marketing practices that have the greatest impact on our children.
3. And finally, we believe the federal government must show leadership on the issue of tobacco. State and local efforts will not be enough. There are a number of positive steps Congress can take in the next session to reduce tobacco use and there are a number of issues that are of immediate concern to us and others in the public health community. For example:

- The next Congress should grant the Food and Drug Administration (FDA) the authority to regulate tobacco products just as FDA regulates other products consumed by Americans.
- Language in a number of appropriations bills designed to block the Department of Justice lawsuit against the tobacco companies should be rejected. This Congress should adopt the Hollings amendment to provide funding for the lawsuit and reject special legal protections for the tobacco companies
- The Foreign Sales Corporation legislation that recently passed the House should be amended to end the current tax subsidy of tobacco company exports.

State Spending on Tobacco Prevention and Cessation

The states' tobacco settlement, known as the Master Settlement Agreement (MSA), presented the states with a unique opportunity to reduce the terrible burden exacted by tobacco on America's families and communities.

We have issued regular reports tracking whether and to what extent the states are living up to their original promise to use a significant portion of the settlement funds to attack the enormous public health problem posed by tobacco in the United States. Virtually every state legislature has now had the opportunity to make at least an initial decision about how to spend the billions of dollars that they are receiving from the tobacco companies.

Our latest report shows that too often the states are not living up to their promise to spend the settlement money to reduce the death toll from tobacco. Fifteen states have made substantial commitments to fund tobacco prevention and cessation, but of those states, only five met the minimum funding levels recommended by the U.S. Centers for Disease Control and Prevention (CDC) for effective programs. Eleven additional states committed only modest amounts to new tobacco prevention and cessation programs (less than one-half the minimum amount recommended by the CDC). Fourteen states have committed minimal amounts to tobacco prevention and cessation (less than 25 percent of the minimum amount recommended by the CDC). Three states committed none of the settlement money to tobacco prevention. One of these, California, currently has a comprehensive tobacco prevention program funded by state cigarette excise taxes, but two have no existing tobacco prevention program. One state placed its funds into a trust fund that would permit, but not require any of the funds to be used for tobacco-related purposes, and six states have not yet acted at all. Finally, of the four states that had comprehensive programs prior to the MSA, only one has used funds from the settlement to enhance its tobacco prevention efforts.

The tobacco settlement has resulted in an increase in the amount of money being spent at the state level on tobacco prevention and cessation, but the numbers are woefully short of what the CDC has concluded represents the absolute minimum necessary to fund a truly effective, sustained comprehensive program.

The new funding levels for tobacco prevention only sound large in comparison to the amount states have traditionally spent on tobacco prevention. When the public health problems posed by tobacco are compared to other health problems, it is clear that the amount the states are spending on tobacco prevention today pales in comparison to the magnitude of the problem, as well as to the amount spent by the tobacco companies to promote the problem.

It is not enough to claim, as some will undoubtedly do, that more of the money in many states is to be spent on other "health" programs. These cases were brought to reduce the death toll from tobacco. There is no single public health action that will save more lives than a dramatic reduction in the number of people who die from tobacco use. By investing in tobacco prevention now, states will save money in the long term, and see their health care costs decline along with tobacco consumption.

And in all states, the investment in tobacco prevention can be made while still leaving the majority of the settlement funds available for other worthy causes.

Comprehensive Prevention Programs Work

The states' failure to fund tobacco prevention is tragic because the evidence is now conclusive that comprehensive state programs work. As others have pointed out, including the Institute of Medicine in its March, 2000 report entitled "State Programs Can Reduce Tobacco Use", and the Surgeon General in his August, 2000 report, entitled "Reducing Tobacco Use," we know how to reduce tobacco use and the harm it causes. The Surgeon General found that our country could make unprecedented progress and reduce tobacco use by 50 percent in one decade through implementation of currently used comprehensive prevention and cessation programs. These reports make clear that state funds spent on tobacco prevention and cessation are not experiments or learning opportunities. To the contrary, they are proven strategies that will produce important results for the health of our country.

The Surgeon General's prediction is grounded in experience. In the six states with comprehensive tobacco prevention programs (California, Massachusetts, Oregon, Arizona, Florida and Mississippi), the results have been impressive. For example, in Florida smoking was reduced by 40 percent among middle school students and 18 percent among high school students in less than two years. Between 1996 and 1999, smoking among high school students in Massachusetts decreased by 16 percent. Since 1988, tobacco consumption in California has declined by 50 percent, compared to 30 percent for the country as a whole.

Need for Effective Programs Never Greater—Continued Industry Marketing and Targeting of our Kids

Two years after the state settlement, the tobacco companies are spending more marketing their products than the states are spending on tobacco prevention and cessation. According to the most recent official report of tobacco industry spending by the Federal Trade Commission, in 1998 the tobacco manufacturers spent $6.7 billion, or more than $15.5 million each day, to promote their products. In contrast to the $6.7 billion in annual tobacco industry marketing expenditures, the National Conference on State Legislatures estimates that in FY 2000 and FY 2001, the legislatures appropriated a total of approximately $168 million and $430 million, respectively, of the tobacco settlement money for tobacco prevention and cessation out of a total of more than $8 billion they received.

The need has never been greater. Even if fully enforced the MSA impacts less than 20 percent of cigarette marketing. Tobacco company promotional expenditures that affect children actually increased in the year after the state settlement. Recent studies show that tobacco advertising in magazines read by significant numbers of children, like Sports Illustrated and Rolling Stone, has increased by 33 percent since the MSA (see attachments). And one of these studies found that tobacco advertising in magazines reaches a huge majority of kids with alarming frequency and that this reach has increased dramatically since the settlement for several brands. The study found that eight of the top ten cigarettes brands each reached at least 70 percent of 12 to 17 year olds five or more times with magazine advertising in all of 1999. Marlboro, Kool and Winston each reached at least 89 percent of youth with that frequency in 1999.

Shortly after these studies were released Philip Morris announced that it would suspend advertising in magazines with more than a 15 percent youth readership. However, this action was taken only after they were caught red-handed and publicly chastised. Other companies continue to advertise in magazines with a significant youth readership and of course Philip Morris could reverse its decision.

Similarly, advertising in convenience stores, which three of four teens visit once a week, has jumped substantially since the MSA (see attachment). These studies and other direct evidence provide proof that the claims of Philip Morris and the other tobacco companies that they have changed are not born out by the facts.

It is also important to note that this continued advertising aimed at kids violates both the MSA and the tobacco companies' own publicly stated policies on advertising. The MSA prohibits the tobacco companies from taking any action, directly or indirectly, to target youth. Brown and Williamson Tobacco Co. has stated publicly that its policy is to not advertise in publications with more that 15 percent youth readership, yet it has refused to cease advertising in such publications. Neither self-regulation nor the MSA has proved effective at stopping the tobacco companies from targeting kids. That is why we need for the states to invest in comprehensive tobacco prevention programs and for the Congress to grant the FDA the authority to regulate tobacco.

It should not surprise us that the industry continues its marketing to kids, as well as its double talk and its efforts to evade, circumvent and subvert restrictions imposed upon it. The tobacco industry loses 2 million smokers every year to death or quitting, and it must replace them in order to stay profitable. Virtually no one becomes a smoker after age 18. Almost 90 percent of regular smokers began at or before age 18.

And their marketing works. Kids are susceptible and receptive to marketing. Studies show that kids are up to 3 times as sensitive as adults to cigarette advertising. Almost 90 percent of all adult smokers begin smoking when they are 18 or younger. Sixty percent of kid smokers smoke the most heavily advertised brand—Marlboro. Eighty-six percent of kid smokers choose the 3 most heavily advertised brands, while only one-third of adult smokers do. And we see the effects of tobacco company targeting of ethnic populations when over 80 percent of African American high school seniors who smoke choose Newport.

Continued Industry Double Talk on Basic Issues of Health

As you can see, despite the settlement of the suit by the states Attorneys-General almost two years ago, despite the specific promises as part of that settlement not "to target youth," despite all the public promises since that time not to market cigarettes in magazines with youth readership, despite a multi-million dollar public relations campaign to convince the public that tobacco companies are responsible corporate citizens, the plain truth is that the industry has continued its historic pattern of misdeeds, bad acts, double talk and deadly deception.

I want to address specifically Philip Morris' multi-million dollar TV ad campaign touting the MSA and their philanthropic efforts in the community as evidence of change. As the examples of continued marketing to kids show, this public relations campaign is aimed at creating an illusion of change, and blocking meaningful government action at the federal and state levels to protect our kids and reduce the disease and death caused by tobacco. Unlike some of the other tobacco companies, Philip Morris can't even bring itself to make a clear admission that tobacco is addictive and leads to disease and death.

Despite publicly acknowledging on its website that "there is overwhelming medical and scientific consensus that cigarette smoking causes lung cancer, heart disease, emphysema and other serious diseases . . ." Philip Morris, in papers filed with a federal court in New York in November of 1999, stated "it has not been scientifically established whether cigarette smoking causes any of these diseases in humans . . ."

Despite publicly acknowledging on its website that "Cigarette smoking is addictive, as that term is most commonly used today," Philip Morris, in papers once again filed with the federal court in New York in November 1999, stated that nicotine in cigarettes is not 'addictive' under objective, scientifically verifiable pharmacological criteria used to define that term."

In sworn testimony for the Engle tobacco trial in Florida, Philip Morris CEO Michael Szymanczyk states: "The company's position is that there is an overwhelming scientific and medical consensus that smoking causes lung cancer and disease." When asked if Philip Morris ever agreed with that consensus, Szymanczyk states: "We have not."

Does this sound like a reformed industry? I don't think so.

The Need for Federal Action to Reduce the Toll of Tobacco

There is much that state and local governments can do to reduce tobacco use, particularly among our children. But the federal government should also take action and provide leadership on this nationwide problem.

FDA Jurisdiction over Tobacco Products

Perhaps most importantly, Congress should pass legislation giving the Food and Drug Administration (FDA) authority over tobacco products. The Supreme Court in its ruling this year on FDA authority called tobacco the nation's most significant public health threat, particularly for children and adolescents, and made clear that the obligation to protect our kids from tobacco falls squarely on Congress.

Real FDA authority must include oversight of the sale, marketing and manufacture of tobacco products. The MSA impacted only 20 percent of cigarette marketing, and FDA should be given the authority necessary to stop tobacco marketing to children. The tobacco companies have proven, time and again, that they will exploit every loophole they can find to continue targeting kids for addiction. They will not be stopped until Congress gives the FDA strong, enforceable authority to regulate tobacco.

Unlike the manufacturer of any other product consumed by Americans, tobacco companies continue to escape even the most basic oversight for health and safety.

Tobacco companies are not required to test additives for safety purposes, inform consumers what is in their products or take any action to make their deadly products less harmful or less addictive.

The lack of government regulation or oversight of the tobacco industry leaves American consumers uninformed and at risk. For example, just yesterday a new study was released showing that R.J. Reynolds' new Eclipse cigarettes expose smokers to greater amounts of several cancer-causing chemicals compared to two "ultralight" cigarette brands already on the market. The study casts doubt on RJR's claims that Eclipse "may present smokers with less risk of cancer" and other tobacco-related diseases. When RJR announced the test marketing of Eclipse in April, the company claimed that smoking Eclipse produces 80 percent less carcinogens than a "typical ultralight." Without FDA regulatory authority to verify health claims, RJR can continue to make claims, and American consumers will end up being human guinea pigs. Past experience with so-called 'reduced-risk' products show that they turn out to be marketing frauds aimed at getting more people to start and continue a lethal habit.

Explicitly granting the FDA authority over tobacco products would not subject the tobacco industry or its products to more intensive governmental scrutiny than other industries or products. It would simply apply to tobacco products the same kind of regulatory oversight that already applies to all other legal, and far less harmful, products consumed by Americans. Even Macaroni and Cheese, another Philip Morris product, is more regulated than tobacco. The time for Congressional action granting FDA the authority over tobacco is decades past-due.

Reject Special Legal Protections for the Tobacco Companies

Tobacco industry supporters in Congress have tried this year to attach a never-ending array of misguided amendments to a host of appropriations bills in an effort to derail the Department of Justice lawsuit against the tobacco companies. Congress should adopt the amendment offered by Senator Hollings during Committee consideration of the Commerce-Justice-State appropriations bill to provide DOJ with the funding needed to pursue the lawsuit. Just last week, a U.S District judge ruled that the lawsuit may proceed under U.S. racketeering statutes, repudiating claims that the suit had no merit. The United States Senate should take immediate action to assure funding for the lawsuit so that the American people have their day in court.

Foreign Sales Corporation Repeal and Extraterritorial Income Expansion Act

The House of Representatives recently passed the Foreign Sales Corporation Repeal and Extraterritorial Income Expansion Act. This legislation would continue special tax benefits of more than $100 million a year for the tobacco industry. These enormous tax breaks are nothing other than a subsidy, at American taxpayer expense, for the tobacco industry to export death and disease abroad. Numerous products already are excluded from this legislation for public policy reasons. Tobacco companies should also be excluded and should not receive a tax break.

As smoking rates decline in the West, U.S. tobacco companies are aggressively recruiting smokers in developing nations. The World Bank estimates that between 80,000 to 100,000 children become addicted to cigarettes every day worldwide. Already, tobacco use kills about four million people every year. Based on current trends, the World Health Organization predicts that tobacco will kill ten million people per year by 2030, with 70 percent of those deaths occurring in developing countries. The government of the United States should work to prevent this public health catastrophe, not to promote it. We urge that this gift to the tobacco companies be debated fully in the Senate. There should be an up-or-down vote.

Mr. Chairman, thank you for the opportunity to testify today. I sometimes worry that legislators believe we solved the problem of tobacco and children with the MSA. Nothing could be further from the truth. Much more work needs to be done at the local, state, and federal level. I look forward to continuing to work with you and other Members of this Committee to take advantage of the many opportunities for Congress to protect our children from tobacco.

Camel His Advertised in the Past Year in the Following Magazines:

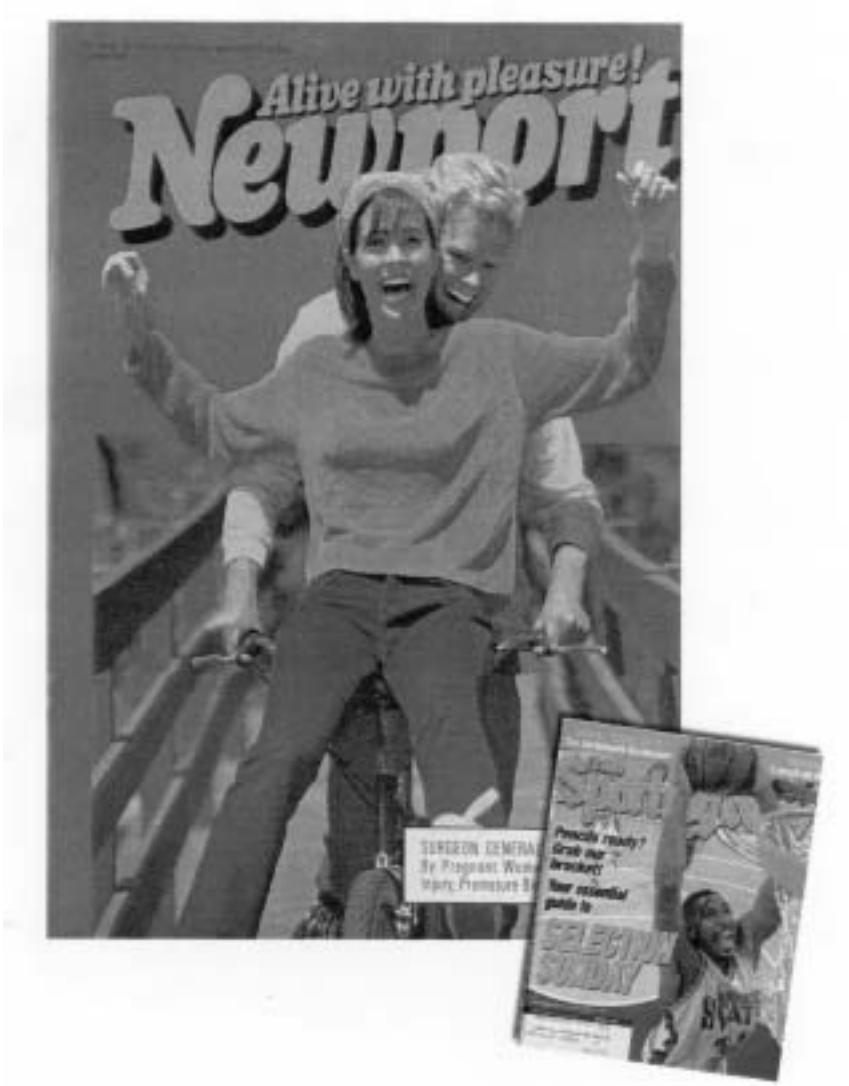
Glamour—19.81% youth readership and 2,882,000 youth readers
Hot Rod—31.14% youth readership and 2,937000 youth readers
Mademoiselle—23.66% youth readership and 1,540,000 youth readers
Rolling Stone—28.17% youth readership and 3,318,000 youth readers
Spin—32.03% youth readership and 1,316,000 youth readers
Sports Illustrated—22.55% youth readership and 7,254,000 youth readers
Vibe—42.23% youth readership and 2,864,000 youth readers
Vogue—18.88% youth readership and 2,353,000 youth readers

Kool Has Advertised in the Past Year in the Following Magazines:

Glamour—19.81% youth readership and 2,882,000 youth readers
Hot Rod—31.14% youth readership and 2,937,000 youth readers
Mademoiselle—2366% youth readership and 1,540,000 youth readers
Motor Trend—25.21% youth readership and 2,131,000 youth readers
Rolling Stone—28.17% youth readership and 3,318,000 youth readers
Spin—32.03% youth readership and 1,316,000 youth readers
Sport—32.99% youth readership and 2,605,000 youth readers
Sporting News—30.01% youth readership and 1,190,000 youth readers
Sports Illustrated—22.55% youth readership and 7,254,000 youth readers
Vibe—42.23% youth readership and 2,864,000 youth readers
TV Guide—16.05% youth readership and 8,131,000 youth readers
Essence—17.49% youth readership and 1,593,000 youth readers
Star—15.17% youth readership and 1,518,000 youth readers

Marlboro Has Advertised in the Past Year in the Following Magazines:

Elle—23.4% youth readership and 1,059,000 youth readers
Glamour—19.81% youth readership and 2,882,000 youth readers
Hot Rod—31.14% youth readership and 2,937,000 youth readers
Mademoiselle—23.66% youth readership and 1540,000 youth readers
Motor Trend—25.21% youth readership and 2,131,000 youth readers
Outdoor Life—20. 33% youth readership and 1,867,000 youth readers
Popular Mechanics—17.52% youth readership and 2,301,000 youth readers
Rolling Stone—28.17% youth readership and 3,318,000 youth readers
Spin—32.03% youth readership and 1,316,000 youth readers
Soap Opera Digest—16.65% youth readership and 1,503,000 youth readers
Sport—32.99% youth readership and 2,605,000 youth readers
Sporting News—30.01% youth readership and 1,190,000 youth readers
Sports Illustrated—22.55% youth readership and 7,254,000 youth readers
TV Guide—16.05% youth readership and 8,131,000 youth readers
Vogue—18.88% youth readership and 2,353,000 youth readers



Newport Has Advertised in the Past Year in the Following Magazines:

Essence—17.49% youth readership and 1,593,000 youth readers
Outdoor Life—20. 33% youth readership and 1,867,000 youth readers
Popular Mechanics—17.52% youth readership and 2,301,000 youth readers
Rolling Stone—28.17% youth readership and 3,318,000 youth readers
Spin—32.03% youth readership and 1,316,000 youth readers
Sporting News—30.01% youth readership and 1,190,000 youth readers
Sports Illustrated—22. 55% youth readership and 7,254,000 youth readers
Star—15.17% youth readership and 1,518,000 youth readers

Virginia Slims Has Advertised in the Past Year in the Following Magazines:

Elle—23.4% youth readership and 1,059,000 youth readers
Glamour—19.81% youth readership and 2,882,000 youth readers
Mademoiselle—23.66% youth readership and 1,540,000 youth readers
Rolling Stone—28.17% youth readership and 3,318,000 youth readers
Vibe—42.23% youth readership and 2,864,000 youth readers
TV Guide—16.05% youth readership and 8,131,000 youth readers
Vogue—18.88% youth readership and 2,353,000 youth readers
Essence—17.49% youth readership and 1,593,000 youth readers
Soap Opera Digest—16.65% youth readership and 1,503,000 youth readers
Self—15.98% youth readership and 814,000 youth readers


Winston
The Taste You Value
$11.95
$11.95
$11.95
220
220

The CHAIRMAN. Thank you, Mr. Myers. Thank you for your impassioned and dedicated advocacy to this issue for many years, and you have brought great credibility, and we thank you for it.

Majority Leader Hurson. Thank you, sir.

STATEMENT OF HON. JOHN HURSON, DELEGATE, MARYLAND GENERAL ASSEMBLY

Mr. HURSON. Mr. Chairman, my name is John Hurson. I am the Majority Leader of the Maryland House of Delegates of the Maryland General Assembly, and before I go on I would just like to also tell you how much, Mr. Chairman, I support your activities on campaign finance reform. We have talked about that. I hope to see you in Annapolis helping us pass that as well.

The CHAIRMAN. It will be my pleasure, sir.

Mr. HURSON. I am speaking on behalf of the National Conference of State Legislatures, where I serve as chairman of the Assembly on Federal Issues, which is the policy making arm of the conference. It is a pleasure for me to be here as part of this distinguished panel to discuss how the states have responded to the tobacco settlement.

I would like to take this opportunity to thank the Surgeon General and the Centers for Disease Control for their extraordinary assistance to the states as we go through this process. I would also like to acknowledge the work of the American Cancer Society and Tobacco-Free Kids. In Maryland we have worked very closely with them and with the rest of the advocacy community to try to make our initiative as strong as it possibly can be.

That being said, I know that I and my colleagues in the state legislatures and across the Nation are not always as receptive to my fellow panelists' recommendations as they might like us to be. However, I urge them to continue to participate in the process and to spend even more time in the Nation's state capitols working on these important issues, and I know that the National Conference of State Legislatures, and in my role as chairman of their Assembly on Federal Issues, will work to promote the best practices that we have going across the states in states like Ohio and Maryland, so that other states can adopt those practices.

I would like to submit the report the State Allocation of Tobacco Settlement Funds, published in August of this year by the Health Policy Tracking Service of NCSL, in its entirety for the record.*

The CHAIRMAN. Without objection.

Mr. HURSON. This report provides a state-by-state breakdown of expenditures for fiscal years 2000 and 2001. Two years after the signing of the agreement in November 1998, the largest single expenditure category so far is health care in the states. If you include tobacco prevention and cessation and long-term care as part of the health care, it represents 55 percent of appropriated expenditures. Breaking that down, we have 43 percent of the expenditures, and this is combining all the states' expenditures, of the appropriated funds are dedicated to health care.

Much of that is in the states' match for SCHP and also for medicaid spending, 9 percent is set aside for tobacco prevention and

*The information referred to has been retained in the Committee files.

cessation, 3 percent for long-term care, 2.5 percent for research, 6.5 percent for services for children and adults—adolescents, I am sorry—5.9 percent for education, much of that actually is to our academic health centers for research in tobacco, 6 percent for budget reserve, 6 percent for tobacco growers, and 17 percent miscellaneous.

Some states have not actually made their final decision on either how to manage the account or what programs to support for the funding. Some of these states are putting the question directly to the people of the state through the ballot initiative process, like Oregon. Last year, the people of Louisiana adopted a spending plan for their settlement dollars through the ballot initiative. This year, six states, Arkansas, Arizona, Montana, Oklahoma, Oregon, and Utah will take the tobacco settlement expenditure question directly to the voters via the ballot initiative.

The Maryland cigarette restitution program had a two-pronged approach, focusing on tobacco prevention and cessation, $18.1 million, and cancer reduction, $30.8 million. My written testimony includes the dollar amounts for specific components of these programs, but the numbers really fail to tell the story of what we are trying to do.

As part of the tobacco prevention and cessation initiative we have awarded a contract to conduct a baseline study of tobacco use by youth and adults in Maryland. We have actively engaged the assistance of our local governments to assist in the overall effort, and the state is providing technical assistance to local governments.

I might add here that one of the things we are hoping is that by giving some of this money to our local governments, they will in fact increase their own spending on some of these initiatives.

Maryland has obtained a grant from the MSA-established American Legacy Foundation to develop a state-wide youth movement against tobacco use. Our cancer prevention education screening and treatment program is well underway. We have already published a baseline cancer report. Fifteen local jurisdictions have already received cancer planning grants and are proceeding. We have also offered assistance to our tobacco growers, a small but important part of our economy.

What is ahead for the states? States are going to continue to make adjustments in their tobacco settlement spending plans and I need to emphasize, particularly after what I have heard here, states are going through the process of getting this thing going. It has been 2 years. Many of the states had to implement the model legislation first. The issue of recoupment had to be settled as well before states knew exactly where their budgets were going to be.

The tobacco settlement also leaves plenty of room for additional state legislative initiatives regarding youth access. The settlement establishes eight areas of state legislation and regulation that the industry is prohibited from lobbying against.

There is a provision in the MSA that prohibits the manufacture of cigarettes in packages of less than 20, and prohibits the sales of cigarettes in packages of less than 20. These provisions sunset December 31, 2001, unless the states enact legislation prohibiting these practices. Maryland will consider that issue in the coming session.

This is likely to be priority legislation in many states across the Nation in our next legislative sessions, but we need help as well at the federal level. Gray market cigarettes are a product that is manufactured for foreign sale but is diverted back to the United states by third parties for domestic sale.

The Balanced Budget Act of 1997 made the reimportation of tobacco products produced domestically for foreign sale illegal for everyone except product manufacturers, but failed to include provisions for cigarettes manufactured overseas for sales overseas that is diverted to the United States market.

As a result, foreign-source product is becoming the dominant source for gray market cigarettes. These cigarettes are typically sold at below-market prices, making them much more attractive to young people. In addition, every pack of gray market cigarettes sold displaces the sale of domestic packs, lowering payments to states through the MSA, since payments are based on the sale of and the market share of domestic product.

Forty-four states have enacted legislation in the area, but state legislation cannot fully resolve this problem. I would urge you to support legislation recently approved by the Senate Finance Committee that includes provisions that would address the growing problem of gray market cigarettes. This legislation will assist in our efforts to reduce youth access to tobacco and will also help states stabilize our tobacco settlement funding.

And again I repeat, in my leadership role at NCSL I will continue to help urge states to adopt models like Maryland and Ohio as their way of dealing with the tobacco settlement. I thank you and applaud your hearing here today to focus interest on this issue.

[The prepared statement of Mr. Hurson follows:]

PREPARED STATEMENT OF HON. JOHN HURSON, DELEGATE, MARYLAND GENERAL ASSEMBLY

Mr. Chairman and Distinguished Members of the Committee:

My name is John Hurson. I am the Majority Leader in the House of Delegates of the Maryland General Assembly. I am speaking on behalf of the National Conference of State Legislatures where I serve as the chairman of the Assembly on Federal Issues, the policymaking arm of the conference.

It is a pleasure for me to be here as part of such a distinguished panel to discuss how the states have responded to the tobacco settlement. I would like to take this opportunity to thank Surgeon General Satcher and the Centers for Disease Control and Prevention (CDC) for the extraordinary assistance they have provided to states. The CDC staff have provided technical assistance to many legislatures and their materials "best practices" are widely used as models. My own state is working in partnership with the CDC to move forward on our tobacco initiative.

I would also like to acknowledge the work of the American Cancer Society and Tobacco Free Kids. In Maryland we are working hand-in-hand with the advocacy community to try to make our initiative as strong as it can be. That being said, I know that I and my colleagues in legislatures in Maryland and across the nation are not always as receptive to my fellow panelists' recommendations as they might like. However, I urge them to continue participating in the process and to spend even more time in the nation's state capitols working on these important issues.

Master Settlement Agreement

Overview

On November 23, 1998 the Attorneys General of 46 states, Puerto Rico, the U.S. Virgin Islands, American Samoa, the Northern Mariana Islands, Guam and the District of Columbia signed an agreement with the five largest tobacco manufacturers, ending a four-year legal battle between the states and the industry that began in 1994 when Mississippi became the first state to file suit. Four states (Florida, Min-

nesota, Mississippi and Texas) had previously settled with tobacco manufacturers for $40 billion. This Master Settlement Agreement (MSA) settled all antitrust, consumer protection, common law negligence, statutory, common law and equitable claims for monetary, restitutionary, equitable and injunctive relief alleged by any of the settling states with respect to the year of payment or earlier years. The MSA cannot be modified in any way unless all the parties agree to the modification.

The Master Settlement Agreement did not include specific provisions for tobacco growers and impacted communities, but did call for participating manufacturers, tobacco growers and state officials from tobacco producing states to continue a dialogue. The National Tobacco Growers Settlement Trust was agreed to on July 19, 1999. In the agreement, the 14 tobacco producing states (North Carolina, Kentucky, Tennessee, South Carolina, Virginia, Georgia, Ohio, Indiana, Florida, Missouri, West Virginia, Alabama, Maryland, and Pennsylvania) agreed on a formula for the distribution of a $5.15 billion trust fund. Under the agreement, the funds would be distributed to the states using the quota system used by the U.S. Department of Agriculture (USDA).

What Have States Been Doing Since the Adoption of the MSA?

Under the provisions of the agreement, states were required to begin implementation of the settlement agreement immediately. States that had suits pending were required to begin actions to settle the suits and to get the consent decree implementing the settlement agreement filed by December 11, 1998. The other states were required to file the necessary paperwork by December 23, 1998. This began the process of obtaining *state specific finality, the trigger for access to the funds.* State courts reviewed the consent decrees and addressed challenges to the implementation of the settlement agreement in the states. States have until December 31, 2001 to obtain state specific finality. Failure to achieve state specific finality by the deadline would effectively remove the state from the MSA. Currently, all but two states (Arkansas and Missouri) have achieved state specific finality.

The most immediate task for state legislatures was: (1) to resolve the Medicaid recoupment conflict with the Administration and Congress; and (2) to consider and enact the "model statute [1]" included in the settlement agreement. This model statute is designed to provide a level playing field between participating and non-participating tobacco manufacturers. Failure to enact the model statute could result in a significant reduction in a state's allotment by triggering the nonparticipating manufacturers adjustment. I am pleased to say that the Medicaid recoupment issues was successfully resolved in the spring of 1999. I am also pleased to report that the Model Statute has now been enacted by all of the states included in the Master Settlement Agreement.

Managing the Tobacco Settlement Funds

The next task for states was to determine how the state would structure the settlement funds. Should a trust fund or endowment be established? Should the state consider bond securitization? Should the funds just go into the general fund and be appropriated under the regular process?

According to our most recent information, 26 states have created trust funds and four states have established endowments. Trust funds are usually subject to the appropriations process and the principal is available for expenditure. The fund is usually maintained as separate accounts in the state treasury. Five states (Idaho, Kansas, Louisiana, Minnesota, Mississippi, and New Mexico) have established endowments. Utah will establish an endowment if a proposed ballot initiative is adopted by the people in November. Most endowments limit expenditures to income generated from investments. The principal is never spent. The other states are gen-

[1] Under the MSA, if in any year the total aggregate market share of the participating manufacturers decreases more than 2 percent and an economic consulting firm determines that the provisions of the MSA were a significant factor contributing to the market share loss, payments to states may be reduced based on that loss. This reduction in state payments is called the nonparticipating manufacturers (NPM) adjustment This analysis is done annually. A state's enactment of the model statute is significant because **if there is an NPM adjustment in any year, a state's payment will not be reduced at all if that state has passed and has in force the model statute.** Payments to the states that do not have a model statute or qualifying statute in full force and effect will be reduced to cover the entire NPM adjustment. This could result in a state losing its entire payment for that year. If a state enacted the model statute, but the statute is overturned or invalidated by a court action, the state would pay no more than 65 percent of its payment toward the NPM adjustment in that year. If a state has enacted a "**qualifying statute**" as opposed to the model act in the MSA, and the qualifying statute is struck down by a court, the state will not enjoy any of the protections afforded states that enact the model act. In other words, those states would be subject to the full NPM adjustment in that year and would not enjoy the benefits of the 65 percent cap.

erally appropriating the funds from the general fund, but are establishing spending guidelines through legislation.

Finally, some states are considering bond securitization, which permits a state to receive a discounted lump sum payment up front. South Carolina enacted legislation to securitize its tobacco payments beginning in 2001, shielding the state from inherent instability in the tobacco settlement funding structure (pending state and federal lawsuits, volume reductions etc.). Florida and Iowa enacted legislation authorizing securitization, but additional legislation would be necessary to move forward. Three jurisdictions in New York (Westchester and Nassau counties and New York City) have securitized the funds they received from the state settlement. Arkansas would authorize the issuance of revenue bonds if the tobacco settlement ballot initiative is adopted by the voters.

Developing Spending Plans for the Tobacco Settlement Funds

I would like to submit the report, *State Allocation of Tobacco Settlement funds: FY 2000 and 2001,* published August 1, 2000 by the Health Policy Tracking Service at NCSL, in its entirety for the record. I will briefly summarize the highlights of the report here.

Approximately, 43 percent of the appropriated funds are dedicated to health care, 9 percent is set aside for tobacco prevention and cessation; 3 percent for long term care; 2.5 percent for research and 6.5 percent for services for children and adolescents. The remaining funds are used for education (5.9%); tobacco growers (6%); budget reserve (6%) and miscellaneous other spending (17%).

My colleagues across the country are working very hard to be responsive to the citizens of their respective states and have made extraordinary efforts to obtain input from the people in their states regarding the disposition of these funds. As you know, if we as elected officials fail to see the signal or heed the call, the voters have a way of letting us know exactly how they feel. I am confident that the decisions of my colleagues in legislatures east, west, north and south and all places in between are enjoying a very high level of support from the citizens in their states.

While I am only aware of two states (Indiana and Illinois) that have current plans to fully implement the Centers for Disease Control and Prevention's (CDC's) best practices guidelines for tobacco cessation and prevention activities, I know that many states are using these guidelines as a model and to set goals. I urge this Committee to continue to support the CDC in these outreach and technical assistance activities.

Implementing the Tobacco Settlement in Maryland

Maryland is moving quickly to implement the provisions of the Maryland Cigarette Restitution Program (CRF). We are working closely with health advocates, our local health departments and academic health centers to make this a successful initiative. It is a two-pronged approach focusing on: (1) Tobacco Prevention and Cessation; and (2) Cancer Reduction.

The Tobacco Prevention and Cessation Program is a $18.1 million program that provides $2.3 million for statewide public health activities; $7 million for local public health activities (administered primarily by county government); $5 million for countermarketing; $3 million for surveillance and evaluation; and $800,000 for program administration.

The $30.8 million Cancer Reduction initiative includes $15 million for academic health centers; $12.8 million for local public health activities; $2.3 million for surveillance and evaluation; and $800,000 for program administration.

November 2000 Ballot Initiatives

Last year Louisiana adopted a constitutional amendment, through a ballot initiative, establishing the Millennium Trust and the Louisiana Fund within the state treasury. These Millennium Trust supports education and academic health center programs. The Louisiana Fund provides funds for Medicaid, attorney general enforcement activities related to the tobacco settlement, smoking prevention and cessation programs and other health-related activities. This year six states (Arkansas, Arizona, Montana, Oklahoma, Oregon and Utah) will take the tobacco settlement expenditure question directly to the voters via ballot initiative.

- Arkansas—a comprehensive tobacco settlement expenditure plan that includes funds for tobacco prevention and cessation, education, and research.
- Arizona—two separate ballot initiatives, both would provide funds for health care for low-income adults and children. One of the initiatives replaces tobacco tax funding with tobacco settlement funding for some health programs.

- Montana—establishes a trust fund, comprised of 40 percent of the tobacco settlement, the proceeds of which can be used for tobacco disease prevention programs and state programs providing benefits, services, or coverage that are health care related.
- Oklahoma—establishes a Tobacco Settlement Endowment Trust Fund, funded by 50 percent of state settlement payments beginning July 1, 2002, phasing up to 75 percent of state settlement payments in 2007, and thereafter. The fund would be used to support tobacco prevention and cessation programs, health care, education, other children's services and programs for seniors.
- Oregon—two separate initiatives, one creates a tobacco settlement trust fund, the earnings from which would fund health care for low-income individuals; the other established the Health Security Fund and all expenditures from the fund would be limited to "health programs," including transportation of the elderly and disabled, housing for the disabled and for low-income families and other programs established as eligible by state law.
- Utah—amends the constitution to establish a permanent state trust fund consisting of the state's tobacco settlement funds, the assets of which will be invested by the state treasurer. Income from the trust fund will be put into the state general fund and be subject to appropriations.

What Are the next Steps for States?

State Legislative/Adminstrative Initiatives

States will continue to make adjustment in their tobacco settlement spending plans. The tobacco settlement also leaves plenty of room for additional state legislative initiatives regarding youth access. After a state has attained state specific finality, tobacco companies are prohibited from opposing certain kinds of state or local legislation, laws or administrative that are intended to limit youth access to and consumption of tobacco products. The settlement establishes eight areas of state legislation/regulation that the industry is prohibited from lobbying against. The restrictions apply to legislation, laws or administrative rules that:

- Limit youth access to vending machines.
- Include cigars within the definition of tobacco products.
- Enhance enforcement efforts to identify and prosecute violations of laws prohibiting retail sales to youth.
- Encourage or support the use of technology to increase the effectiveness of age-of-purchase laws (e.g. the use of programmable scanners, scanners to read drivers' licenses, or use of other age/ID data banks).
- Limit promotional programs for non-tobacco goods using tobacco products as prizes or give-aways.
- Enforce access restrictions through penalties on youth for possession or use.
- Limit tobacco product advertising in or on school facilities, or the wearing of tobacco logo merchandise in or on school property.
- Limit non-tobacco products that are designed to look like tobacco products, such as bubble gum cigars, candy cigarettes etc.

There is a provision in the MSA that prohibits the manufacture of cigarettes in packages of less than 20 and prohibits the sale of cigarettes in packages of less than 20. These provisions sunset December 31, 2001, unless a state enacts legislation prohibiting these practices. I am certain that many state legislatures will consider this and other youth access issues during the 2001 legislative session.

Supporting the Passage of Federal Legislation on Gray Market Cigarettes

"Gray Market" cigarettes are product that is manufactured for foreign sale, but is diverted back to the United States by third parties for domestic sale. These cigarettes are typically sold at below market prices, making them more attractive to youth. In addition, every pack of gray market cigarettes sold, displaces the sale of a domestic pack, lowering payments to the states through the MSA, since payments are based on the sale of and the market share of domestic product. While 44 states have enacted legislation in this area, state legislation cannot fully resolve the problem.

The Balanced Budget Act of 1997 (BBA '97) made the reimportation of tobacco products produced domestically for foreign sale (Export Labeled) illegal for everyone except product manufacturers. Unfortunately, BBA '97 had no similar provisions for

product manufactured overseas for sale overseas (Foreign Source) that is diverted to the United States market. As a result, Foreign Source product is becoming the dominant source of gray market cigarettes.

I would like to take this opportunity to urge your support of legislation recently approved by the Senate Finance Committee that includes provisions that would address the growing problem of gray market cigarettes by:

- Banning Foreign Source tobacco products not intended for sale or consumption in the United States;
- Limiting the reimportation of previously-exported tobacco products to only the original manufacturer, its authorized agent or authorized warehouse;
- Applying criminal penalties for the diversion-before-export of tobacco products manufactured domestically for export only;
- Making all export labeled tobacco products contraband by a date certain to eliminate the enforcement confusion created by the legal status of export labeled product that was "removed" prior to January 1, 2000;
- Require the forfeiture and destruction of all gray and black market product seized; and
- Clarify the law regarding purchases of products for personal use at duty-free stores of a limited quantity of cigarettes.

I thank you for this opportunity to discuss tobacco settlement issues with you and would be happy to answer questions.

The CHAIRMAN. Thank you, sir, and thank you for taking the time to be with us.

Attorney General Montgomery, I just want to quote from the letter from Christine Gregoire, the Attorney General of the State of Washington. She said, I recognize Washington is in the minority of states who have used a significant portion of the money for tobacco prevention and public health. Keeping the money for these purposes has been a hard-fought battle. Many state legislators have erroneously considered the tobacco dollars a windfall and used it for a variety of purposes unrelated to public health. I believe this is a mistake, but it is also a mistake that can be rectified in each legislative session. I hope she is correct in the rectification.

Mr. Myers, do you share the concern that Majority Leader Hurson expresses about the gray market situation?

Mr. MYERS. I think the gray market situation is a real problem. I think we need to put it in perspective as well. Your bill 2 years ago sought to look at the whole problem of cross-border sales, black market and gray market, and I think combined they pose a real problem.

In the 2 years since that time, what we have discovered is a virtual explosion of evidence about the potential for black market. And if you will remember when you were working on the legislation, every time we talked about the cost and a number of other steps, we kept hearing threats there would be a black market.

What I would urge is, this Congress take a close look at both sets of problems and try to solve in a unifying manner the problem of cross-border sales. It is affecting our ability to reduce tobacco use in the states here. And as well we have an increasing problem because of the manufacturing plants in Mexico that many of our companies have actually purchased in the last 2 years. So I think it is a problem we need to approach very carefully, but with really strong legislation.

The CHAIRMAN. Mr. Coolidge, do you share that concern?

Mr. COOLIDGE. I do, and I would reiterate something that is in our written testimony, and that is that there is presently underway an effort to draft a framework convention that I think has to be supported by Congress if we are to bring a global perspective to this issue. It is something that cannot be limited to our Nation's borders. It is an international problem and requires international solutions, and I urge Congress to help identify and enact those solutions.

The CHAIRMAN. Thank you.

Majority Leader Hurson, first I would like to say that without objection we will put the report entitled, Show us the Money, and Update on the state's Allocation of the Tobacco Settlement Dollars, which was compiled, as I mentioned earlier, by the Campaign for Tobacco-Free Kids, American Cancer Society, American Heart Association, and American Lung Association, and Majority Leader Hurson, I appreciate the fact that sometimes these things do take time, but let me just quote a couple of items from the report that these organizations have compiled.

Article, *USA Today,* January 15, 1999, Connecticut Attorney General Richard Blumenthal has teamed up with antismoking advocates to propose legislation for spending the state's $5.5 billion settlement with big tobacco. Under the plan, 45 percent go to education, prevention and cessation initiatives, 45 percent to health programs, and 10 percent would be invested in an endowment fund.

Connecticut legislature appropriated $5 million over 2 years for tobacco prevention, CDC minimum recommendation is 21.2 million a year. There's a long list of states here, Illinois Attorney General Jim Ryan wants half the state's $9.1 billion windfall from the national tobacco lawsuit to go to health and antismoking programs, and he wants the legislation now to keep Washington's hand out of Illinois' cookie jar.

Ryan's plan would earmark 50 percent of the money for uninsured children, smoking cessation, antismoking education programs, helping police enforce tobacco restrictions on minors. That was January 23, 1999. Illinois has allocated $28.5 million for tobacco prevention. The CDC minimum recommendation is $64.9 million.

The list goes on and on of the states who have had an opportunity already to take action, and unless that action is reversed, it is pretty clear that they will not comply with, again, the commitments that they made.

I did not make these commitments when this master settlement agreement was made. The states did, and I have got to say, Attorney General Montgomery, I do not know if the Attorneys General were able to speak for the states or not, but everyone understood that this money was not going to go for tax rebates. At least, that was the distinct impression that Americans were given.

So I do not expect you, Majority Leader Hurson, to be responsible for these other states, but you do wear another hat, and so I wonder if you could respond.

Mr. HURSON. Well, it is difficult to respond. I would only just get onto the last point that you made. It really is somewhat of a structural issue. The Attorney Generals did settle this case, and there

was great expectation that they could, in fact, lead their legislatures and their Governors to do those things. I am sure it is hard. I do not think the U.S. Attorney General could speak for Congress.

But it is a difficult structural issue, and I would only point out, and I cannot speak for my colleagues in Connecticut or Illinois. I can tell you that the operative word, when we looked at passing legislation on this issue, was feeding frenzy. When we finally got the Governor's bill in front of us—in fact, it was not a bill. The Governor just wanted us to give him the money and he was going to spend it himself, and we decided to draft a bill, which I thought was a wise idea.

But the thing that most dominated the legislature at that point was many, many, many pressures from a lot of groups who saw this as their salvation, and we made a commitment as a legislature to use this money primarily for the things that the CDC has recommended. Other legislatures have not been able to I suppose withstand some of those pressures.

But the one thing I would point out is this is—and the reason this hearing is so important and such a good idea is that this is an ongoing process. I think some of these legislatures will reverse themselves and take another look at the use of these funds. Maryland may, in fact, change its use. I mean, that is possible as well, so there has got to be vigilance on the part of all of the advocacy communities to be down there in the state capitols and making sure that the message that we are hearing here today is heard loud and clear in those state legislatures.

So again, I commit the NCSL, which has already committed itself to continue to provide guidance and work with the CDC, try to get our colleagues across the country to recognize the value of those recommendations, and to follow them when we use these funds.

The CHAIRMAN. I thank you.

Attorney General Montgomery, I have a list in front of me that will be included in the record of the tobacco settlement attorneys' fees. Some of them vary from 1.3 percent of the settlement to as high as 34.1 percent of the settlement. For example, Mississippi, the total settlement was $4 billion. Mississippi attorney's fees were $1.43 billion. In Florida, $13 billion settlement, $3.43 billion attorney's fees.

God bless the State of Maine. The State of Maine enacted a law that gave an hourly rate. An hourly rate. It seems that that has some logic associated with it. Some of the other percentages have not been settled.

I understand, and I would like for Majority Leader Hurson to comment on that, that there is an individual in Maryland that wants a billion-dollar settlement. It will be very interesting what that hourly rate might be.

Attorney General Montgomery, I am very concerned, because you will argue and Attorneys General will argue that's a separate pot of money. It all comes—as Mr. Myers will testify, it all comes from the tobacco companies. It does not fall down from heaven. So when you—you have got 25 percent, 34 percent, Connecticut $900 million estimated out of a $3.6 billion settlement, 25 percent South Carolina, $3 billion out of $12 billion, and those are in addition to the

settlement, but they are that percentage of the settlement. It all comes from the same place.

Now, do you think that these attorney's fees are fair and equitable?

Ms. MONTGOMERY. Mr. Chairman, I cannot stand here and say to you that these dollars are not anything but excessive. In Ohio, I was measured in entering this lawsuit. We did a year's long study, and when we did get into it we did a lot to try to control those fees, so that the states would not be, as many of them are now, subject to lawsuit for the contingency fee percentage.

The fallout of this tobacco suit has been enormous, the whole sense of whether an Attorney General can hire at contingent fees, and whether there is any control over who makes those decisions, what percentages and that. I believe that the Attorneys General collectively have learned a great deal in this lawsuit. I do not think, any Attorney General in the quiet of their own chambers is not now saying that we have learned a great deal from what has happened here.

I am not going to be here to say to you that I think that these dollars are defensible. They are a huge amount of dollars, and I believe that the legislatures, you see the NCSL and some of the legislative associations looking to open dialogue, sometimes with a bomb, sometimes with legislation.

I am fortunate that I am able to talk to my legislature and my Governor. But there is a huge public policy debate, a huge public policy issue that I think clearly we have to continue to debate here, and particularly in terms of the size of these settlements.

The CHAIRMAN. Majority Leader Hurson.

Mr. HURSON. I would agree with the Attorney General of Ohio. The fees that we are looking at in Maryland are excessive, and the legislature tried to address that issue. The Attorney General had negotiated a 25-percent contingency fee, and they were about to lose their case in court and so they came to court—or they came to the legislature to get the law changed, literally to help them, and in that process we cut that fee in half.

It is still a lot of money, and now the legislative leadership and the Attorney General are urging the attorney to go directly to the fund first and determine what kind of payment he will get from them before using up the state's money, or getting some of the tobacco settlement from the state. He has refused to do that, and we are in court as a result of that. It is very unfortunate.

We are in the process now where we are having to withhold some of the funds, to escrow some of the funds, that we have already appropriated for cancer research. We cannot start the research programs that follow the CDC recommendations, some of those programs, because we have to escrow the funds until that lawsuit is settled, and it's very unfortunate.

The CHAIRMAN. How long do you estimate that will be?

Mr. HURSON. We hope we are going to settle it during the next year, but literally this year, in this fiscal year we are escrowing funds that could go to cancer research and smoking cessation because of this issue, and it is very, very unfortunate.

The CHAIRMAN. Has Mr. Angelos shown a willingness to negotiate?

Mr. HURSON. Mr. Angelos always negotiates.

[Laughter.]

Mr. HURSON. We are continuing to talk with him, and the Attorney General is doing that.

The CHAIRMAN. Mr. Myers, do you want to comment on the situation?

Mr. MYERS. We have focused our energies on trying to make sure that the states spend the money to protect the public health, to be candid with you, and so we have not followed each state decision all that closely. Our real concern has been to make sure that the money the states actually got were used to maximize the effort to reduce tobacco use, particularly among our children.

The CHAIRMAN. Mr. Coolidge.

Mr. COOLIDGE. Again, we have not taken an official position. However, I must say, as you said and know better than anyone, this whole development proves yet again that when you dump a lot of money into the political scene it is like dumping a lot of blood in front of a shark. There is a feeding going on here, and personally I find that this is greed beyond your wildest dreams of avarice.

The CHAIRMAN. Well, I am reminded, when I look at these attorneys' fees, of the line that was used about the missionaries that went to Hawaii, they have done very well by doing good, and so I just think it is very harmful to the whole public perception of what was intended here, and Mr. Myers and Mr. Coolidge, your organization is made up of thousands and thousands of volunteers. That is what makes your organization work.

You would have thought that the legal community would have done some of this anyway in a voluntary fashion, particularly when we are talking about the goals that we are trying to achieve here, saving lives of children. That does not seem to be the case as far as some of the lawyers who were involved in the settlement.

I do not know what can be done, frankly, about it, because of the master settlement agreement, but I hope that we do not have—well, I hope that the weight of public opinion will have some effect here. That usually is sometimes helpful.

I want to thank you all for being here. We will have another hearing, probably in January or February, after the next report is made available. I thank you very much for your participation, and I think this has been very helpful, and Mr. Myers, we will continue to make efforts and Majority Leader Hurson, we would like to work with you on this gray market issue as well, and the black market issue.

We anticipated that, by the way, when we talked about this issue that there would be a dramatic increase in gray market/black market activity, so we would like to have a look at that, and I will do whatever I can to see the legislation that is in the Finance Committee move forward. I do not know if that is possible this year or not.

I thank all of you for being here, and this hearing is adjourned.

[Whereupon, at 11:15 a.m., the Committee adjourned.]

○