

**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 4/19/95

BILL NO. \_\_\_\_\_  
OR

SUBJECT  Tobacco Settlement

Carnie Sullivan  
(NAME)

W247 N2358 Saddle Creek  
(Street Address or Route Number)

Dewaule WI 53072  
(City and Zip Code)

American Cancer Soc  
(Representing)

Speaking in Favor:

Speaking Against:

Registering in Favor:  
but not speaking:

Registering Against:  
but not speaking:

Speaking for information  
only; Neither for nor against:

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Senate Sergeant-At-Arms  
State Capitol - B35 South  
P.O.Box 7882  
Madison, WI 53707-7882

**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: April 4, 1999

BILL NO. \_\_\_\_\_  
OR

SUBJECT Tobacco Deal

Senator Robert D. Kasten  
(NAME)

6236 Upper Park  
(Street Address or Route Number)

Madison WI 53707  
(City and Zip Code)

Philly  
(Representing)

Speaking in Favor:

Speaking Against:

Registering in Favor:  
but not speaking:

Registering Against:  
but not speaking:

Speaking for information  
only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 3/1/95

BILL NO. \_\_\_\_\_  
OR

SUBJECT Comprehensive

P. Baco control Mountain

MOIRA HARRINGTON  
(NAME)

8562 Stonebrook Circle  
(Street Address or Route Number)

MADISON 53562  
(City and Zip Code)

(Representing)

Speaking in Favor:

Speaking Against:

Registering in Favor:  
but not speaking:

Registering Against:  
but not speaking:

Speaking for information  
only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 3/4/99

BILL NO. Comprehensive

OR

SUBJECT Tobacco Control Program

Eden SCHAFER  
(NAME)

2229 Luann Lane #4  
(Street Address or Route Number)

Madison 53713  
(City and Zip Code)

(Representing)

Speaking in Favor:

Speaking Against:

Registering in Favor:  but not speaking:

Registering Against:  but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 3/4/99

BILL NO. \_\_\_\_\_

OR

SUBJECT Tobacco Settlement

Mickey Beil  
(NAME)

5225 W. Vliet  
(Street Address or Route Number)

Milwaukee WI 53208  
(City and Zip Code)

Milwaukee Public Schools  
(Representing)

Speaking in Favor:

Speaking Against:

Registering in Favor:  but not speaking:

Registering Against:  but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 3/4/99

BILL NO. \_\_\_\_\_

OR

SUBJECT Tobacco Settlement

Nancy Freeman  
(NAME)

76 Hurg 14  
(Street Address or Route Number)

Brooklyn 53521  
(City and Zip Code)

Wisconsin Cancer Council  
(Representing)

Speaking in Favor:

Speaking Against:

Registering in Favor:  but not speaking:

Registering Against:  but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 3/4/99

BILL NO. \_\_\_\_\_  
OR \_\_\_\_\_

SUBJECT Tobacco  
legislation + funds

Debbi Vorass  
(NAME)

2008 Highway Ct.  
(Street Address or Route Number)

Beloit, WI 53511  
(City and Zip Code)

(Representing) \_\_\_\_\_

Speaking in Favor:

Speaking Against:

Registering in Favor:   
but not speaking:

Registering Against:   
but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: March 4, 1999

BILL NO. \_\_\_\_\_  
OR \_\_\_\_\_

SUBJECT Tobacco

Sharon Lyatt  
(NAME)

551 Williams  
(Street Address or Route Number)

Janesville, WI 53545  
(City and Zip Code)

(Representing) \_\_\_\_\_

Speaking in Favor:

Speaking Against:

Registering in Favor:   
but not speaking:

Registering Against:   
but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 3-4-99

BILL NO. \_\_\_\_\_  
OR \_\_\_\_\_

SUBJECT Tobacco Reduction,  
Education and Prevention,

Robert Burke  
(NAME)

33 Nob Hill Dr.  
(Street Address or Route Number)

Madison WI 53708  
(City and Zip Code)

WI Education Assoc Council  
(Representing)

Speaking in Favor:

Speaking Against:

Registering in Favor:   
but not speaking:

Registering Against:   
but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 3-4-99

BILL NO. \_\_\_\_\_

OR

SUBJECT Tobacco Issue

John Kiesow &

John Chapin

(NAME)

W. Wilson

(Street Address or Route Number)

MADISON

(City and Zip Code)

Available for

DHFS / Questions

(Representing)

MUST LEAVE BY

Speaking in Favor:  11 AM

Speaking Against:

Registering in Favor:

but not speaking:

Registering Against:

but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 3/4/99

BILL NO. \_\_\_\_\_

OR

SUBJECT Tobacco Settlement

Movies

(NAME)

Peter A. Peshek

(Street Address or Route Number)

2 E. Myrtle

(City and Zip Code)

Janesville

Autonomous

(Representing)

Speaking in Favor:

Speaking Against:

Registering in Favor:

but not speaking:

Registering Against:

but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 3-3-99

BILL NO. \_\_\_\_\_

OR

SUBJECT Tobacco Settlement

Scott Peterson

(NAME)

(Street Address or Route Number)

(City and Zip Code)

111 Health & Hospital Ave.

(Representing)

Speaking in Favor:

Speaking Against:

Registering in Favor:

but not speaking:

Registering Against:

but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 3/4/99

BILL NO. Tobacco Briefing

OR  
SUBJECT \_\_\_\_\_

Greg Connolly  
(NAME)

State of Massachusetts - Dept. of Health  
(Street Address or Route Number)

Mass. Tobacco Control Program  
(City and Zip Code)  
(Representing)

Speaking in Favor:

Speaking Against:

Registering in Favor:   
but not speaking:

Registering Against:   
but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 3/4/99

BILL NO. Tobacco Briefing

OR  
SUBJECT \_\_\_\_\_

Bruce Wolfe  
(NAME)

State of Florida  
(Street Address or Route Number)

Florida Pilot Program  
(City and Zip Code)  
(Representing) Tobacco

Speaking in Favor:

Speaking Against:

Registering in Favor:   
but not speaking:

Registering Against:   
but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 3/4/99

BILL NO. \_\_\_\_\_

OR  
SUBJECT \_\_\_\_\_

David Ahrens  
(NAME)

\_\_\_\_\_  
(Street Address or Route Number)

\_\_\_\_\_  
(City and Zip Code)  
Tobacco Free Wisconsin  
(Representing)

Speaking in Favor:

Speaking Against:

Registering in Favor:   
but not speaking:

Registering Against:   
but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

①

DATE: 3/4/99

BILL NO. Tobacco Briefing

OR

SUBJECT \_\_\_\_\_

\_\_\_\_\_  
(NAME) Lot Remington, MD

\_\_\_\_\_  
(City and Zip Code) UIC Dept of Preventive Medicine

\_\_\_\_\_  
(Street Address or Route Number)

\_\_\_\_\_  
(City and Zip Code)

\_\_\_\_\_  
(Representing) TRUST Campaign

Speaking in Favor:

Speaking Against:

Registering in Favor:

but not speaking:

Registering Against:

but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 3-4-99

BILL NO. \_\_\_\_\_

OR

SUBJECT Tobacco Settlement

\_\_\_\_\_  
(NAME) Gina Dennik-Champion

\_\_\_\_\_  
(City and Zip Code) 617 Monna Dr N

\_\_\_\_\_  
(Street Address or Route Number)

\_\_\_\_\_  
(City and Zip Code) Madison 53716

\_\_\_\_\_  
(Representing) WIS NURSES ASSOC

\_\_\_\_\_  
(Representing) I need to leave by 11 AM

Speaking in Favor:

Speaking Against:

Registering in Favor:

but not speaking:

Registering Against:

but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: Mar 4 - 1999

BILL NO. \_\_\_\_\_

OR

SUBJECT Tobacco Reg.

\_\_\_\_\_  
(NAME) Howell Haugen

\_\_\_\_\_  
(City and Zip Code) 508-4th st

\_\_\_\_\_  
(Street Address or Route Number)

\_\_\_\_\_  
(City and Zip Code) Bamboo, WI 53913

\_\_\_\_\_  
(Representing) Public Health - Sup. Dist 18

Speaking in Favor:

Speaking Against:

Registering in Favor:

but not speaking:

Registering Against:

but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 3/3/99

BILL NO. \_\_\_\_\_  
OR \_\_\_\_\_

SUBJECT: Tobacco Settlement

BRIDGET DOERR  
(NAME)

225 W. NORTH AVE  
(Street Address or Route Number)

WAUWATOSA, WI 53213  
(City and Zip Code)

WAUWATOSA HEALTH DEPT  
(Representing)

Speaking in Favor:

Speaking Against:

Registering in Favor:  
but not speaking:

Registering Against:  
but not speaking:

Speaking for information  
only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 3/4/99

BILL NO. \_\_\_\_\_  
OR \_\_\_\_\_

SUBJECT: Tobacco Control

Funding

JOSEPH CISNOSKI  
(NAME)

1700 CLIFFVIEW DR.  
(Street Address or Route Number)

OSTKOST 54901  
(City and Zip Code)

SETORES AND  
TOWNS ON LOC PUBLIC HEALTH  
(Representing)

Speaking in Favor:

Speaking Against:

Registering in Favor:  
but not speaking:

Registering Against:  
but not speaking:

Speaking for information  
only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 3/5/99

BILL NO. \_\_\_\_\_  
OR \_\_\_\_\_

SUBJECT: Local Public Health

Agency Perspective on the

Tobacco Settlement

BILL WUCHERER RN/HEALTH OFFICER  
(NAME)  
(Street Address or Route Number)

CITY OF FRAUCIN  
(City and Zip Code)

BEFORE NOON IF POSSIBLE  
(Representing)

Speaking in Favor:

Speaking Against:

Registering in Favor:  
but not speaking:

Registering Against:  
but not speaking:

Speaking for information  
only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 3/4/99

BILL NO. \_\_\_\_\_  
OR \_\_\_\_\_

SUBJECT Tobacco Settlement

Creating a Health Trust

Fund for Public Health

(NAME) PROGRAMS

MARIAN SHERIDAN

(Street Address or Route Number) Call up to be CISMOSKI

(City and Zip Code) \_\_\_\_\_

Fond du Lac County Health

(Representing) Dept -

Speaking in Favor:

Speaking Against:

Registering in Favor:

but not speaking:

Registering Against:

but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 4/6/99

BILL NO. \_\_\_\_\_  
OR \_\_\_\_\_

SUBJECT TRUST

Dona Wininsky

(NAME) \_\_\_\_\_

1728 N. Hi Mount Blvd.

(Street Address or Route Number) \_\_\_\_\_

Milwaukee, WI 53208

(City and Zip Code) \_\_\_\_\_

Self American Lung Assn

(Representing) \_\_\_\_\_

Speaking in Favor:

Speaking Against:

Registering in Favor:

but not speaking:

Registering Against:

but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: April 14

BILL NO. \_\_\_\_\_  
OR \_\_\_\_\_

SUBJECT Tobacco Money

How well it be Budgeted

Jennin Murphy

(NAME) \_\_\_\_\_

1107 Harmon

(Street Address or Route Number) \_\_\_\_\_

Beloit, WI 53511

(City and Zip Code) \_\_\_\_\_

(Representing) \_\_\_\_\_

Speaking in Favor:

Speaking Against:

Registering in Favor:

but not speaking:

Registering Against:

but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 4-14-99

BILL NO. \_\_\_\_\_  
OR

SUBJECT Tobacco Money

Bill Hallstrom  
(NAME)

2042 Meridith Dr  
(Street Address or Route Number)

Beloit  
(City and Zip Code)

(Representing)

Speaking in Favor:

Speaking Against:

Registering in Favor:  
but not speaking:

Registering Against:  
but not speaking:

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only; Neither for nor against:

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*gyle*

**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 4/14/99

BILL NO. Use of tobacco  
OR settlement

SUBJECT \_\_\_\_\_

Markon Fass  
(NAME)

2616 Austin Pl  
(Street Address or Route Number)

Beloit WI  
(City and Zip Code)

Rock Co Tobacco Free  
(Representing) Coalition

Speaking in Favor:

Speaking Against:

Registering in Favor:  
but not speaking:

Registering Against:  
but not speaking:

Speaking for information  
only; Neither for nor against:

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*gyle*

**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 4/14/99

BILL NO. \_\_\_\_\_  
OR

SUBJECT Tobacco Settlement  
Funds

Bonnie Cunningham  
(NAME)

7414 W Victory Hills  
(Street Address or Route Number)

Beloit 53511  
(City and Zip Code)

self  
(Representing)

Speaking in Favor:

Speaking Against:

Registering in Favor:  
but not speaking:

Registering Against:  
but not speaking:

Speaking for information  
only; Neither for nor against:

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*gyle*

**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: April 14, 1999

BILL NO. \_\_\_\_\_  
OR

SUBJECT Tobacco Settlement

Dollars

Asley Driver  
(NAME)

1740 Sumac St.  
(Street Address or Route Number)

Beloit, WI 53511  
(City and Zip Code)

Tobacco Free Kids  
(Representing)

Speaking in Favor:

Speaking Against:

Registering in Favor:   
but not speaking:

Registering Against:   
but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: April 14, 1999

BILL NO. \_\_\_\_\_  
OR

SUBJECT Tobacco settlement

money

Josh Seefeld  
(NAME)

4925 Pitt Rd 7540950  
(Street Address or Route Number)

Apex 53501  
(City and Zip Code)

A. J. K. E. (Dunsmuir)  
(Representing)

Speaking in Favor:

Speaking Against:

Registering in Favor:   
but not speaking:

Registering Against:   
but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: April 14, 99

BILL NO. \_\_\_\_\_  
OR

SUBJECT Tobacco settlement

Money

Ryan Bach  
(NAME)

1822 DELL Dr  
(Street Address or Route Number)

Beloit 53511  
(City and Zip Code)

Nike  
(Representing)

Speaking in Favor:

Speaking Against:

Registering in Favor:   
but not speaking:

Registering Against:   
but not speaking:

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: April 14-99

BILL NO. \_\_\_\_\_  
OF \_\_\_\_\_  
SUBJECT Tobacco

Settlement Money

(NAME) Riley

815 Dell Dr  
(Street Address or Route Number)

53511  
(City and Zip Code)

(Representing) \_\_\_\_\_

Speaking in Favor:

Speaking Against:

Registering in Favor:  **but not speaking:**

Registering Against:  **but not speaking:**

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 4-14-99

BILL NO. \_\_\_\_\_  
OF \_\_\_\_\_  
SUBJECT Tobacco Settlement

ment

(NAME) Annette Baker

509 N. Wuthering Hills Dr  
(Street Address or Route Number)

JSU 53546  
(City and Zip Code)

(Representing) Tobacco Free Co + Heartland

Speaking in Favor: 50%

to issue  
Speaking Against:

Registering in Favor:  **but not speaking:**

Registering Against:  **but not speaking:**

Speaking for information only; Neither for nor against:

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**SENATE HEARING SLIP**

(Please Print Plainly)

DATE: 4-14-99

BILL NO. \_\_\_\_\_  
OF \_\_\_\_\_  
SUBJECT Tobacco Settlement

(NAME) Mr Davies - Morris

8785 Milwaukee Rd  
(Street Address or Route Number)

Beloit, WI 53544  
(City and Zip Code)

(Representing) Wal-Mart

Speaking in Favor:

Speaking Against:

Registering in Favor:  **but not speaking:**

Registering Against:  **but not speaking:**

Speaking for information only; Neither for nor against:

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(Please Print Plainly)

DATE: 4/14/99  
BILL NO. \_\_\_\_\_  
OR  
SUBJECT Tobacco Settlement

Sharon Pratt  
(NAME)  
551 Williams  
(Street Address or Route Number)  
Jamesville  
(City and Zip Code)  
Tobacco Free Kick  
(Representing)

Speaking in Favor:   
Speaking Against:   
Registering in Favor:   
but not speaking:  
Registering Against:   
but not speaking:  
Speaking for information only; Neither for nor against:

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SENATE HEARING SLIP  
(Please Print Plainly)

DATE: 4-14-99  
BILL NO. \_\_\_\_\_  
OR  
SUBJECT Tobacco  
Settlement fund  
(NAME)  
~~for~~ Jennifer  
260 Eighth St  
(Street Address or Route Number)  
Beloit 53511  
(City and Zip Code)  
Tobacco free kids  
(Representing)

Speaking in Favor:   
Speaking Against:   
Registering in Favor:   
but not speaking:  
Registering Against:   
but not speaking:  
Speaking for information only; Neither for nor against:

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SENATE HEARING SLIP  
(Please Print Plainly)

DATE: 4-14-99  
BILL NO. \_\_\_\_\_  
OR  
SUBJECT Tobacco Settlement  
(NAME)  
I had Snyder  
1328 S. Crosby Ave  
(Street Address or Route Number)  
Jamesville WI 53540  
(City and Zip Code)  
Tobacco free kids  
(Representing)

Speaking in Favor:   
Speaking Against:   
Registering in Favor:   
but not speaking:  
Registering Against:   
but not speaking:  
Speaking for information only; Neither for nor against:

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SENATE HEARING SLIP

DATE: 4/14/99

BILL NO. \_\_\_\_\_  
OR \_\_\_\_\_

SUBJECT TOBACCO MONEY -  
TO BE USED FOR PROACTIVE  
PREVENTATIVE PROGRAMS  
NEIL DEURREE

(NAME) 49 S FRANKLW  
(Street Address or Route Number)  
JAMESVILLE, WI 53545  
(City and Zip Code)

(Representing) \_\_\_\_\_

Speaking in Favor:

Speaking Against:

Registering in Favor:

but not speaking:

Registering Against:

but not speaking:

Speaking for information only; Neither for nor against:

Please return this slip to a messenger PROMPTLY.  
Senate Sergeant-At-Arms  
State Capitol - B35 South  
P.O. Box 7882  
Madison, WI 53707-7882

SENATE HEARING SLIP

(Please Print Plainly)

DATE: 4/14/99

BILL NO. \_\_\_\_\_  
OR \_\_\_\_\_

SUBJECT TOBACCO SETTLEMENT

(NAME) Tabitha Hornby

2135 Morningside Dr  
(Street Address or Route Number)

JONESVILLE WI 53546  
(City and Zip Code)  
TATU

(Representing) \_\_\_\_\_

Speaking in Favor:

Speaking Against:

Registering in Favor:

but not speaking:

Registering Against:

but not speaking:

Speaking for information only; Neither for nor against:

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State Capitol - B35 South  
P.O. Box 7882  
Madison, WI 53707-7882

SENATE HEARING SLIP

(Please Print Plainly)

DATE: 4/14/98

BILL NO. \_\_\_\_\_  
OR \_\_\_\_\_

SUBJECT TOBACCO TRUST

(NAME) Chubbin With Specific

Mnt Auger  
(Street Address or Route Number)

3605 Edgewood Dr  
(City and Zip Code) JAMESVILLE 53545

(Representing) \_\_\_\_\_

Speaking in Favor:

Speaking Against:

Registering in Favor:

but not speaking:

Registering Against:

but not speaking:

Speaking for information only; Neither for nor against:

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State Capitol - B35 South  
P.O. Box 7882  
Madison, WI 53707-7882

**SENATE HEARING SLIP 5.**

(Please Print Plainly)

DATE: 4/14/99  
BILL NO. S-90 + Tobacco  
OF  
SUBJECT Settlement/Budget

Bill Breidenstein  
(NAME) Janesville  
1810 Kensington St.  
(Street Address or Route Number)  
Janesville, WI 53546  
(City and Zip Code)  
American Heart / UAW  
(Representing)

Speaking in Favor:   
Speaking Against:   
Registering in Favor:   
but not speaking:  
Registering Against:   
but not speaking:  
Speaking for information only; Neither for nor against:

Please return this slip to a messenger **PROMPTLY.**  
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State Capitol - B35 South  
P.O. Box 7882  
Madison, WI 53707-7882

**SENATE HEARING SLIP 4.**

(Please Print Plainly)

DATE: 4/14/99  
BILL NO. \_\_\_\_\_  
OF  
SUBJECT Tobacco Settlement

Dollars  
(NAME) Debbie Vorass  
2008 Highway Ct  
(Street Address or Route Number)  
De Witt WI 53811  
(City and Zip Code)  
Tobacco Free Kids  
(Representing)

Speaking in Favor:   
Speaking Against:   
Registering in Favor:   
but not speaking:  
Registering Against:   
but not speaking:  
Speaking for information only; Neither for nor against:

Please return this slip to a messenger **PROMPTLY.**  
Senate Sergeant-At-Arms  
State Capitol - B35 South  
P.O. Box 7882  
Madison, WI 53707-7882



# Tobacco-Free Wisconsin Coalition

1930 Monroe St., Suite 302, Madison, WI 53711-2027 • (608) 265-6386 • FAX: (608) 255-0461

## TOBACCO-FREE WISCONSIN POLICY TELECONFERENCE

Tuesday, April 13, 1999

1 to 2:15 p.m.

### Agenda

1:00 – 1:05 Introduction

1:05 – 1:20 Local Update

1:20 - 1:30 National Update

1:30 – 1:45 State Update

1:45 – 2:15 Presentation: "Tobacco Control – International Vigilance and Activism Also Required," by Robert Weissman, Co-Director of Essential Action and Editor of the Multinational Monitor

**\*\*\*Please RSVP by March 31, 1999\*\*\***

To participate in the policy teleconference, fax the response form below to Moira Harrington, Tobacco-Free Wisconsin Coalition (608) 255-0461 or e-mail her at [harringt@cis.wisc.edu](mailto:harringt@cis.wisc.edu). On the day of the conference, call (608) 265-1000 a few minutes prior to the start time. When prompted, enter the conference code 2567.

YES, I would like to participate in the April 13 teleconference. (Participants will receive background materials prior to the call.)

Name: \_\_\_\_\_

Coalition/Affiliation: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone/Fax: \_\_\_\_\_

Future Topics I'd Like to Discuss: \_\_\_\_\_

American Cancer Society, Wisconsin Division • American Heart Association of Wisconsin • Center for Tobacco Research & Intervention • Coalition of Wisconsin Aging Groups • March of Dimes Maternal and Child Health Coalition • Medical College of Wisconsin • State Medical Society of Wisconsin • University of Wisconsin Comprehensive Cancer Center • Wisconsin Association of School Boards  
Wisconsin Board of Vocational, Technical and Adult Education • Wisconsin Cancer Council • Wisconsin Coalition for Responsible Investment • Wisconsin Conference of Local Public Health Officials  
Wisconsin Dental Association • Wisconsin Dental Hygienists Association • Wisconsin Department of Public Instruction • Wisconsin Division of Health • Wisconsin Education Association Council  
Wisconsin Initiative on Smoking & Health • Wisconsin Nurses Association • Wisconsin Pharmacy Association • Wisconsin Positive Youth Development • Wisconsin Public Health Association

Tobacco-Free Coalitions • Barron County • Brown County • Burnett • Chippewa County • Dane County • Door County • Douglas County • Fond du Lac County • City of Franklin  
Green County • Iowa County • Jefferson County • Kenosha County • La Crosse Area Health Initiative • Manitowoc County • Marathon County • Marinette/Menominee County • Milwaukee Coalition Against Drug  
& Alcohol Abuse • Oneida County • Ozaukee County • Pierce / St. Croix County • Polk County • Portage County • Price County • Racine County • Rock County • Sauk County • Sawyer County  
Shawano County • Sheboygan County • Vilas County • Washington County • Waukesha County • Waupaca County • West Allis/West Milwaukee • Winnebago County • Wood County

## ROBERT WEISSMAN

Robert Weissman has been the editor for Multinational Monitor for 10 years. The publication serves as a watchdog for corporations operating in the multinational arena. The magazine is published monthly except for its bimonthly January/February and July/August issues. The magazine has spotlighted tobacco industry activities in past issues.

Weissman is also co-director of Essential Action, a corporate accountability group founded by Ralph Nader.

Weissman is based in Washington, D.C.



# Cost-effectiveness of the Clinical Practice Recommendations in the AHCPR Guideline for Smoking Cessation

Jerry Cromwell, PhD; William J. Bartosch, MPA; Michael C. Fiore, MD, MPH;  
Victor Hasselblad, PhD; Timothy Baker, PhD

**Context.**—The Agency for Health Care Policy and Research (AHCPR) published the *Smoking Cessation: Clinical Practice Guideline* in 1996. Based on the results of meta-analyses and expert opinion, the guideline identifies efficacious interventions for primary care clinicians and smoking cessation specialty providers.

**Objective.**—To determine the cost-effectiveness of clinical recommendations in AHCPR's guideline.

**Design.**—The guideline's 15 recommended smoking cessation interventions were analyzed to determine their relative cost-effectiveness. Then, using decision probabilities, the interventions were combined into a global model of the guideline's overall cost-effectiveness.

**Patients.**—The analysis assumes that primary care clinicians screen all presenting adults for smoking status and advise and motivate all smokers to quit during the course of a routine office visit or hospitalization. Smoking cessation interventions are provided to 75% of US smokers 18 years and older who are assumed to be willing to make a quit attempt during a year's time.

**Intervention.**—Three counseling interventions for primary care clinicians and 2 counseling interventions for smoking cessation specialists were modeled with and without transdermal nicotine and nicotine gum.

**Main Outcome Measure.**—Cost (1995 dollars) per life-year or quality-adjusted life-year (QALY) saved, at a discount of 3%.

**Results.**—The guideline would cost \$6.3 billion to implement in its first year. As a result, society could expect to gain 1.7 million new quitters at an average cost of \$3779 per quitter, \$2587 per life-year saved, and \$1915 for every QALY saved. Costs per QALY saved ranged from \$1108 to \$4542, with more intensive interventions being more cost-effective. Group intensive cessation counseling exhibited the lowest cost per QALY saved, but only 5% of smokers appear willing to undertake this type of intervention.

**Conclusions.**—Compared with other preventive interventions, smoking cessation is extremely cost-effective. The more intensive the intervention, the lower the cost per QALY saved, which suggests that greater spending on interventions yields more net benefit. While all these clinically delivered interventions seem a reasonable societal investment, those involving more intensive counseling and the nicotine patch as adjuvant therapy are particularly meritorious.

JAMA. 1997;278:1759-1766

From Health Economics Research, Inc, Waltham, Mass (Dr Cromwell and Mr Bartosch); the Center for Tobacco Research and Intervention (Drs Fiore and Baker), Section of General Internal Medicine, Department of Medicine (Drs Fiore and Baker), Comprehensive Cancer Center (Dr Fiore), and Department of Psychology (Dr Baker), University of Wisconsin Medical School, Madison; and the Center for Health Policy Research and Education, Duke University, Durham, NC (Dr Hasselblad).

Since publication of the AHCPR Smoking Cessation Clinical Practice Guideline in April 1996, Dr Fiore has done consulting, received funding for clinical research studies, and/or spoken on behalf of GlaxoWellcome, SmithKline Beecham, and McNeil pharmaceutical companies. Dr Baker has done consulting, research,

and/or speaking for SmithKline Beecham pharmaceutical company. Prior to 1994 (when work on the Guideline began), Drs Baker and Fiore had worked on clinical research studies funded in part by ALZA Corp, CIBA-Geigy Corp, Elan Pharmaceutical, Lederle Laboratories, Glaxo Wellcome, SmithKline Beecham, and Hoechst Marion Rousel Inc. Prior to 1994, Dr. Fiore had received honoraria for educational activities from CIBA-Geigy, Elan, Lederle, Marion Merrell Dow Inc, and Parke-Davis.

The statements contained in this article are solely those of the authors and do not necessarily reflect the views or opinions of the Agency for Health Care Policy and Research.

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TOBACCO use has been cited as the chief avoidable cause of death in the United States, responsible for more than 420 000 deaths annually.<sup>1</sup> Despite this, physicians and other practitioners fail to assess and counsel smokers consistently and effectively.<sup>2-4</sup>

This study analyzes the cost-effectiveness of the Agency for Health Care Policy Resource's (AHCPR's) *Smoking Cessation: Clinical Practice Guideline*.<sup>3</sup> Released in April 1996, the guideline was developed over a 2-year period by a panel of smoking cessation specialists using extensive quantitative analysis of published effectiveness data. Recommendations include screening all presenting patients for tobacco use, advising patients who use tobacco to quit, and providing interventions that appear most efficacious. The recommendations were based on rigorous logistic regression meta-analyses of various cessation intervention outcomes, ranging from self-help materials to multisection group counseling lasting several hours or more. Recommendations were targeted specifically to 3 audiences: primary care clinicians; cessation specialists; and administrators, insurers, and purchasers of health care services.

Formulation of optimal health care policy requires an analysis of the costs of recommended interventions relative to their clinical effectiveness. This information is not readily available in the case of the AHCPR's guideline. Few claims data exist to quantify current practice. Most counseling services are an integral part of physician-patient contacts with no separate billing, while other services, such as nicotine replacement and intensive counseling, are generally not covered by insurance and, hence, do not produce a claims trail.

Finally, the benefits of stop-smoking treatments may be difficult to assess accurately. The immediate effect of efficacious treatment is smoking cessation, and this may or may not be related to immediate health benefits. Even when cessation leads to health benefits, these benefits are delayed many years, occurring

through decreased morbidity or mortality across a wide range of illnesses. Many studies<sup>6,7</sup> have found single smoking cessation interventions to be cost-effective. However, these studies do not provide cost-effectiveness data on the range of effective interventions that are both in current use and recommended for clinical practice by the AHCPR.

## METHODS

### General Approach

The cost estimates developed in this study were not based on individual patients. Instead, they were based on recommended resource inputs found in the guideline report. Similarly, estimates of the marginal effectiveness of interventions were taken from the guideline and were based on prospective clinical trial results.

Two general methodological approaches were taken, both incorporating a societal perspective. Under one approach, three quarters of all smokers were assumed to undertake a particular intervention during a year's time. This represents the approximate percentage of current US smokers who have made a previous quit attempt.<sup>8</sup> This answers the question, "What would be the cost-effectiveness of the guideline if all willing smokers could be encouraged to undertake 1 of the 15 interventions recommended by the guideline panel?" When the resulting 15 cost-effectiveness ratios are compared across all cessation interventions, this informs policymakers as to which interventions appear to be the most cost-effective.

Under the second scenario, panel experts were queried regarding the likelihood of patients choosing 1 of the 5 counseling interventions with or without nicotine replacement. These probabilities were used to weight the costs and quit rates of the interventions. The result was a combined global cost-effectiveness ratio for the guideline as a whole, which answers the question, "How much would the guideline likely cost per life-year saved or quality-adjusted life-year (QALY) if adopted by practitioners, given the expected preferences of smokers for different interventions?"

### Calculation of Cost-effectiveness Ratios

A cost-effectiveness ratio for a specific smoking cessation intervention can be decomposed into 4 components: (1) the cost of physicians screening the US patient population; (2) the cost of physicians advising smokers; (3) motivating unwilling smokers to try and quit; and, (4) the direct intervention costs incurred in helping smokers quit, expressed per quitter or per life-year saved.

Aggregating across interventions, the overall cost-effectiveness of the guideline can be expressed as the ratio of expected total guideline costs and expected benefits, eg, number of quitters or QALYs saved. Expected intervention costs include the total fixed screening, advice, and motivation costs, which are assumed to be independent of which intervention is chosen, plus a weighted sum of the direct costs per intervention for smokers selecting 1 of the 15 interventions. Expected benefits are a weighted sum of smokers' expected marginal quit rates across all interventions, multiplied by QALYs saved per quitter, using patient intervention preference proportions as weights. For example, if three quarters of adult Americans who smoke (25% of US adults are smokers) are willing to try to quit during a year, and 40% of them prefer particular intervention, then 15 million persons could be expected to incur the guideline's estimations for the direct costs associated with this intervention (ie, approximately 200 million adult Americans  $\times 0.25 \times 0.75 \times 0.4$ ). Similarly, if a particular intervention is found to raise the underlying natural quit rate by 0.1, then 1.5 million new quitters could be anticipated to justify the extra costs. When weighted and summed across all interventions, the result is an average cost-effectiveness ratio for the entire guideline. A lower cost-effectiveness ratio is better, implying less cost outlay per quitter or QALY saved. Holding everything else constant, a higher marginal quit rate would lower the overall cost-effectiveness, which would be lower, too, if smoker preferences shifted to more efficacious interventions.

### Patient Intake

The guideline recognizes 2 loci of patient intake: the office and the hospital. Interventions in each of these sites were analyzed separately and then combined into a single cost-effectiveness ratio. Screening, advice, and motivation costs, which are incurred repetitively during several annual office visits, were added to similar screening costs of hospitalized patients. Direct intervention costs of hospitalized patients were debited from those incurred by ambulatory patients. This avoids double counting such costs, as only 1 quit attempt was assumed during a year's time regardless of whether a smoker was an inpatient.

### Identification of Direct Interventions

The amount of counseling that smokers receive depends largely on patient and/or physician preferences. Based on the guideline, we modeled 5 possible counseling options that a patient may choose after receiving advice from a phy-

sician: (1) minimal, (2) brief, (3) full, (4) individual intensive, and (5) group intensive. The level of provider time and number of sessions vary widely among these 5 options. The first 3 interventions involve primary care clinicians, assumed to be physicians, while intensive counseling is performed by smoking cessation specialists. Each of the counseling options was analyzed both by itself and in conjunction with nicotine replacement (transdermal nicotine and nicotine gum).

### Time Inputs

The assumptions that we made concerning the providers and length of time required for each intervention scenario are outlined in Table 1. The guideline recommends that health professionals screen all adult patients (aged 18 years or older) for smoking status during each office visit or hospitalization. We assumed that this task is performed by a registered nurse (RN) and that it requires 1 minute of provider time.

Following the identification of a smoker, initial smoking cessation advice is provided by physicians in either an office or a hospital setting. This task involves delivering a clear, strong, and personalized message urging every smoker to quit. We assumed that this would take 1 minute of physician time and that all smokers would be advised to quit at each of their office visits or sometime during the course of their hospitalization. Patients unwilling to quit after receiving initial advice are provided with a motivational intervention that involves an additional minute of physician time. We assumed all smokers would require a motivational intervention during at least 2 annual office visits or during the course of hospitalization.

Minimal, brief, and full counseling interventions are provided to smokers willing to make a quit attempt. These are delivered by primary care clinicians and involve increasing amounts of physician time. Among these 3 interventions, full counseling involves the greatest amount of physician time—15 minutes during an initial visit with two 10-minute follow-up visits. When nicotine replacement is used, an extra 3 minutes was allocated to the minimal, brief, and full counseling interventions to account for the time required to prescribe the pharmacotherapies and instruct patients in their use.

The individual intensive and group intensive counseling interventions begin with screening and advising tasks performed by primary care clinicians. Patients are then referred to a smoking cessation specialist. We assumed that smokers undergoing an individual intensive intervention receive 5 counseling ses-

sions that are each 30 minutes long. The first session involves 10 minutes of physician time for the purpose of assessing the patient and prescribing pharmacotherapy and an additional 20 minutes of time with an RN. The remaining time is divided between an RN with health education experience and a psychologist (three 30-minute visits for the former and two 30-minute visits for the latter). Across the 5 sessions, there is a total of 10 minutes of physician time, 80 minutes of RN time, and 60 minutes of psychologist time. We assumed that group intensive counseling is delivered to groups of 10 patients over 7 sessions that are each 1 hour long. Under this scenario, a physician is also available for a portion of the first session (in this case, 20 minutes). The remaining time for the first group session and sessions 2 through 7 involves an RN and a psychologist. These 2 professionals jointly provide services, and each contributes a total of 400 minutes of time across all sessions.

### Input Costs

Physicians are the most costly provider group among primary care clinicians. Their costs include not only a return to their own time input but also any overhead costs associated with maintaining their practice. Other studies<sup>5</sup> have used physician charges, but very few patients or insurers pay full charges today. Medicare rates were used instead, under the assumption that they more accurately reflect the physician's true marginal cost of providing an office visit. To determine the per minute cost of physician time for the initial intervention, per patient 1994 Medicare allowed charges for 10-, 20-, 30-, 45-, and 60-minute visits were calculated based on Current Procedural Terminology (CPT) codes for new patients receiving services in an office or another outpatient setting. They were then adjusted for medical services inflation through 1995. Next, a per minute cost was calculated for each office visit code using the specified time intervals and a weighted average taken across visit types to account for differences in patients with respect to length of visit.

Based on this approach, we estimated that the Medicare effective physician allowable charge per minute for an initial visit was \$1.97 in 1995. Using the same method, we estimated that the average per minute cost of physician time for follow-up office visits was \$2.20. We used the CPT codes for subsequent hospital care to estimate initial physician advice and counseling costs in a hospital setting, ie, \$1.92 per minute. We assumed that hospitalized patients would receive follow-up after discharge in an office or outpatient setting at the same \$2.20 cost per minute.

Table 1.—Resource Utilization Assumptions\*

Interventions for Primary Care Clinicians	Intervention Time, min		
	Minimal Counseling	Brief Counseling	Full Counseling
Screening for tobacco use			
Registered nurse	1	1	1
Advice to quit			
Physician alone	1	1	1
Initial cessation counseling			
Physician alone	3	7	15
Physician with patch or gum	6	10	18
Follow-up counseling			
First follow-up physician visit	3-6	10	10
Second follow-up physician visit	...	...	10

Intensive Interventions for Smoking Cessation Specialists	Intervention Time, min†	
	Individual‡ Intensive	Group§ Intensive
Screening for tobacco use		
Registered nurse	1	1
Advice to quit		
Physician	1	1
Cessation counseling sessions		
Physician	10	20
Registered nurse	80	400
Psychologist	60	400

\*Data from Fiore et al.<sup>2</sup>

†Patients referred to a smoking cessation specialist are first screened in an office or hospital setting and advised to quit by a primary care clinician.

‡Counseling time for "individual intensive" patients are distributed over five 30-minute sessions.

§Counseling time for "group intensive" patients are distributed over seven 1-hour sessions.

We used estimates from the US Bureau of Labor Statistics for mean weekly earnings to calculate the per minute cost of RN and psychologist time. In 1995, the average weekly earnings of RNs and psychologists were \$729 and \$698, respectively. Assuming that these professionals work an average of 40 hours each week, the per minute labor cost of RNs is \$0.30, and for psychologists, the per minute labor cost is \$0.29. To account for additional fringe and overhead costs, we doubled their salaries. Medicare physician claims already include a practice cost allowance and were not adjusted further.

The guideline recommends that patients receive educational materials during the course of their smoking cessation intervention. While physicians and hospitals often receive self-help pamphlets from government agencies or antismoking groups free of charge, there is a cost associated with these materials that is incurred by society at large. For each intervention scenario, we assumed that patients would receive 2 educational pamphlets during their counseling session at a total societal cost of \$2.00 per patient per intervention.

The guideline recommends that providers offer nicotine replacement therapy to all smokers except in special circumstances, eg, pregnant women. Guideline recommendations were followed on the amount and dosages that each patient should receive.<sup>9</sup> A complete smoking cessation intervention using the patch requires that patients use different dosages

over a period of 8 weeks. We used the 1995 average wholesale price as an estimate of the cost of nicotine replacement.<sup>10</sup> The average cost of an 8-week supply of the patch is \$219.23. Nicotine gum is available under 1 brand name in 2-mg or 4-mg doses. Both doses come in boxes of 96, and the average wholesale price per box is \$38.85 and \$63.29, respectively. We assumed that patients use nicotine gum for the first 3 months of their quit attempt and chew an average of 10 pieces per day. This requires a single patient to purchase 10 boxes of gum. Therefore, complete treatments with 2-mg gum and 4-mg gum cost \$388.50 and \$632.90, respectively.

Only a portion of patients willing to undergo an intervention quit successfully. We assumed unsuccessful quitters would purchase only a 4-week supply of the patch or gum. For transdermal nicotine, the average cost for the first month of patches is \$114.38. A 4-week supply of nicotine gum requires approximately 3 boxes of gum at a cost of \$116.55 for 2-mg gum or \$189.87 for 4-mg gum.

### Resource Costs by Intervention Activity

Table 2 displays our cost estimates of the guideline's recommended smoking cessation interventions. These estimates assume that patients first encounter a physician during the course of a routine office visit. All the interventions have the same cost per participant for preintervention screening (\$0.60), advice (\$1.97), and motivation (\$1.97). Per participant direct

Table 2.—Smoking Cessation Costs per Participant\*

Cessation Intervention	Total Cost per Participant	
	Successful	Failed
Without nicotine replacement		
Minimal counseling	14.51	14.51
Brief counseling	37.79	37.79
Full counseling	75.55	75.55
Individual intensive counseling	104.50	104.50
Group intensive counseling	53.14	53.14
With transdermal nicotine		
Minimal counseling	246.25	141.40
Brief counseling	262.93	158.08
Full counseling	300.69	195.84
Individual intensive counseling	323.73	218.88
Group intensive counseling	272.37	167.52
With nicotine gum		
Minimal counseling	415.52	143.57
Brief counseling	432.20	160.25
Full counseling	469.96	198.01
Individual intensive counseling	493.00	221.05
Group intensive counseling	441.64	169.69

\* All costs reported in 1995 dollars. Data from Fiore et al<sup>7</sup>; 1996 *Physician's GenRX*<sup>10</sup>; Medicare allowed charges; the *Current Population Survey: 1995 Estimates of Weekly Earnings*, published in 1996 by the US Bureau of Labor Statistics; and 1994 Medicare Part B data.

intervention costs naturally increase with the intensity of counseling provided. The estimated cost of a single minimal counseling intervention without pharmacotherapy is \$14.51. The initial intervention takes 3 minutes and costs \$5.91 of physician time. A 3-minute follow-up (provided via telephone) by a physician costs \$6.60. Finally, education materials cost \$2.00. The brief intervention assumes a longer initial physician visit and follow-up time, with a per participant cost of \$37.79. The full counseling intervention, requiring 15 minutes of physician time during the initial visit plus two 10-minute follow-up visits, costs \$75.55.

Adding pharmacotherapy greatly increases intervention costs. For brief counseling, the per participant cost rises to \$262.93 with the addition of transdermal nicotine and to \$432.20 with nicotine gum. Full counseling with complete transdermal nicotine treatment costs \$300.69 vs \$469.96 with nicotine gum. These costs, however, are much lower for patients who fail to quit because they do not require complete treatment with nicotine replacement.

Intensive interventions are divided into 5 sessions for individual counseling and 7 sessions for group counseling. The cost of educational materials and pharmacotherapy is assumed to be the same under these scenarios. While the group counseling sessions are longer than individual counseling sessions (1 hour as opposed to 30 minutes), their per participant costs (\$53.14 per patient) are much lower because the cost for each group session is distributed across 10 pa-

tients. Adding a complete treatment of transdermal nicotine increases intensive counseling costs to \$323.73 for individual counseling and \$272.37 for group counseling, respectively. A complete, successful intensive intervention with nicotine gum costs \$493 when provided through individual counseling and \$441.64 when provided in a group context. Again, among the scenarios that use pharmacotherapy, costs would be substantially less for patients who fail.

### Effectiveness of Smoking Cessation Interventions

The guideline uses long-term quit rates as its effectiveness indicator. Primarily using a modified intent-to-treat analysis technique, the researchers who support the guideline panel drew from peer-reviewed, published clinical trial literature based on at least 5 months of follow-up data to calculate percentages of individuals who successfully quit smoking using different interventions. Meta-analyses evaluated basic treatment characteristics such as counseling format (eg, individual vs group), duration of treatment, and use of pharmacotherapy. Studies that included the same intervention were grouped together, screened to ensure methodological rigor, and analyzed using either fixed or random effects logistic models. The guideline odds ratios (ORs), which indicate an intervention's marginal effectiveness, are generated by exponentiating the logistic regression coefficients obtained from 56 studies in the meta-analyses.

From the meta-analyses, the average baseline "no intervention" quit rate was 8.8% vs 10.7% for minimal counseling, 12.1% for brief counseling, and 18.7% for full counseling lasting more than 10 minutes, all excluding pharmacotherapy. The baseline and intervention quit rates for intensive counseling (4-7 sessions) were 10.4% and 22.6%, respectively. Baseline quit rates vary by intervention owing to different samples and "self-help" activities among the various control groups in the clinical trials. Odds ratios for the patch and gum over and above counseling alone were found to range between 2.1 to 2.6 and 1.4 to 1.6, respectively. Intervention-specific marginal quit rates were derived by subtracting the underlying baseline quit rate.

Despite statistically controlling for "all-comers" vs "want-to-quit" subjects, the logistic coefficients estimated from the meta-analyses generated unreasonably high baseline quit rates (eg, 8.8%) for 2 reasons: many studies include only want-to-quit subjects, and some control subjects receive very low-intensity cessation interventions (eg, self-help materials). To apply the results of the meta-

analyses to the entire US smoking population, the ORs derived from the analyses were applied to the underlying 3-month-or-more quit rate of all smokers (ie, all-comers) in the United States. We assumed this rate was 5% (vs 5.7% for smokers quitting for at least 1 month).<sup>11</sup>

To illustrate our method, the estimated OR for brief counseling was 1.4, implying roughly a 40% gain in quitters. Using the most conservative ORs for the patch (2.1), the combined OR for brief counseling with the patch is 2.94 (ie, 1.4×2.1). Multiplying the underlying 5% quit rate by 2.94, after converting it into an OR (0.05/0.95=0.0526), results in an estimated OR of 0.155. Converting this OR back into a percentage quit rate equals 0.134 (ie, 0.155/[1+0.155]). Finally, subtracting the underlying 5% quit rate gives 8.4% as the marginal quit rate of brief counseling using the patch as adjuvant therapy. This is a more conservative estimate than one based on the average quit rate of the control groups in the clinical trials. Using the 8.8% baseline would have produced almost 60% more quitters.

Sensitivity analysis (discussed below) was also applied to the percentage of smokers willing to make a quit attempt during the year. To recognize that not all quitters stay abstinent, a 45% relapse rate is applied as well to the marginal quit rates.<sup>12</sup> The 45% figure is based on considerable relapse data showing that most relapses typically occur within the first 6 months.<sup>13</sup> Therefore, this figure estimates the relapse rate for subjects who have already passed the time of maximal relapse risk. Long-term follow-up data show that, of subjects who have been abstinent for 1 year, only some 30% or so will relapse over the subsequent 5 years.<sup>8</sup> After 5 years relapse occurs, but the rate is extremely low.<sup>8,12</sup> Also, after prolonged abstinence, the rate of relapse is approximately balanced by cessation occurring through subsequent quit attempts.<sup>8</sup>

### Quality-Adjusted Life-Years Saved

The guideline does not differentiate interventions by patient age. All smokers, regardless of age, are deemed candidates to try to quit. Moreover, the clinical trial results do not differentiate quit rates by intervention by age group. Quit rates were applied uniformly to the age- and sex-specific distribution of smokers and then were converted into years of life saved using published and unpublished estimates developed by Fiscella and Franks.<sup>6</sup> The authors calculated sex- and age-specific years of life saved using life expectancy data for smokers and never smokers taken from Rogers and Powell-Griners.<sup>14</sup> Fiscella and Franks<sup>6</sup> extrapolated mortality rates for smokers vs never smokers using a 20-year phase-in period

based on mortality ratios of long-term quitters to never smokers derived from the American Cancer Society's Cancer Prevention Study II.<sup>8</sup> They also made a quality-of-life adjustment to the raw years-of-life-saved figures using an index of years of healthy life constructed from questions on the National Health Interview Survey (NHIS).<sup>3,15</sup>

Assuming that marginal quit rates apply uniformly to all age groups, an overall estimate of life-years saved was derived by weighting expected years saved within age group by the actual distribution of smokers by age group and by the uniform quit rate. Men aged 25 to 29 years are expected to gain 1.31 years of life, discounted at 3%, which is equivalent to 2.34 QALYs. Older men, aged 65 to 69 years, only save 0.47 years of life (0.69 QALYs). Women gain more years of life from quitting than men. Female quitters aged 25 to 29 years save 1.43 life-years (1.94 QALYs), while those aged 65 to 69 years save 1.41 life-years (1.08 QALYs). Given the current distribution of smokers, we calculated a weighted average of 1.46 life-years saved per quitter (1.97 QALYs). Our analysis (and the analysis of Fiscella and Franks<sup>6</sup>) assumes a 3% discount rate for life-years saved. Sensitivity analyses were performed at 0% and 5%.

Table 3 shows the intervention's marginal quit rates, expected number of quitters, and life-years and QALYs saved for each of the guideline interventions. If intensive counseling with transdermal nicotine were provided to three quarters of smokers in the United States willing to try to quit during a year's time, it would generate the largest number of quitters, 3 346 000 (6 602 000 QALYs). Minimal counseling without pharmacotherapy results in the fewest quitters, 189 000 (373 000 QALYs). Based on patient preferences for the various interventions (discussed next), adoption of the guideline could be expected to generate 1.67 million additional quitters and nearly 3.3 million QALYs, discounted at 3% (Table 3).

#### Intervention Decision Probabilities

In actual practice, patients and providers vary in their intervention preferences, and it is highly unlikely that all smokers would choose the same intervention. While group intensive counseling costs less per quitter than any of the other interventions, very few patients would actually choose this treatment option. Conditional probabilities incorporating willingness to quit and preferences concerning format and use of pharmacotherapy were calculated for the 15 interventions. Our baseline assumes that 25% of the US adult population smokes<sup>16</sup> and that 75% of smokers would be willing to make a quit attempt in a year's time. The

Table 3.—Expected Annual Number of Quitters and Life-Years Saved by Smoking Cessation Intervention, Assuming 75% of Smokers Attempt to Quit Once During the Year\*

Interventions	Overall Guideline			
	Marginal Quit Rate, %	Quitters,† No. in Thousands	Life-Years Saved,‡ No. in Thousands	Quality Life-Years Saved,§ No. in Thousands
Minimal counseling alone	0.94	189	276	373
With patch	6.70	1347	1968	2658
With gum	3.68	734	1072	1448
Brief counseling alone	1.86	374	546	738
With patch	8.40	1689	2467	3333
With gum	4.95	995	1454	1964
Full counseling alone	6.20	1247	1821	2460
With patch	16.00	3217	4700	6348
With gum	10.90	2192	3202	4325
Intensive counseling alone	6.62	1331	1945	2627
With patch	16.64	3346	4888	6602
With gum	11.50	2312	3378	4563
Combined intervention¶	...	1669	2439	3294

\*Data from Fiore et al<sup>2</sup> and Fiscella and Franks.<sup>6</sup> Ellipses indicate not applicable.

†The number of quitters was discounted by 45% to account for post-follow-up relapse.

‡Life-years (discounted 3%) were derived using a 1.46 adjustment factor. The adjustment factor represents the average life-years saved per quitter given the current distribution of smokers and expected life-years saved for each sex-specific age group.

§Quality-adjusted life-years (discounted 3%) were derived using a 1.97 adjustment factor. The adjustment factor represents the average life-years saved per quitter given the current distribution of smokers and expected quality-adjusted life-years saved for each sex-specific age group.

||Different quit rates were not available for "individual counseling" vs "group intensive counseling". Therefore, the same quit rate (6.62%) was used for both interventions.

¶The variable was derived by weighting the individual interventions by the likelihood of smokers choosing each intervention.

75% estimate reflects the total percentage of smokers who will try to make a quit attempt in a given year and reflects the increase in cessation attempts caused by introduction of the guideline interventions (eg, brief interventions offered across diverse health care settings). Based on the expert opinion of the guideline panel, we assumed that 40% of smokers would choose brief counseling, 30% would choose full counseling, 25% would choose minimal counseling, and 5% would choose intensive counseling (2.5% individual intensive counseling and 2.5% group intensive counseling). We further assumed that 75% of all smokers who are willing to try to quit, regardless of the length of counseling they choose, would use pharmacotherapy. Among those willing to use pharmacotherapy, 83% would choose the patch and 17%, nicotine gum. In our model, for example, 1.875% ( $0.25 \times 0.75 \times 0.40 \times 0.25 \times 100$ ) of the entire US population would undergo brief counseling alone, 4.67% ( $0.25 \times 0.75 \times 0.40 \times 0.75 \times 0.83 \times 100$ ) would likely receive brief counseling and transdermal nicotine, and 0.96% ( $0.25 \times 0.75 \times 0.40 \times 0.75 \times 0.17 \times 100$ ) would undergo brief counseling using nicotine gum as adjuvant therapy. When summed across the 15 interventions, the percentages add to the 18.75% of the entire US population who would be expected to undergo a quit attempt.

Sensitivity analysis of the decision probabilities involved testing the 75% rate of those who are willing to try and quit at 50% and 100%. The 45% relapse

rate (after 5 months of abstinence) was also tested at 35% and 55% in some simulations.

#### Basic Parameters

Each of the smoking cessation scenarios that we modeled is based on a common set of basic parameters. As of January 1, 1996, the US resident population older than 18 years was estimated by the US Bureau of the Census at 195 million. The probability of smoking is based on the NHIS, which found that, in 1993, 25% of the US adult population smoked cigarettes.<sup>16</sup> We assumed that the proportion of the population who smoked remained constant between 1993 and 1996, producing approximately 48 745 000 adult smokers in 1996.

Our estimate of the number of physician office visits per year is based on the National Ambulatory Medical Care Survey.<sup>14</sup> This study found that there was a total of 606 877 000 office visits in the United States in 1992 among the population aged 15 years and older, resulting in 3.11 physician office visits per year per adult.

Smokers have higher physician office and hospital utilization rates than people who have never smoked. Rice et al<sup>17</sup> found that, on average, smokers experienced about 6% more physician office visits and spent 27% more days in the hospital than never smokers. If the ratio of the average number of physician visits among smokers vs nonsmokers is 1.06, and the average number of visits

Table 4.—Cost-effectiveness of Smoking Cessation by Intervention\*

Intervention	Cost per Quitter	Cost per Life-Year Saved, (3% Discount)	Cost per Quality-Adjusted Life-Year (3% Discount)
<b>Without nicotine replacement</b>			
Minimal counseling	7922	5423	4015
Brief counseling	6276	4296	3181
Full counseling	2989	2046	1515
Individual intensive counseling	3595	2461	1822
Group intensive counseling	2186	1496	1108
<b>With transdermal nicotine</b>			
Minimal counseling	4745	3248	2405
Brief counseling	4184	2864	2120
Full counseling	2715	1859	1376
Individual intensive counseling	2871	1969	1455
Group intensive counseling	2310	1581	1171
<b>With nicotine gum</b>			
Minimal counseling	8962	6135	4542
Brief counseling	7350	5031	3725
Full counseling	4237	2900	2147
Individual intensive counseling	4407	3016	2233
Group intensive counseling	3596	2461	1822

\*Data from Fiore et al<sup>12</sup> and Fiscella and Franks.<sup>16</sup> This table assumes that 75% of patients who smoke attempt to quit at least once during the year. Quitters were discounted by 45% to account for relapse. All costs are in 1995 dollars.

per capita is 3.11, then the average smoker would experience 3.25 visits while nonsmokers would average 3.06 visits. We estimated that 158 580 925 physician office visits were made by smokers (3.25 × 48 475 000) in 1992.

Using NHIS estimates of the distribution of short-term hospital episodes by age and sex,<sup>18</sup> we calculated that there were 29 051 900 admissions among the adult population aged 18 years or older of a total of 32 315 795 admissions, excluding newborn and psychiatric, reported by the American Hospital Association (AHA) in its 1993 survey of hospitals.<sup>19</sup> Therefore, there were approximately 0.149 admissions per adult resident (29 051 900/194 980 000). We assumed that because smokers experience 27% more hospital days per year than nonsmokers,<sup>17</sup> they would also be 27% more likely to be admitted to the hospital. We calculated that 17.8% of smokers would experience an inpatient stay during the year, while only 13.9% of nonsmokers would be admitted, using the formula:  $(0.149 = 0.25 \times 1.27 \times \text{ARNS} + (0.75 \times \text{ARNS}))$ , where ARNS indicates the estimated admission rate of nonsmokers. These estimates generated 8 653 757 smoker admissions (0.178 × 48.7 million smokers). However, among the general population, only 80.5% of admissions are unique hospital admissions, according to NHIS estimates; the remaining 19.5% are readmissions. We calculated that the total number of unique smoker admissions eligible for an intervention would be 6 966 275, assuming each patient would undergo a smoking intervention only once on an inpatient basis during a year's time.

## RESULTS

### Cost-effectiveness of Individual Interventions

Table 4 shows cost-effectiveness ratios for 15 smoking cessation interventions that are described in the guideline. These results were derived by assuming that 75% of smokers would make 1 quit attempt during the year with all using a particular intervention. Hence, the figures answer the question, "What would be the guideline's cost-effectiveness if all willing-to-quit smokers undertook a single intervention?" Cost per quitter among the counseling interventions without pharmacotherapy ranged from a low of \$2186 for group intensive counseling to a high of \$7922 for minimal counseling. Cost per QALY (discounted at 3%) was lower and therefore better, ranging from \$1108 for group intensive counseling to \$4015 for minimal counseling.

As the amount of clinician time increases, intervention costs and the number of quitters both increase while the cost per quitter decreases (except for individual intensive counseling). Group intensive counseling is a particularly low-cost intervention, excluding patient time costs, even though it involves the greatest amount of patient-clinician time (seven, 1-hour sessions). This is because it generates a large number of new quitters because of its intensity of contact and because intervention costs are shared across groups of 10 patients, which lowers the cost per quitter even further.

Adding pharmacotherapy increases the cost of each intervention, but it also

increases their marginal effectiveness substantially. When using transdermal nicotine (the patch) as adjunct therapy to each of the counseling interventions, the cost per quitter ranged from \$2310 for group intensive counseling, which is slightly less cost-effective, to \$4745 for minimal counseling, which is far more cost-effective than it would have been without nicotine replacement. This translated to \$1171 and \$2405 per QALY, respectively. The cost per quitter for counseling with nicotine gum ranged from \$3596 for group intensive counseling to \$8962 for minimal counseling. The cost per QALY ranged from \$1822 to \$4542, respectively.

### Cost-effectiveness of Combined Interventions

Table 5 shows total costs, number of quitters, life-years saved, and the ultimate cost-effectiveness of the combined smoking cessation guideline, derived by weighting each of the individual intervention's costs and benefits by the likelihood of a smoker choosing it. For example, the total cost of minimal counseling without nicotine replacement is \$93 578 727. This was derived by assuming that only 6.25% of smokers (0.25 × 0.25) would receive this intervention. Direct intervention costs would be \$33 105 235 vs \$60 473 492 in total preintervention costs (screening, advice, and motivation). Minimal counseling without pharmacotherapy would generate 12 000 quitters under the combined guideline, 17 000 life-years saved, and 23 000 QALYs saved.

Overall, the average cost per quitter was \$3779; the average cost per life-year saved, \$2587; and the average cost per QALY saved, \$1915.

Brief and full counseling with pharmacotherapy are expected to generate the preponderance of both costs and benefits, in part because they are more costly and efficacious; but it is also because they are among the most popular choices for trying to quit, ie, 24.9% opt for brief counseling with the patch and 18.7% for full counseling with the patch.

Based on the guideline and the likely cessation intervention preferences of patients, it would cost \$6.3 billion annually to screen, motivate, and provide 75% of ambulatory and hospitalized smokers with the intervention of their (expected) choice. Screening, advice, and motivation account for \$968 million, or 15.4% of the total cost. Implementation of the guideline would result in 1.67 million new quitters during the first year, with more than 60% resulting from brief and full counseling using the patch. The figure of 1.67 million new quitters is derived from the 48.7 million smokers in the United States figure. We assumed that 36.6 mil-

lion of those smokers would make a new quit attempt during the year, generating 3.03 million new quitters based on a combined intervention marginal quit rate of 8.3%. The guideline would cost an average of \$3779 per quitter. The cost per life-year saved (discounted at 3%) would be \$2587. Adjusting for improved quality of life further lowers the cost per life-year saved to \$1915.

### Sensitivity Analysis

We performed a series of 1-way sensitivity analyses on several of our major assumptions. Our baseline analysis assumes that 75% of smokers are willing to make a quit attempt. When we assumed that only 50% of patients would be willing to try the intervention of their choice, the cost per QALY saved (discounted at 3%) increased from \$1915 to \$2073, or by 8.25%. If we assumed that all smokers would be willing to undergo an intervention, the cost per QALY decreased further to \$1836, or by 4.12% more. Altering the assumption about the number of smokers willing to try to quit has a slight impact on the cost-effectiveness ratios because pre-intervention costs are unchanged, while the number of quitters varies at the various willing-to-quit rates.

The cost-effectiveness ratios proved quite sensitive to the discount rate used to adjust life-years saved. When QALYs were discounted by 5%, the cost for the guideline was \$3205 per QALY saved—or two thirds more; without any discounting, the guideline would cost only \$745 per QALY saved—61% less.

At press time, a new analysis by CDC estimated that the baseline, 3-month quit rate for smokers is 4.6% (C. Husten, MD, MPH, unpublished data, November 1997). We tested the sensitivity of our combined model to the new baseline and found that the cost per QALY increased to \$2048, or 6.9%.

The sensitivity of the relapse rate was tested at 35% and 55%. The lower relapse rate decreased the guideline cost per QALY to \$1620 (a 15.4% decline). Increasing the relapse rate to 55% raised costs per QALY by 22% to \$2340, which is still a low figure.

Treatments that involve more direct intervention time and 1 or more follow-up visits can have substantial patient costs. For each intervention, we estimated the costs associated with patient travel and cessation counseling time. Travel time for initial physician visits was excluded because patients would have incurred these costs in the absence of the smoking cessation intervention. Patient-specific time costs associated with each smoking cessation intervention (including travel to follow-up or intensive counseling sessions) were calculated assuming that pa-

Table 5.—Cost-effectiveness of the Combined Agency for Health Care Policy and Research Resource Guideline\*

Interventions	Costs, \$ in Thousands	Quitters, † No. in Thousands	Life-Years Saved, ‡ No. in Thousands	Quality-Adjusted Life-Years Saved, § No. in Thousands
<b>Without nicotine replacement</b>				
Minimal counseling	93 579	12	17	23
Brief counseling	234 730	37	55	74
Full counseling	279 425	93	137	184
Intensive counseling	29 908	8	12	16
Group counseling	18 186	8	12	16
<b>With transdermal nicotine</b>				
Minimal counseling	998 787	210	308	415
Brief counseling	1 766 540	422	617	833
Full counseling	1 637 972	603	881	1190
Intensive counseling	150 075	52	76	103
Group counseling	120 769	52	76	103
<b>With nicotine gum</b>				
Minimal counseling	205 551	23	34	45
Brief counseling	335 782	50	73	98
Full counseling	348 209	82	120	162
Intensive counseling	31 843	7	11	14
Group counseling	25 981	7	11	14
Combined interventions	6 307 337	1669	2439	3294

\*Data from Fiore et al<sup>2</sup> and Fiscella and Franks.<sup>3</sup>

†The number of quitters was discounted by 45% to account for post-follow-up relapse.

‡Life-years (discounted 3%) were derived using a 1.46 adjustment factor. The adjustment factor represents the average life-years saved per quitter given the current distribution of smokers and expected life-years saved for each sex-specific age group.

§Quality-adjusted life-years (discounted 3%) were derived using a 1.97 adjustment factor. The adjustment factor represents the average life-years saved per quitter given the current distribution of smokers and expected quality-adjusted life-years saved for each sex-specific age group.

||This variable was derived by weighting the individual interventions by the likelihood of smokers choosing each intervention.

tients would travel an average of 1 hour (round-trip) for each visit. Patient time per intervention ranged from 3 minutes for minimal counseling to 340 minutes for group intensive counseling, ie, seven 1-hour sessions plus 7 additional travel hours. According to the Bureau of Labor Statistics, in 1995, the median weekly salary of full-time wage and salary workers was \$479. We assumed an average workweek was 40 hours long and calculated an average per minute patient opportunity cost of \$0.20 (\$479/2400 minutes). Group intensive counseling involved the greatest amount of travel and direct intervention time (seven 1-hour visits), costing each participant \$168 in lost time for other activities.

As the intensity of the interventions increases, they become more sensitive to patient opportunity costs. Group intensive counseling without pharmacotherapy experienced the greatest change in cost per QALY, rising from \$1108 when patient costs were ignored to \$3446 when they were included in the analysis, more than tripling the estimate. Still, minimal counseling and brief counseling without pharmacotherapy remained less cost-effective at \$4132 and \$3944 per QALY saved, respectively. However, when patient costs were incorporated into the analysis of interventions without pharmacotherapy, group intensive counseling with 7 sessions became less cost-

effective than full counseling with 2 follow-up sessions, eg, \$3446 per QALY vs \$1975 per QALY. Adding patient costs to the combined interventions increased overall cost per QALY from \$1915 to 2167 (13%).

### COMMENT

These analyses demonstrate that full implementation of the guideline throughout 1 year could cost \$6.3 billion annually, or \$32.31 per capita. For this investment, society could expect to gain approximately 1.67 million new quitters over and above the current baseline 5% quit rate after allowing for a 45% relapse rate among those abstinent for 5 months from the day of cessation. These quitters could expect to enjoy 2.4 million extra life-years (3.3 million extra QALYs), even after discounting by 3%. Given that smokers at all ages experience reduced life expectancy and survival rates,<sup>20</sup> certainly many younger quitters would enjoy more productive years of employment.

For \$2587, society could expect to save another life-year by implementing the guideline. Given the negative health associated with smoking, the cost-effectiveness of the guideline is even better on a QALY basis, ie, \$1915. The more intensive the cessation intervention, the lower the cost per year of life saved. While all interventions seem a reasonable societal investment, those involv-

ing more intensive counseling and the nicotine patch are particularly meritorious. Nicotine gum with counseling is also more effective than counseling alone, although it does not generate as many new quitters as the patch.

A study like ours naturally has several limitations. Results reflect only the first year of guideline implementation. It is not at all clear how the success rates of the various interventions would change, if at all, with repeated years of the guideline. Clinical trials data were unavailable to build a dynamic, recurring intervention model.

Differences in marginal quit rates by intervention with respect to age, sex, severity of illness, and motivational level could not be determined through meta-analysis because of small samples. However, our model uses a sex- and age-specific distribution of smokers when constructing average life-years and QALYs saved per quitter.

Further, it is probably unrealistic to assume the same permanent marginal quit rate for all willing smokers who are triaged through a single intervention. Nevertheless, we believe the quit rates give a reasonable guide to the relative advantages of the various interventions.

Following previous cost-effectiveness studies of smoking cessation interventions,<sup>5,7</sup> we excluded lifetime medical expenditures from our analysis. Whether lifetime medical expenditures should be included in cost-effectiveness analyses has been debated in the literature.<sup>21-25</sup> Warner and Luce<sup>22</sup> argue that offsetting the lower medical costs of nonsmokers in their working lifetimes by higher medical costs because of their longer lives ignores the consumption (and productivity) gains from living longer.

In any event, recent analysis<sup>25</sup> has shown that net medical costs over a person's lifetime are \$6239 higher for US smokers (in discounted 1990 dollars) during his or her remaining lifetime than people who never smoked. Simply counting the excess medical costs of smokers to age 65 years averages \$9000 to \$11 000.<sup>26</sup> Subtracting excess medical costs from the guideline's average cost per life-year saved would turn the ratio negative, implying that smoking cessation interventions actually save more in lifetime medical expenditures than they cost, initially. By excluding all excess lifetime medical expenditures from our analysis, we believe the guideline could be considered even more cost-effective than reported above.

Moreover, our analysis does not attempt to compare the psychosocial costs of smoking treatment, such as the pain and suffering of nicotine withdrawal, with the pain and suffering produced by other

preventive interventions. Such issues are certainly important in evaluating the net benefits of preventive interventions.

Relative to other medical interventions, all the smoking cessation interventions recommended in the guideline appear cost-effective and should be promoted. Tengs et al<sup>27</sup> reviewed 500 life-saving interventions and adjusted them for inflation (all costs are expressed in 1993 dollars), discount rate (all findings converted to 5% discount rate), exclusion of indirect costs, and consistent effectiveness measures (years of life saved).

The costs of the AHCP's guideline are \$3539 per life-year saved when discounted at a comparable 5% rate. Several well-targeted prevention strategies listed in the study by Tengs et al<sup>26</sup> show very low cost-effectiveness ratios as well, including a 1-time screening for cervical cancer for women older than 64 years (\$2053) and pneumonia vaccination for people older than 64 years (\$1769). Other screening strategies targeted at younger age groups cost considerably more, including an annual mammography for women aged 40 to 49 years (\$61 744) and hypertension screening for men aged 40 years (\$23 335). The smoking cessation interventions are all the more remarkable in that the guideline is not targeted to any one population group.

The guideline's cost-effectiveness ratio is favorable relative to most other medical interventions, confirming Eddy's<sup>28</sup> treatment of smoking cessation as the "gold standard" by which all other screening tests can be compared. Of course, the guideline does not address public health strategies aimed at stopping smoking that may be even more cost-effective relative to clinical smoking cessation treatments.

In summary, our findings reinforce the guideline's central challenge to clinicians, insurers, purchasers, and administrators to identify and intervene universally with all smokers presenting in a health care setting.

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# Evaluation of Antismoking Advertising Campaigns

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**Context.**—Active and passive smoking are the first and third leading preventable causes of death. Many states are running or initiating antitobacco media campaigns.

**Objective.**—To review research on the effectiveness of different antismoking messages and published evidence of the effectiveness of paid antismoking advertising.

**Data Sources.**—Focus group studies conducted by professional advertising agencies that contract with California, Massachusetts, and Michigan to run their antismoking advertising campaigns, the Centers for Disease Control and Prevention's *Media Campaign Resource Book*, and copies of the advertisements. In total, we reviewed the results of 186 focus groups involving more than 1500 children and adults dealing with 118 advertisements that had actually been aired and additional concept advertisements that were not produced. Published literature was located using MEDLINE and standard bibliographic sources on the effectiveness of large, paid antitobacco media campaigns. We also reviewed reports and studies conducted by, or for, the California and Massachusetts health departments on program effectiveness, and conducted our own comparison of California vs Massachusetts using cigarette consumption data from the Tobacco Institute.

**Study Selection.**—All available studies.

**Data Synthesis.**—Eight advertising strategies to prevent people from starting to smoke and persuading them to stop were reviewed: industry manipulation, secondhand smoke, addiction, cessation, youth access, short-term effects, long-term health effects, and romantic rejection. These focus groups identified strategies that would be expected to be effective and ineffective. Regression analysis was used to compare the cost-effectiveness of the California and Massachusetts programs.

**Conclusions.**—Focus group participants indicated that industry manipulation and secondhand smoke are the most effective strategies for denormalizing smoking and reducing cigarette consumption. Addiction and cessation can be effective when used in conjunction with the industry manipulation and secondhand smoke strategies. Youth access, short-term effects, long-term health effects, and romantic rejection are not effective strategies. More aggressive advertising strategies appear to be more effective at reducing tobacco consumption.

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SINCE 1989, California,<sup>1</sup> Massachusetts,<sup>2,4</sup> and Arizona<sup>5</sup> have implemented large-scale, paid, tobacco-control campaigns to discourage people from starting to smoke and to encourage smokers to stop. (Michigan has a smaller campaign.) California uses a general market approach with strong, antitobacco industry and secondhand smoke components.<sup>6</sup> Massachusetts uses a more youth-oriented approach and, although it has sought to discredit the industry, its spots are less confrontational with the industry than California's advertisements. The Arizona program is the most narrowly focused, limiting itself to youth and pregnant women,<sup>7</sup> with no messages attacking

the tobacco industry. This article reviews the qualitative marketing research used to develop antitobacco media campaigns and compares the overall cost-effectiveness of the California and Massachusetts campaigns. We found that more aggressive campaigns are more effective.

## METHODS

### Effectiveness of Different Messages and Advertising Strategies

California,<sup>8-13</sup> Massachusetts,<sup>14-16</sup> and Michigan<sup>17</sup> provided the focus group research that their advertising agencies used to develop their campaigns. Arizona's advertising agency, the Riester Corporation, refused to share its research with us. The Centers for Disease Control and Prevention provided a copy of its *Media Campaign Resource Book*,<sup>18</sup> which contains information from the advertising agencies and state health depart-

ments on their advertisements, including target audience, optimal placement, key message, and focus group results.

We obtained 118 advertisements and the results from 186 focus groups involving more than 1500 children and adults that evaluated both produced advertisements and additional concept advertisements that were not produced. We categorized the advertising strategies as industry manipulation, secondhand smoke, addiction, cessation, youth access, short-term effects, long-term health effects, or romantic rejection.

Because focus groups are qualitative research and are subject to methodological limitations such as group dynamics and small sample size, broad quantitative conclusions should not be drawn from the findings. Nonetheless, focus groups are widely used by advertising agencies in designing new advertisements.<sup>19</sup> Conclusions about effectiveness or ineffectiveness of various strategies are based on the responses of the participants in these focus groups, not testing in other ways.

### Relative Cost-effectiveness of the California and Massachusetts Campaigns

California's advertisements have been on the air since 1990, and Massachusetts' since 1994, which allows a rough comparison of the cost-effectiveness of these campaigns. Using per capita cigarette consumption from the Tobacco Institute's *The Tax Burden on Tobacco*,<sup>20</sup> we examined the difference in per capita consumption of cigarettes between California and Massachusetts and the rest of the United States (excluding California and Massachusetts) as our outcome variable. The population estimates for computing the per capita numbers in *The Tax Burden on Tobacco* are based on the number of potential smokers, obtained by dividing reported total consumption by reported per capita consumption. We then computed a simple linear regression with time as the independent variable for the differences over time beginning the fiscal year before media program expenditures occurred (1989 for California and 1993 for Massachusetts). The slopes of the resulting regressions are a measure of the difference in the rate of decline in per capita consumption in California or Massachusetts compared with the rest of the United

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States. By taking this difference as the dependent variable, we partially account for changes in pricing and other trends in the national environment, without requiring the assumption that there is a linear decline in national (excluding California and Massachusetts) cigarette consumption. We then divided the slopes of these regressions by the total per capita expenditures (in 1996 dollars) on media over the lives of the programs<sup>21,22</sup> to obtain an estimate of the rate of per capita decline in cigarette consumption per year and per per capita dollar spent.

## RESULTS

### Effectiveness of Paid Media in General

Paid media is most effective when used as part of a multifaceted approach to reduce smoking, including community programs,<sup>23</sup> higher taxes, and school-based programs.<sup>24-28</sup> Because the various program elements are designed to work together, it is difficult to separate the effects of paid media from other contemporaneous tobacco control interventions. Nonetheless, there is considerable evidence that paid antismoking advertisements are effective in reducing cigarette consumption.

**California.**—Examination of tobacco consumption data shows a relationship between the presence of the media campaign and declines in consumption in California. The first wave of the media campaign began in April 1990 and lasted until the following year. It was gradually phased out between March and June 1991. Pierce et al<sup>29,30</sup> found that tobacco consumption in California declined 13.7% from September 1988 to May 1989 (5 months after the imposition of the \$0.25 per pack tax), then increased by 3% between October 1989 and March 1990. Between April 1990 and March 1991, roughly the same period as the first wave of the media campaign, consumption again decreased, this time by 12.2%. Because the effects of the tax seemed to dissipate after May 1989 and no other Proposition 99-related tobacco control interventions were in effect during the first wave of advertising, the second dramatic drop in consumption can be attributed to the media campaign. Cigarette consumption declined again by 12% between February 1992 and April 1993.<sup>30</sup> Because the second phase of the media campaign did not begin until October 1992 and the other Proposition 99 programs went into effect in 1992, this decline could reflect both the media campaign and the other interventions.

Media campaigns can also be effective in influencing smokers' decisions to quit smoking. Popham et al<sup>31</sup> surveyed adult Californians who had quit smoking dur-

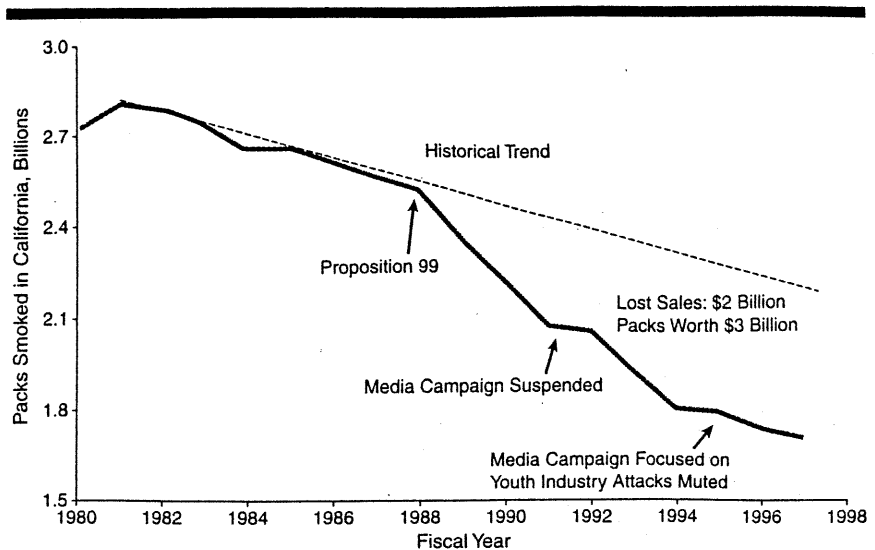


Figure 1.—The long-term pattern of decline in tobacco consumption in California tracked the presence or absence of the media campaign. Reproduced from Glantz<sup>36</sup> with permission of *American Journal of Public Health*.

ing the first wave of the California media campaign in 1990 to 1991. In response to uncued questions, 6.7% of smokers cited an advertisement that they had seen or heard as a factor in their decision to quit smoking. When asked direct questions about the media campaign, an additional 34.3% of smokers in the survey replied that a tobacco-control advertisement had been influential in their decision to quit. This result translates to 33 000 former California smokers for whom the 1990 to 1991 media campaign was a significant factor in their decision to quit and an additional 173 000 former smokers for whom the advertisements contributed somewhat to their decision to quit smoking.

Popham et al<sup>32</sup> also evaluated the effect of the first media campaign on California students before the campaign began and 3 times during the campaign. To determine whether the media campaign met the goal of reducing tobacco use, Popham et al<sup>32</sup> evaluated the campaign's effects according to 5 indicators: campaign awareness, tobacco use, smokers' intention to quit, nonsmokers' intention to start smoking, and attitudes regarding smoking. Over the course of the campaign, awareness of the campaign increased, smoking prevalence decreased, nonsmokers thinking about starting decreased, and health-enhancing attitudes about smoking increased. When Popham et al<sup>32</sup> compared campaign-exposed and campaign-unexposed students from the fourth wave of data gathering, they found mixed results: health-enhancing attitudes about smoking were stronger among the exposed students, but the percentage of nonsmokers thinking about starting was also higher among exposed students. Popham et al<sup>32</sup> recognized, however, that the method

they used to measure nonsmokers' intentions was experimental and may not have been accurate.

Glantz<sup>33</sup> estimated that prior to the passage of Proposition 99, total cigarette consumption was falling by 45.9 million packs per year in California. After enactment, the rate tripled to 164.3 million packs per year. In 1992, the rate of reduction slowed to 19 million packs per year at approximately the same time the media campaign was suspended<sup>33</sup> by Gov Pete Wilson (based on claims that it was not effective). The American Lung Association sued Wilson and the media campaign was restored in 1992<sup>34</sup>, cigarette consumption began to decline again. From 1995 to 1997, when there had been little tobacco-control advertising in California<sup>35</sup> and no new advertising produced, tobacco consumption was essentially flat (Figure 1).

Hu et al<sup>37</sup> conducted an econometric analysis of cigarette consumption in California between 1980 and 1992 using quarterly data and controlling for time, price excluding taxes, state tax, federal tax, and the media campaign. They estimated that cigarette sales were reduced by 1.33 billion packs from the third quarter of 1990 through the fourth quarter of 1992. They attributed 232 million packs of this decline (7.7 packs per capita) to the media campaign. Hu et al<sup>37,38</sup> probably underestimated the impact of the media campaign because it does not take into account the tobacco industry's increased use of promotional activities to counter the media campaign.<sup>39</sup>

**Massachusetts.**—In November 1992, residents of Massachusetts approved a measure similar to California's Proposition 99 that increased the tobacco tax by

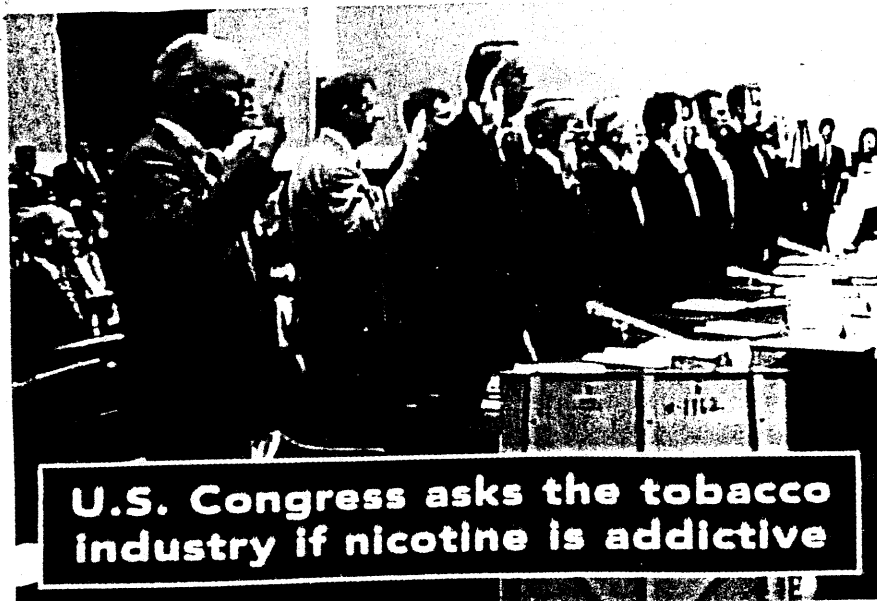


Figure 2.—“Nicotine Soundbites” is a California advertisement that uses footage from the April 14, 1994, Congressional hearings before Henry A. Waxman’s Subcommittee on Health and Environment in which the chief executive officers of the 7 major tobacco companies testified before Congress that they did not believe nicotine was addictive. The advertisement contained messages about industry deception, nicotine addiction, and secondhand smoke. Shortly after “Nicotine Soundbites” aired, lawyers for RJ Reynolds threatened to sue both the California Department of Health Services and the television stations airing the advertisement on the basis that the spot implied RJ Reynolds’ chief executive officer, James Johnston, perjured himself before Congress. When the California Department of Health Services stood by the advertisement and continued to run it, Reynolds dropped its complaint. The department later quietly dropped the advertisement from its rotation and has refused to run it despite repeated requests from the American Heart Association and Americans for Nonsmokers Rights and later the American Cancer Society<sup>45</sup> and the Tobacco Education and Research Oversight Committee, which has statutory oversight over the California antitobacco program.<sup>46</sup> Photograph courtesy of the California Department of Health Services.

\$0.25 per pack with the funds devoted to antitobacco activities.<sup>23</sup> In 1993, when the tax went into effect, the tobacco companies reduced their wholesale prices to the 1992 pretax level.<sup>40</sup> These changes in wholesale pricing essentially eliminated the price increase associated with the tax. Massachusetts’ tobacco control media campaign began in October 1993, after the price cut. Even so, per capita consumption in Massachusetts continued to decline from 1992 to 1996.<sup>40</sup> This evidence suggests that the media campaign in Massachusetts played a role in reducing cigarette smoking.

Similarly, an evaluation of the media campaign compared Massachusetts youth to their counterparts in states without antismoking media campaigns and found encouraging results.<sup>41</sup> Massachusetts youth had significantly more knowledge about tobacco use, were more likely to cite additional reasons (other than health) not to smoke, and held stronger antismoking attitudes than youth in other states.

#### Effectiveness of Different Messages and Advertising Strategies

The focus groups we reviewed provided information on what strategies were thought to be effective or ineffective by the participants.

**Industry Manipulation.**—Tobacco advertising portrays smoking as glamorous and smokers as attractive and appealing. The industry manipulation strategy seeks to delegitimize the tobacco industry<sup>42</sup> and deglamorize smoking. Industry manipulation advertisements make the industry the problem by exposing its predatory business practices. The message is, “Tobacco industry executives use deceitful, manipulative, dishonest practices to hook new users, sell more cigarettes and make more money.”<sup>16</sup>

Industry manipulation advertisements carry different messages for adults and youth. Most adult smokers recognize the negative social and physical consequences of their smoking and are frustrated by their addiction. Industry manipulation advertisements help them redirect their feelings of guilt over their own smoking toward anger at the tobacco industry and its desire to profit from a deadly product.<sup>11,43,44</sup> The advertisement that opened the California campaign, “Industry Spokesman,” depicts tobacco industry executives sitting around a conference table in a smoke-filled room discussing ways to entice new smokers. This advertisement made all targeted adult groups angry and resentful and focused those feelings on the tobacco industry rather than on individu-

als.<sup>11</sup> Another advertisement, “Nicotine Soundbites,” presents real industry executives denying that nicotine is addictive before Congress (Figure 2).

For youth, the industry manipulation strategy succeeds for a different reason. Young people begin smoking to express independence by rebelling against their parents and others who admonish them not to smoke.<sup>47</sup> They believe that they can make their own decisions, including the decision to smoke.<sup>48</sup> By making youth aware of the industry’s calculated attempts to manipulate them, these advertisements tell young people that they are not acting independently. They also transform a low-interest topic, smoking, into an attention-getting, emotional issue.<sup>8,49</sup> and reconfigure the parent-rebellious child dynamic by giving both youth and adults a common enemy—the tobacco industry.<sup>8,50</sup>

Massachusetts found that the most effective positioning statement for young people is one that shows the industry as “money-hungry companies that intentionally and willfully target very young and vulnerable kids with manipulative and deceptive tactics in order to get them addicted to cigarettes at an early age so they become customers for life (or until tobacco kills them).”<sup>14</sup> Focus groups showed youth disliked being manipulated by the tobacco industry.<sup>18</sup>

One California advertisement that tested well with youth, “Hooked,” portrays a man fishing and tossing caught fish onto the dock. With the image of fish fighting to get away in the background, the narrator reveals that tobacco companies are using nicotine to hook more smokers since so many quit or die each day. The advertisement ends with the line, “The Tobacco Industry. They profit. You lose.” This spot was effective at communicating to youth that the industry is relentless in its pursuit of profits.<sup>10</sup>

The most successful industry manipulation advertisements specifically attack the tobacco industry by name, rather than using a vague “they” or “them.” The Centers for Disease Control and Prevention<sup>48</sup> conducted interviews with teenagers to test its antismoking advertisements and found that they misunderstood the reference to “they” in the advertising campaign, even though the cognitive content of the advertisements was clearly antitobacco. Only 10% of participants understood that “they” referred to the industry while a majority thought “they” referred to their friends or peers. Thirty-eight percent of the participants even thought the advertisements were promoting smoking.

**Secondhand Smoke.**—Secondhand smoke advertising seeks to convince smokers that their smoking endangers

others; to help denormalize smoking by portraying the dangerous effects of secondhand smoke on nonsmokers; and to motivate smokers to quit. To counter the industry's use of patriotic concepts like liberty and freedom to choose whether to smoke, this strategy shows that many people involuntarily breathe secondhand smoke at work and in public places and that children breathe their parents' smoke. Among youth, secondhand smoke messages can awaken a "sense of injustice for the little guy."<sup>11</sup> "Living Room," a California advertisement, portrays a brother and his much younger sister watching television. As the brother smokes, the sister begins coughing and smoke comes out of her mouth. This advertisement was effective among both adults and youth because it showed the child as a helpless victim and made people aware of the effects of their smoking on others.<sup>18</sup>

**Addiction.**—Addiction advertisements make both smokers and potential smokers aware that nicotine is an addictive drug and that the tobacco industry is using nicotine to hook smokers. This message angers current smokers and deters nonsmokers from starting. Adolescents believe cigarettes are addictive.<sup>48</sup> Coupled with the finding that youth do not want to feel they are being manipulated, the Centers for Disease Control and Prevention determined that an advertisement that emphasized the industry's deliberate use of nicotine to keep people smoking could be effective.

The California campaign uses the issue of nicotine addiction in combination with its industry manipulation strategy. "Industry Spokesman," "Nicotine Soundbites," and "Hooked" all conveyed the idea that nicotine is addictive and that the tobacco industry understands and uses this information to recruit new smokers and to keep old ones. These advertisements were some of the most effective of the California campaign (B. Silverman, interview, May 5, 1997).<sup>10,11</sup> Youth remembered "Nicotine Soundbites" (Figure 2) and when they were asked to visualize the tobacco industry, they described a negative image of the chief executive officers in the tobacco industry (B. Silverman, interview, May 5, 1997).

Massachusetts found that youth do not believe industry claims that nicotine is not addictive and people smoke for pleasure. They responded well to a positioning statement that both refuted the industry's arguments and cited the statistic that "74% of all smokers aged 12 to 18 say they wish they could quit but can't because they are addicted to the nicotine."<sup>14</sup> However, when youth were asked to rank the effectiveness of various positioning statements, this one was not rated as highly as others, such as,

"The tobacco industry trades human lives for profit."<sup>14</sup>

**Cessation.**—The cessation strategy tries to convince current smokers to quit smoking, either on their own or with help from a local cessation program, by providing smokers with a rationale for quitting, such as health, money, and family.<sup>15</sup> The ads may also emphasize that quitting is not simple and that many people are only successful after several attempts to quit. Michigan has used the slogan "Don't Quit Quitting" in several of its advertisements, presenting smokers with both reasons to quit and information about different ways to quit.<sup>51</sup> California's advertisement, "Quitting Takes Practice," depicts a frustrated smoker who has tried to quit smoking but failed. He is standing in front of a steep incline, which represents his inability to quit, and when the announcer tells the smoker to take his time and try to quit slowly, for good, the ramp gradually flattens. This advertisement became part of local quit smoking programs throughout California.<sup>50</sup> In early 1991, when California's advertising focused heavily on cessation, calls to local health departments and toll-free quit lines increased dramatically.<sup>43</sup>

**Youth Access.**—Youth access advertisements depict how easily youth can obtain cigarettes from vending machines, stores, parents, or siblings. These advertisements try to counter tobacco industry recruitment of underage smokers by convincing adults to reduce youth access to tobacco products. A California advertisement, "Vending Machine," shows children asking for various types of cigarettes. As the last child buys his cigarettes, the camera shows him walking away from a vending machine. This advertisement was tested with teenagers only, and many were concerned about the ease with which children can obtain cigarettes. After the advertisement aired, adults reacted angrily to how easily children can get cigarettes. However, some of the respondents saw the issue as a vending machine problem, not an underage smoking problem.<sup>18</sup> In addition, adults in 2 other studies voiced concern that there was no way to keep youth from obtaining cigarettes if they really wanted them.<sup>9,10</sup>

**Short-term Effects.**—The purpose of this strategy is to counter the industry's portrayal of smoking as glamorous, attractive, and healthy by showing the immediate health and cosmetic effects of smoking and how uncool smoking actually is. These advertisements often use gross humor to focus on the physical consequences of smoking (such as yellow teeth and fingers, headaches, and unpleasant smelling clothes and hair). California's "Clifford" advertisements humorously

portray a high school student in a smoke-filled school bathroom discussing the consequences of smoking, such as premature aging and bad breath. Adolescents understood the messages of these advertisements and liked the humor. In an unintended consequence, however, they found some of the advertisements unbelievable because of their use of humor and exaggeration. Many had friends who smoked, and these friends didn't look any different than nonsmokers.<sup>13</sup>

The evidence on the effectiveness of these advertisements is mixed. In their controlled study of smoking in movies, Pechmann and Shih<sup>52</sup> found that students shown 1 of the Clifford advertisements before watching a movie with attractive lead actors who smoked did not find the smoking appealing. In another controlled study, Pechmann and Ratneshwar<sup>53</sup> showed short-term effects of magazine advertisements to nonsmoking seventh graders and evaluated their perceptions of peers who smoked, finding that students who saw these advertisements rated smokers lower on such traits as common sense, personal appeal, glamour, and maturity.

One California focus group, however, found that many youth reject the emphasis on short-term effects because it "trivializes the seriousness of smoking."<sup>18</sup> Others believe that such problems would only occur among heavy smokers, many years in the future. These youth think that they do not smoke enough for the negative effects to occur, and that they will quit before they are harmed. The short-term effects advertisements, therefore, are not conveying the message they are supposed to—smoking has immediate, negative consequences.

**Long-term Health Effects.**—This strategy involves detailing the potential long-term health consequences of smoking, such as lung cancer and emphysema. This strategy is one of the least effective, especially with youth, for 2 reasons: most already know the potential health hazards associated with smoking, which are printed on the cigarette packs themselves, and young people live in the present and believe they are invulnerable. Unless adolescents have personal experience with these smoking-related diseases (for instance, they know someone who has such an illness), they do not feel threatened.<sup>13</sup> Reminding youth of the long-term health consequences of smoking and telling them that they will die prematurely in 20 years do not have much impact.<sup>48,54-56</sup>

**Romantic Rejection.**—This strategy tries to convince smokers and those contemplating smoking that they will be undesirable if they smoke. The advertisements point out that the majority of

Relative Effectiveness of Tobacco Control Advertising Strategies for Youths and Adults

Component	Youths	Adults
Industry manipulation	Highly effective	Highly effective
Secondhand smoke	Highly effective	Highly effective
Addiction	Effective	Effective
Cessation	Impact unknown	Effective
Youth access	Not effective	Moderately effective
Short-term effects	Moderately effective	Not effective
Long-term health effects	Not effective	Moderately effective
Romantic rejection	Not effective	Not effective

people don't smoke and find smoking socially unacceptable. Like the short-term effects strategy, romantic rejection tries to counter industry advertising portraying smokers as sexy and alluring. Adult smokers found this message offensive and noted that their own personal experiences differed from the situation portrayed in the advertising. Others saw the message as a sign of the advertisers' superficiality.<sup>11,12</sup> Young smokers responded similarly.<sup>8,11</sup> For young nonsmokers, however, a person's smoking status was only relevant if that person was unappealing. The respondents were willing to overlook the smoking if the person was otherwise desirable.<sup>8</sup>

#### Relative Cost-effectiveness of the California and Massachusetts Campaigns

From 1989 through 1996, California per capita consumption of cigarettes fell 1.93 ( $\pm 0.21$ ) (SE) packs per year faster than the rest of the United States, excluding Massachusetts. California spent an average of \$0.50 (in 1996 dollars) per capita per year on the media program during this time. Dividing the rate of decline in consumption by the average annual per capita media expenditure of \$0.50 yields an estimate of a fall of 3.9 packs per capita per year for each per capita dollar spent on the media campaign.

Likewise, for Massachusetts, between 1993 and 1996 per capita consumption of cigarettes fell 1.28 ( $\pm 0.90$ ) (SE) packs per year faster than the rest of the United States, excluding California. Dividing this decline in consumption by the average annual per capita media expenditure<sup>4</sup> of \$2.42 yields an estimate of a fall of 0.5 pack per capita per year for each per capita dollar spent on the media.

Thus, the California media campaign appears to be about a factor of 7 more cost-effective than the Massachusetts campaign. These results are consistent whether one uses media campaign or total program spending. Similar results were obtained using several other analytical models (available from the authors).

#### COMMENT

The type and target of antitobacco advertising messages matter (Table). In-

dustry manipulation and secondhand smoke are the most effective strategies for reaching all audiences. The industry manipulation strategy denormalizes smoking and delegitimizes the tobacco industry. By showing to what lengths the industry will go to recruit and keep new smokers, these advertisements have sparked interest in smoking and opened people's minds to other antitobacco messages. Secondhand smoke advertisements also denormalize smoking and heighten interest about smoking among both smokers and nonsmokers. The addiction and cessation messages can be effective, but work best when used in combination with, or rotated with, the more powerful industry manipulation and secondhand smoke strategies.

Youth access, short-term effects, long-term health effects, and romantic rejection all have limited effectiveness. Youth access advertisements can send a mixed message to youth by showing them how to obtain cigarettes and can reinforce the tobacco industry's advertising by portraying smoking as an adult activity.<sup>57</sup> Both the short-term effects and long-term health effects strategies can lose their impact among youth who believe that they do not smoke enough to suffer any negative consequences or that they will quit smoking before the cigarettes harm them. The romantic rejection strategy fails to have a significant impact because both adult and youth smokers find the message offensive, while youth nonsmokers see a person's smoking status as irrelevant if the person is attractive.

The tobacco industry clearly understands the power of antitobacco advertising and works to limit its effectiveness. An RJ Reynolds document,<sup>58</sup> which discusses the industry's reaction to California's aggressive campaign, states that "the California campaign, and those like it, represents a very real threat to the intermediate term. . . . Impact on self-esteem, social acceptance and smoking utility will ultimately influence business" [emphasis in original]. This same document summarized research on various California advertising strategies. Industry manipulation advertisements were generally seen as "believable, even among many smokers" and such an ad-

vertisement "presents risk of demotivating smokers." The industry also developed a sophisticated strategy, including working through other organizations, in an effort to eliminate funding for the media campaign or reduce its aggressive tone.<sup>59,60</sup> Continuing industry awareness of the effectiveness of the power of antiindustry messages is reflected in the settlement of Florida's Medicaid suit against the tobacco industry, which provided \$200 million for an antitobacco campaign, but explicitly prohibited attacking specific tobacco companies or advertisements.<sup>61</sup>

The comparison of the cost-effectiveness of the California and Massachusetts campaigns suggests that California's more aggressive approach is about an order of magnitude more cost-effective than Massachusetts' approach, using as an outcome measure the rate of decline in per capita consumption. In drawing this conclusion, however, it is important to remember that the statistical model we used is relatively simple. It does not model price changes, income distributions, age distributions, underlying economic conditions, or the precise patterns of air time purchased in the 2 states. This simplicity is dictated by the relatively limited data set that are available (annual data from *The Tax Burden on Tobacco*<sup>20</sup>) and annual appropriations for the media campaigns.<sup>4,21,22</sup> The fact that the differences hold up under a variety of different modeling approaches, combined with the large differences we find, suggests that there is a real difference in the cost-effectiveness of the 2 campaigns.

Two strategies are effective in reaching all audiences: industry manipulation and secondhand smoke. The addiction and cessation strategies can also be effective. Advertisers should refrain from spots that focus on youth access, short-term effects, long-term health effects of smoking (for youth), and romantic rejection. To compete with tobacco industry advertising, antitobacco advertisements need to be ambitious, hard-hitting, explicit, and in-your-face. Unless the advertisements grab and hold people's attention, their messages will be lost amid other advertising. Advertisements must clearly refer to the tobacco industry, rather than to "they" or "them."

A strong media campaign is a key element of any tobacco control effort. The tobacco industry has consistently tried to limit the size and scope of these campaigns by focusing them on children.<sup>62</sup> Perhaps because of the power of paid media to shape public attitudes toward tobacco and the tobacco industry, public health advocates need to be prepared for a continuous battle to defend the existence and quality of the media.<sup>34,63-65</sup>

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# WISCONSIN EDUCATION ASSOCIATION COUNCIL

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*Affiliated with the National Education Association*

**STATEMENT IN SUPPORT OF THE TRUST CAMPAIGN INITIATIVE  
FROM THE WISCONSIN EDUCATION ASSOCIATION COUNCIL  
MARCH 4, 1999**

Good health and a safe home environment are prerequisites for any child to learn. In addition, learning and using information to improve health as an adult is also a very important part of leading a productive life. Educators realize that an unhealthy child is a poor learner and also realize that young children are an easy target for the tobacco industry. WEAC is a proud member of the Tobacco-Free Wisconsin Coalition and the TRUST Campaign. The TRUST campaign stands for **Tobacco Reduction Using the Settlement**.

Youth smoking in Wisconsin is higher than the national average. Nearly two out of five children aged 14-17 currently smoke. In an effort to turn back the tide of teen smoking, WEAC has joined forces with many key players in the education and health care communities to promote education initiatives designed to prevent smoking by minors.

Too many children smoke or are duped into experimenting with tobacco, setting them up for a harmful, even deadly addiction. This is why WEAC supports initiatives to help promote safe and healthy kids. One such initiative is centered around the prevention of smoking by minors.

WEAC has worked with TRUST campaign partners such as the State Medical Society to develop lesson plans complete with real-world examples of how tobacco destroys lives. It is our hope that these efforts will have a lasting impression on kids.

-more-

*Terry Craney, President  
Donald E. Krahn, Executive Director*

The historic settlement of Wisconsin's lawsuit against the tobacco industry presents the opportunity to create a permanent source of funding for education programs and initiatives that will effectively reduce the loss of life attributable to tobacco use.

Organizations participating in the TRUST campaign are working together in support of funding for statewide comprehensive programs and services that will reduce the addiction, disease, disability, and premature death caused by the use of tobacco. It is time to prevent children from beginning a lifelong addiction to tobacco products.



**Human Services and Aging  
Public Hearing  
Rock County Courthouse  
Janesville, WI  
4-14-99**

In attendance:

Senator Robson

Senator Erpenbach

Representative Wood

Representative Schooff

Laura Rose, Legislative Council

Cory Mason, Committee Clerk

Kevin Lewis, DHFS

**1. \*Don Mulry**

**Rock County Human Services Director**

*W-2 Right of First Selection*

Standards not available until November

Not enforced equally

Don't have access to open government in this regard.

Rock County missed

We don't know why were denied or how we compare to other counties

Finds it interesting that no private companies were denied

Robson: How much infrastructure money was spent?

No actual figures on this issue

*Community Aids Funding*

Leads to erosion in programs

Wants a 3% increase each year to maintain programs

Don't want DHFS to be able to with hold funds

*Youth AIDS*

Now state only covers 45%

Need it restored to previous levels.

*W-2 Funds*

Little flexibility in use of the money

They want to be able to use it for community aids

11 million of the property tax bill, 9 million go to pay short falls

**2. \*Cathy Hinds**

**Local AFSCME 1258**

*Wage Pass through*

Serious shortage of workers

She has been working in the field for 20 years

Shortage has never been so low

The people for whom they care deserve better

Facility does not close on holidays or Sundays

Support the 7% wage increase and the 3% Medicaid increase

Concerned about the Caregiver Background Checks

Going to have a real impact in October

Average employee lasts 4-5 years for C.N.A.'s

**3. \*Terry Scieszinski**

**Health Care Center Administer**

**Rock County**

*Wage Passthrough*

Need the wage pass through desperately

Would hire 50 nurses tomorrow if they were available

Also worried about Intergovernmental Transfer Program

90% are on Medical Assistance

The would prefer 60%

**4. Debbie Vorass**  
**Director of Tobacco Free Kids**  
**Beloit**

*Here to support TRUST*

Tobacco is the first drug that children are exposed

Do presentations to about 1000 kids a month

2/5 of kids of 14-17 year-olds smoke

Want to support the trust campaign

Want as much as half of the dollars to spent

Kids will be at the capitol on April 28<sup>th</sup>

**5. Bill Breidenstein**  
**American Heart Association**  
*Tobacco Settlement*

Thinks it is shameful how little the Gov. has proposed so little of the settlement on tobacco prevention

Supports the Robson budget amendment for \$50 million

*SB 90*

Like SB 90. Don't want any new amendments to it.

**6. \*Luanne Kane**  
**Rock County Human Services**  
*Community Aids and Community Integration*

Both sources of funding has been seriously reduced

Want per diems to go from \$125 to \$146

Need to increase funding to the disabled community

Need for respite care is very real across the state

**7. \* Lowell Trewartha***Family Care*

Don't want Family Care expanded statewide without real evaluation

The state has failed to maintain support for these programs

Roughly \$16 million that the county should be receiving that the state is "stealing". That's 12% of every person's tax bill

Counties seem to be viewed as leaches through the state administration's eyes.

**8. Donald Kret****Chair****Walworth County Human Services Board**

59% of tax levy is do to state's "stealing"

Mandatory sentencing increased youth aids \$16,000 at the same time decrease state aid

**9. \*Ann Capela****Walworth County Human Services Administrator***Block Grants*

Block grants are a scam

It basically results in less money for the counties, especially the rural one.

Budget a three-legged stool

1. Lock 'em up
2. Income taxes
3. Promised services

State should take back the courts

Has rural school that does not fall under the schools 2/3's funding

**10. \*Helen Kraus****Rock County Local Public Health**

Dollars are always being decreased as new formulas are established

There is no public health agenda

**11. Jerry Sveum**

**Grand Avenue Pharmacy**

*Reimbursements for pharmaceuticals*

Worried about the 18 million drug funding

New drugs are extremely expensive

Will result in less medicine for people

This might result in not honoring Medicaid prescriptions at pharmacies

**12. \*Valerie Fjalstad**

*Lifespan Respite Care*

Will alleviate some of the many problems we here about that are more than three years time.

Also cuts down on the need for permanent care facilities if some respite care was available

Supports the Robson/Baldwin Bill to provide lifespan respite bill

**13. \* Mat Haeger**

**Rock County Health Department**

*Children with special health care needs*

MCH funding is too strict

Consolidation does not allow for flexibility to do local pilots and address local needs and services

State siphons these dollars off

**14. Emma Seweger**

*Respite care*

Respite is the only thing that keeps her family together

Would like to see respite for work hours

Systems are not in place to address these concerns

Put in school until a certain age, and sometimes have to stay out of school for up to a year

Strongly supports the lifespan respite bill

**15. \*Debra Shanley**

*Caregiver Background Checks*

Has huge impact on people

Sets a tone of allegation, abuse, and reliving crimes, some as old as twenty years

Nursing wage out of college is \$7.50, \$2 per hour less than McDonald's hourly wage

Punitive nature of the business has to STOP

Supports wage pass through

**16. \*Timothy C. Banwell**

**Rock County Health Department**

*PECFA*

Worried about PECFA

Proposed alternative—remove high-risk tanks before they leak.

**17. Dorothy Knutson**

*Respite care bill*

Here to support lifespan respite care bill

Could afford to give up the rights if they stayed at home and raised the child as a foster parent

**18. \*Tom Larsen**

**AFSCME Council 40**

*Family Care*

*Youth Aids*

**19. Craig Knutson**

**Rock County**

Never have counties been so angry at the state

**20. Char Schooner**

*Life span respite bill*

Respite Care is a huge problem for her

Her husband has Huntington disease

She can't find the help out there that she needs

On a COPS list 2 years long

Support the Lifespan Respite Care Bill

**21. \*Gwen Daluge**

**AARP**

*Family Care*

Here to say some good things about it

Like the funds following the consumer instead of the other way around

Like the pilots and the number thereof

Want changes made after what we learn from the pilots, but don't want to interrupt services

Don't want counties to have to compete until after four years

Wants more money for COPS program

**22. Julie Elliot**

*W-2 and education*

Received AFDC for 5 years

Hated the stigma of being on welfare

It saved her family

Received a grant of \$517 a month AND allowed her to get an education

Got a BA in Madison

Only way she got out of poverty was through education

She could not do that under the current W-2 system

20,000 students have been forced to stop getting an education and take up minimum wage jobs under W-2

Poor people, especially women need access to higher education

W-2's you go girl attitude implies that you can start at the bottom and work your way up

This is not true if you have a family. Her chances of working her way up under W-2 simply does not exist

Want education and training expanded

Allow work-study

Allow 20 hours a week instead of 35 if they are working towards education

### **23. \*Ed Reich**

*Mental Health and Alternative Medicine*

On disability

Had severe mental illness

Plays violin extremely well

Is 80% cured

Is extremely environmentally sensitive

Says this leads to more mental illness and more prisons

Says we should use alternative medicine for mental illness, like St. John's Root



**24. Phillip Harper****Hales Corners***Family Care*

Thinks DD should not be included in Family Care

Thinks DD should have ombudsman

Likes the idea of respite care

Wants less wait on COPS list

Keep the centers open

**25. Robert Kellerman****Director of Area Aging Agency, including Rock County***Long Term Care and Aging*

Never before has he felt it more important to testify as an advocate for the elderly

Family Care needs its chance to work

Likes the one stop shopping

Three essential elements

1. Entitlement for home care services
2. Consumer Choices
3. Community Resources

Nutrition is important too.

Transportation support is essential

# Gundersen Lutheran

March 3, 1999

State Senator Judy Robson, Chair and  
Members, Senate Committee on Human Services  
State Capitol Building  
Room 15 South  
Madison, WI 53702

**RE: UTILIZATION OF TOBACCO SETTLEMENT PROCEEDS**  
**HEARING DATE: MARCH 4, 1999, 9:30 A.M.**

Dear Chair Robson:

I am forwarding this letter to you on behalf of Gundersen Lutheran, Inc. and its principal affiliates, Gundersen Clinic, Ltd. and Lutheran Hospital - La Crosse, Inc. (collectively "Gundersen Lutheran"). Headquartered in La Crosse, Wisconsin, the Gundersen Lutheran Health System is comprised of 31 affiliated corporations that provide a full range of acute inpatient, outpatient, nursing home, home health, and medical transportation services for patients residing in western Wisconsin, southeastern Minnesota and northeastern Iowa. For more than a century, Gundersen Lutheran and its health care professionals have been a strong voice in the battle over tobacco utilization, particularly among Wisconsin's younger citizens. For that reason, we applaud those who worked so hard to craft the long-term settlement with the tobacco industry.

The recent settlement with the tobacco companies, of course, represents only part of society's challenge. The remaining challenge lies in the wise use of the proceeds of this decade-long battle. In that regard, Gundersen Lutheran would like to offer two points on behalf of Wisconsin's citizens and taxpayers.

First, there are few times in the history of a state the size of Wisconsin that its state government would receive dedicated funds from a lawsuit settlement of this magnitude. The long-term utilization of such proceeds should both recognize the singularity of the opportunity and be structured to benefit our children and their children to come. Likewise, the use of the settlement proceeds should encompass both a sound long-term vision and provide for an enduring quality heritage. Simply utilizing the proceeds on a yearly basis to balance the budget or pay for tax cuts will not, in our opinion, best serve Wisconsin's long-term goals.

**Gundersen Clinic, Ltd.**

1836 South Avenue • La Crosse, Wisconsin 54601 • (608) 782-7300 • (800) 362-9567

Second, employment of the settlement monies should be clearly directed towards two key objectives:

- Preventive medicine and treatment of the health care needs of those who have been harmed by inappropriate use of tobacco products;
- Education of our children concerning the harms associated with the use of such products.

We firmly believe that wise utilization of the settlement proceeds can best be assured through the creation of the "Wisconsin Tobacco Health Care Foundation". As we envision it, the Foundation would be organized under Wisconsin's not-for-profit corporate statutes and managed by state government, with the broad-based support of Wisconsin's health care providers. The Foundation's mission would be to improve the health care status of Wisconsin's citizens.

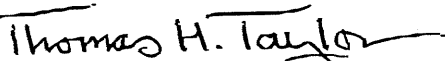
We strongly recommend that fifty (50) percent of the Tobacco Settlement proceeds be put into a "Health Care Endowment Fund." The Endowment Fund, which would be governed by a public-private partnership comprised of representatives from state government, health care providers and the business sector, would be allowed to accept gifts and donations from other persons. From its earnings, the Endowment Fund would fund long-term projects geared toward improving the health status of Wisconsin's citizens including, for example, smoking cessation, education, research and treatment.

Obviously, the budget which has been brought before the Legislature does not contemplate the creation of an Endowment Fund with fifty (50) percent of all proceeds from the Tobacco Settlement. Although it may be necessary to phase in this initiative over the next several years, we genuinely believe that its goal is reasonable and its objectives are in the best interests of Wisconsin's citizens.

Thank you very much for your consideration of our views.

Sincerely yours,

**GUNDERSEN LUTHERAN, INC.**



Thomas H. Taylor  
Vice President and General Counsel

THT:jaf

## DRAFT LEGISLATION - - UTILIZATION OF TOBACCO PROCEEDS

Section 1. Section 14.29 is created to read:

### 14.29 Wisconsin Tobacco Health Care Foundation

(1) Definitions. In this section:

(a) "Foundation" means the Wisconsin tobacco health care foundation

(b) [reserved]

(2) Foundation characteristics. The governor may provide for the participation of this state in the formation and operation of the foundation if all of the following conditions are satisfied:

(a) The foundation is organized under ch. 181 and operated with the participation of this state and the broad-based support and participation of Wisconsin health-care providers.

(b) The purpose of the foundation is to improve the health status of the citizens of Wisconsin.

(c) Notwithstanding s. 13.94(4)(b), the foundation is subject to full audit of all of its records and operations under s. 13.94.

(d) The foundation is considered to be an authority, as defined in s. 13.32(1), and the records of the foundation are open to public inspection under ss. 19.31 to 19.39.

(dm) The foundation is considered to be a governmental body, as defined in s. 19.82(1), and meetings of the board of directors of the foundation and all committees of the foundation are open to the public under subch. V of ch. 19.

(e) The foundation, with the advice of the ethics board, adopts ethics guidelines applicable to its directors, employees and paid consultants which are similar to subch. III of ch. 19, except that the foundation may not require its paid consultants to file financial disclosure statements.

(f) The governor is authorized to appoint, with the advice and consent of the senate, 11 of the 13 directors of the foundation, with the other 2 directors

being appointed by the co-chairpersons of the joint committee on finance of the Wisconsin legislature. Of the 11 directors appointed by the Governor, one shall be the secretary of administration, or the secretary's designee, 2 shall be physicians, 2 shall represent Wisconsin hospitals, 2 shall represent Wisconsin long-term care institutions, and 4 shall represent Wisconsin charitable organizations or Wisconsin chapters of national associations concerned with the prevention and treatment of disease, such as the lung, heart or cancer associations.

- (g) If the foundation substantially ceases operations, all of the state's unencumbered contributions to the foundation's endowment fund will be returned to the state.

(3) Funding of Endowment Fund.

- (a) Once the governor has determined that a foundation has satisfied the requirements set forth (2), within 30 days after the state treasurer receives a payment pursuant to the terms of [insert name of litigation and/or agreement settling such litigation] the state treasurer shall transfer an amount equal to 50% of such payment into a fund hereby created in the state treasury to be known as the "Health Care Endowment Fund." Such fund shall be used solely for the purposes set forth in this section. Any monies in such fund at the end of any biennium shall not be transferred and shall remain in such fund.
- (b) The endowment fund may also accept gifts and donations from other persons, at the discretion of the foundation. Non-cash gifts and donations must be disposed of for cash as soon as the foundation can maximize the value of such gifts or donations. Such gifts and donation shall be credited to the principal of the endowment fund.

(4) Endowment Fund.

- (a) The foundation may fund, from the earnings of the endowment fund and such portion of the principal of the endowment fund as may be fiscally prudent after [describe standard, such as reserves reaching a certain level, approval of a business plan which allows principal spending at a certain rate until principal reaches a certain level, etc.], projects which improve the health status of the citizens of Wisconsin, including but not limited to smoking cessation, education, research or treatment.
- (b) 1. This state, a local governmental unit in this state, an educational institution or health care provider located in this state or any other person located in this state may apply for funding under par. (a).

2. The foundation shall give priority to funding applications received from [if any types of recipients have priority, insert here].

3. The foundation shall consider other financial resources available to an applicant in evaluating funding applications.

(5) Reports.

(a) Before January 1, \_\_\_\_\_, and biennially thereafter, the foundation shall submit a report to the joint committee on finance on projects that have been undertaken during the reporting period and [describe any further reporting requirements to joint finance committee].



**Judith B. Robson**  
Wisconsin State Senator

February 11, 2000

Ms. JoAnna Richard  
Wisconsin Department of Justice  
123 West Washington Avenue  
Madison, WI

Dear Ms. Richard:

Attached please find the documents that I have pulled from our files relating to litigation against the tobacco manufacturers and to use of the settlement money from that lawsuit. These documents relate in some way to the awareness of some counties of the lawsuit and/or of the subsequent debate on how to use the settlement money.

There are two sets of documents. One has been culled from the official records of the Senate Committee on Human Services and Aging. The other has been taken from our office files.

If I can be of any other service in this matter, please let me know.

Sincerely,

A handwritten signature in cursive script that reads "David A. Austin".

David A. Austin  
Committee Clerk and Records Custodian  
Senator Judith Robson's office

# STATE OF WISCONSIN

**Legislative Council**  
David J. Stute, Director

One East Main, Suite 401  
Madison, WI 53703  
(608) 266-1304



**Legislative Fiscal Bureau**  
Robert Wm. Lang, Director

One East Main, Suite 301  
Madison, WI 53703  
(608) 266-3847

February 12, 1999

**TO:** Senator Peggy Rosenzweig  
Room 407, 100 North Hamilton

**FROM:** Barbara Zabawa, Fiscal Analyst, Legislative Fiscal Bureau  
Richard Sweet, Senior Staff Attorney, Legislative Council Staff

**SUBJECT:** Proposals for Tobacco Settlement Monies in Other States

This memorandum responds to your inquiry regarding tobacco settlement money proposals in the states of Alabama, Arizona, Kansas, Minnesota, Ohio, Texas, and Washington.

Barbara Zabawa from the Legislative Fiscal Bureau gathered information about the proposals in Arizona, Kansas, Texas and Washington. Richard Sweet from the Legislative Council obtained information about the proposals in Alabama, Minnesota, and Ohio. A brief synopsis of each state's proposed plan for the tobacco settlement monies is provided below. Please note that variations in length of proposal descriptions may be attributed to degree of information available concerning each state's proposed plan and its status in the legislative process.

**Alabama.** Alabama's tobacco settlement totals \$3.1 billion over 25 years. According to the Alabama Legislative Fiscal Office, Alabama passed legislation in 1998 that created a Children First Program. The legislation directed that \$85 million in tobacco revenues be placed in a Children First Trust Fund. While the legislation directed that the funds be used for certain specific purposes, the Legislative Fiscal Office indicated that the legislation only applies to revenues received in the current fiscal year that ends on September 30, 1999. The Children First Program had been proposed for the last several years, funded by a tobacco tax, but failed to pass with that funding source. Therefore, the idea of creating a segregated trust preceded the tobacco settlement.

The Legislative Fiscal Office indicated that there are no proposals currently on the table for use of tobacco revenues after that date, but that advocates would like to see \$85 million put in the Children First Trust Fund each year.



Under the Children First Program, allocations were made for specific programs as follows: (1) 10.5% to the Department of Public Health (94% of this for children's health insurance and 6% for tobacco control among children); (2) 22% to the State Board of Education (56% of this for alternative schools and 44% for the School Safety Enhancement Program); (3) 20% to the Department of Human Resources (29% of this for foster care basic monthly maintenance rates, 13% for therapeutic foster homes, 46% for child care facilities, 6% for shelter care and residential foster homes and 6% for special needs adoptions); (4) 5% to the Children's Trust Fund (50% of this to fund community-based programs providing unification of prevention services and 50% for at-risk children); (5) 5% to the State Multiple Needs Children Fund (50% of this to counties and 50% for children whose needs exceed available local resources); (6) 5% to the Department of Mental Health and Mental Retardation (50% of this for community-based services for children and families in crisis and 50% to fund intensive long-term programs relating to drug and alcohol problems); (7) 10% to the Juvenile Probation Services Fund (61% of this to convert juvenile probation officers and support staff to state employe status and 39% to fund additional probation service positions); (8) 17% to the Department of Youth Services (43% of this for facilities for secure beds and graduated release facilities, 43% for intensive programs, 7% for alternative programs and 7% for regional detention facilities); (9) 3.5% to the Department of Public Safety to fund child pornography investigations; (10) 1% to the Alcoholic Beverage Control Board for education and enforcement regarding youth access to tobacco products; and (11) 1% to the Department of Forensic Sciences to fund specified forensic services.

**Arizona.** Arizona's tobacco settlement totals \$2.8 billion over 25 years. The Governor's November proposal, which according to staff at the Joint Legislative Budget Committee (JLBC) is likely to pass, splits the tobacco settlement money into "up front" payments (worth \$177 million) and "annual" payments of \$59 million (until the year 2018, when annual payments increase to \$118 million). JLBC staff expect that a separate appropriation for the tobacco settlement money will be established. From that appropriation, the money would be allocated as described below.

Regarding uses for the up front payments, the Governor proposes to use \$76 million for Arizona State Hospital construction, \$30 million for State Health Laboratory capital construction, \$12 million for rural community health centers/clinics capital construction, and \$59 million to deposit into the "Arizona Health Trust Fund."

Thirty-three percent of the annual payments would be deposited into the Arizona Health Trust Fund. Approximately 35% of the annual payments would pay for items currently funded from the tobacco tax, such as the Medically Needy Account. Placing tobacco settlement money into the Medically Needy Account would allow the state to resume a "rainy day" fund, which ensures funding for programs during economic slow-downs when demand for all services grows. Increases in annual settlement payments (due to inflation) would be deposited into the rainy day fund. Approximately 25% of the annual payments would provide health care block grants to counties for locally determined health care initiatives. These block grants would be appropriated through a formula process. Finally, approximately 7% of the annual payments would fund Department of Health Services programs, such as Health Start, psychotropic medications, and

HIV/AIDS medications.

The annual interest earnings from the Arizona Health Trust Fund would be used for research and treatment of health conditions such as Alzheimer's, diseases of the liver, heart and lungs, cancer, and research and education for smoking cessation. The interest earnings would be appropriated by the Legislature. Some of the programs funded through the trust fund would be awarded monies through a competitive grant process. JLBC staff state that the idea of establishing of a trust fund was the result of uncertainty about receipt of the tobacco settlement monies. Some government officials do not want to start ongoing programs that will lose funding if the tobacco settlement payments are reduced or cease. According to JLBC staff, spending interest earnings from the trust fund will provide a more consistent source of revenue.

It should be noted that the amount of Arizona's settlement money available to the state is currently uncertain due to a pending lawsuit between the state and the counties. Though the Governor proposed 25% of the annual payments be distributed to the counties, the counties are seeking a larger share of the state's tobacco settlement monies.

**Kansas.** Kansas' tobacco settlement totals \$1.6 billion over 25 years. Kansas passed a law last year that allocates half of the tobacco settlement money the state receives (after subtracting 60% of the payment for a potential federal recoupment claim), into a segregated fund to pay for children's health care or children's services (such as a school finance program). According to staff at Kansas' Legislative Research Bureau (LRB), the children's fund was established partly to prevent a federal Medicaid recoupment claim of the settlement monies, since a children's fund relates to the intent of the lawsuit.

The Governor has recommended that the monies in the children's fund be targeted at Medicaid, health and environment issues, and providing enhancements to school funding and parent education. According to LRB staff, the Governor wishes to enhance 15 to 20 different programs with tobacco settlement money. Depending on the program, some of the monies may be allocated through a competitive grant process. Though it is unclear whether the interest earnings or principal from the children's fund would fund the Governor's proposal, LRB staff state that the fund may be handled similarly to other trust funds in the state.

The other half of the tobacco settlement payment that the state receives would be deposited into the general fund, though LRB staff indicate that the Legislature may establish a separate account to house the remainder of the tobacco settlement monies. According to LRB staff, a legislative task force to address tobacco settlement money issues was established, but has not met. LRB staff doubt the task force will meet anytime soon, since the appeals pending in New York, California, and New Jersey are likely to delay state payments until June 30, 2000. LRB staff state that legislators will wait until the next legislative session to decide how to appropriate the other one-half of tobacco settlement payments if the first payments arrive on or after June 30, 2000.

**Minnesota.** Minnesota settled its litigation against the major tobacco companies prior to the settlement agreement reached between the tobacco companies and attorneys general for 46 states. As part of the settlement, the defendants agreed to pay \$102 million into a smoking cessation account, with the money to be used to offer smoking cessation opportunities to Minnesota smokers. In addition, the defendants agreed to pay \$100 million into a national research account; the purpose of this money would be to further the elimination of tobacco use by children and for other tobacco control purposes. These two amounts together represent approximately 3% of the total settlement funds that Minnesota received from the tobacco companies. There are currently no concrete plans for use of the remainder of the tobacco settlement revenues.

**Ohio.** Ohio's tobacco settlement totals \$9.8 billion over 25 years. According to the Ohio Legislative Budget Office, there are no proposals on the table for use of the tobacco settlement revenues. According to the office, there have been "low-level discussions" about using funds for preventive health, including anti-smoking campaigns, and for school construction. However, it appears that Ohio is waiting to see how much revenue will be available and whether or not the federal government will attempt to recoup any of the revenue.

**Texas.** It is estimated that Texas will receive \$17.3 billion over 25 years from its own settlement agreement with the tobacco industry (Texas is not one of the 46 participating states in the Master Settlement Agreement). The former attorney general of Texas and the chairs of the House Appropriations Committee and the Senate Finance Committee issued a Memorandum of Understanding (MOU) on February 3, 1999, and it is now going through the regular legislative committee process. According to a document comprised of suggestions by the MOU and the Legislative Budget Board (MOU document), \$1.7 billion of the settlement payments would be used to fund 23 different programs over the next biennium. Payments that Texas has received from the tobacco industry have been deposited to the general revenue fund, but the monies have a separate accounting code. The MOU document proposes to move the tobacco settlement monies into a dedicated general revenue fund, similar to Wisconsin's segregated funds. Most of the items listed in the MOU document are endowments, which, under separate legislation, would move the appropriations into trust accounts. Items not listed as endowments would be appropriated from the proposed dedicated general fund.

Texas officials indicate that the rationale behind creating endowments for most of the tobacco settlement monies is to buffer any adverse effect of potential federal Medicaid recoupment claims. The Texas officials state that a decrease in endowments would be a less severe consequence than if the monies were allocated for operating expenses.

According to a Legislative Budget Board official, if the MOU document is enacted, the Legislature would appropriate the interest from the trust accounts to fund the proposed items (though the Legislature is not limited to appropriating the interest earnings to the beneficiary of the trust fund). The attachment lists the MOU document's proposed uses for the tobacco settlement monies and the associated amounts in the 1999-01 biennium (the amounts listed are biennial appropriations). For appropriations without a specific institution named, Texas officials

believe a competitive grant process will likely be the allocation mechanism for the tobacco settlement monies.

Legislators may also create a separate fund to appropriate money to the Municipal Employee Group Benefit Risk Pool (item number 20 on the attachment). In Texas, general fund monies may not be appropriated to non-state entities. Consequently, a separate fund from which a locality could receive these monies would need to be created.

The State of Texas received an additional \$300 million from the tobacco industry through the Most Favored Nation provision when the State of Minnesota reached its settlement agreement. However, Texas has already allocated the additional \$300 million to county hospitals.

**Washington.** The State of Washington's tobacco settlement totals \$4.0 billion over 25 years. Currently, at the request of the Attorney General and Governor, a bill has been proposed to spend \$323 million of the tobacco settlement monies in the next biennium on health care for the working poor and low-income children, and tobacco-related programs. The bill proposes to place two-thirds of the \$323 million into an already-existing health services account. This account, which currently has a deficit, would help provide health care for the working poor, and also help cover low-income children under the state's Medicaid program. The other one-third of the tobacco settlement payments, approximately \$100 million, would capitalize a trust fund for public health (tobacco-related) programs. The Legislature needs to decide whether to appropriate the interest and/or principal from the trust fund. However, according to a Washington State official on the Senate Ways and Means Committee, there will be a cap on the amount the Legislature can spend out of the fund. It is likely that some programs funded through the trust fund will participate in a competitive grant process for the funds.

The establishment of a trust account and the decision to spend the monies on health care was premised on the state's desire to protect the tobacco settlement monies from federal Medicaid recoupment claims. The state's Attorney General advised the state's leaders to spend the money on health care, and advised that a trust account would help prevent the federal government from making any claims. In addition, according to a Senate Ways and Means Committee official, the Governor and Attorney General's decision to appropriate all the tobacco settlement monies is, in part, an effort to deter the federal government from making any claims, since doing so would eliminate already-established programs.

The fiscal portion of the proposed bill is currently in the state's Ways and Means Committee. A Ways and Means Committee official predicted that the proposed bill will likely pass during this legislative session.

I hope this information is helpful. Please contact us with any further questions.

BZ/RS/dls  
Attachment

## ATTACHMENT

### Proposed Use of Texas Tobacco Settlement Monies

	<u>Proposed Amount for the 1999-01 Biennium</u>
Out of the General Revenue Fund - Dedicated (Tobacco Settlement Receipts):	
1. Permanent Health Fund for Higher Education	\$400,000,000
2. Permanent Fund for Children and Public Health	150,000,000
3. Pilot Project to Reduce Smoking	200,000,000
4. The University of Texas Health Science Center at San Antonio Endowment	200,000,000
5. Children's Health Insurance Program	179,600,000
6. The University of Texas M.D. Anderson Cancer Center Endowment	100,000,000
7. Department of Health (EMS/Trauma System Endowment)	100,000,000
8. Healthcare Facility Capital Fund Endowment	50,000,000
9. Texas Tech University Health Sciences Center (El Paso)	50,000,000
10. The University of Texas Southwestern Medical Center at Dallas Endowment	50,000,000
11. Long-Term Health Care for Children (Waiting List)	50,000,000
12. Department of Health Hospitals/Facilities	35,000,000
13. Department of Mental Health and Mental Retardation (New Generation Medications)	30,500,000
14. Texas Tech University Health Sciences Center Endowment (other than El Paso)	25,000,000
15. The University of Texas Medical Branch at Galveston Endowment	25,000,000
16. The University of Texas Health Science Center at Houston Endowment	25,000,000
17. The University of Texas Health Center at Tyler Endowment	25,000,000
18. Texas A&M University System Health Science Center Endowment	25,000,000
19. University of North Texas Health Science Center at Fort Worth Endowment	25,000,000
20. Municipal Employee Group Benefit Risk Pool	10,000,000
21. TASB Group Health Benefit	5,000,000
22. Lower Rio Grande Valley Regional Academic Health Center	5,000,000
23. Texas Healthy Kids Fund/Corporation	3,000,000
<b>Grand Total - Tobacco Settlement Receipts</b>	<b><u>\$1,768,100,000</u></b>