

PRODUCED THROUGH
A CONTRACT FROM
ST. LUKE'S CHARITABLE
HEALTH TRUST

BY MORRISON INSTITUTE
FOR PUBLIC POLICY

JANUARY 2000

When the Smoke Clears:

ARIZONA'S PROPOSITION 200

TOBACCO TAX EXPERIENCE

AND WHAT IT TEACHES US

FOR SPENDING THE SETTLEMENT



ARIZONA STATE
UNIVERSITY



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In November 1994, Arizona voters raised the tax on all tobacco products in the state by approving Proposition 200, the Tobacco Tax and Health Care Act.¹ The revenue generated by the tax increase was dedicated to three primary purposes: health care for the medically needy, tobacco use prevention, and research on tobacco-related diseases.

Between 1995 and 1999, the new tobacco tax raised a total of approximately \$520 million. The Arizona Legislature has spent portions of the money, creating dozens of programs and line-item expenditures that have provided more than 150,000 medical services. Large amounts of the revenue – as much as \$100 million per year – have gone unspent, however.

In November 1998, four years to the month after Arizona passed Proposition 200, a lengthy legal battle between the tobacco industry and the Attorneys General from 46 states ended when a historic multi-state settlement agreement was signed. The largest U.S. tobacco companies agreed to pay out more than \$200 billion over 25 years in exchange for the states' promise not to pursue future liability lawsuits against the tobacco companies.

Based on the settlement's disbursement formula, Arizona's portion of the agreement is estimated to be roughly \$3 billion, paid out over two and a half decades. In contrast to the voter-approved Proposition 200, however, the multi-state tobacco agreement is silent on how individual states can spend their settlement dollars – the states face no restrictions on how the money can be spent.

In late 1998, a dialogue was quickly initiated over how to spend Arizona's share of the multi-state tobacco settlement. However, few policy makers were looking upon the four-year old Proposition 200 as a potential learning experience for the state. Thus, this research project was initiated in early 1999 with two primary questions:

- What has happened with the voter-approved Proposition 200 funds since passage in 1994?
- What lessons does the implementation of Proposition 200 offer Arizona for how it might spend its portion of the settlement agreement?

WHAT HAS HAPPENED WITH PROPOSITION 200 SINCE PASSAGE IN 1994?

■ The spirit and letter of Proposition 200 have been violated.

Despite several early attempts in the Arizona Legislature to modify the framework for where the newly-passed Proposition 200 money would go, the four accounts established in the original voter-approved Tobacco Tax and Health Care Act have been maintained as intended since 1995. However, large sums of Proposition 200 revenue – on average \$90 million annually – have gone unallocated and unspent by the Legislature. In addition, interviews conducted for this project indicate that two technical provisions of the Act have likely also been violated. The first provision in question prohibits the Legislature from using the new revenue to “supplant” previously existing health care services funded by the state, and the second disallows the new funds from being “subject to appropriation.” Despite ambiguity and questions about the intent of both provisions, it appears that the Legislature has both supplanted and appropriated Proposition 200 tobacco tax revenues.

■ Politics and the lack of an overarching state health policy have caused large unspent carry forward balances and created a “shotgun blast” of programs to address a variety of perceived healthcare needs.

The spending of Proposition 200's revenue began very slowly in the largest of the four accounts created (the Medically Needy Account) for a variety of reasons. Although politics and special interests have caused a significant increase in spending in the Medically Needy Account in recent years, the lack of a state health care needs assessment and the absence of overarching state health policy goals have caused a scattering of the funds to dozens of programs. In addition, despite the creation of many programs, large amounts of money are still not being spent out of the Medically Needy Account, and the Joint Legislative Budget Committee is projecting large balances through fiscal year 2005.

¹ In addition to raising taxes on smokeless tobacco products, Proposition 200 included a 40-cents per pack increase on cigarettes.

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■ Data and evaluation information regarding programs in Prop. 200's Medically Needy Account are inconsistent, making it difficult to assess performance.

Although this research project was never intended as a performance evaluation of the Medically Needy Account and its programs, an attempt to examine the Account in aggregate was complicated by the wide variety of programs and inconsistent data available from them. In the final analysis, though access to certain health care services has increased, few conclusions can be drawn about the quality of the programs operating within the Medically Needy Account. In addition, evaluations are sorely lacking, as the only statutorily mandated “evaluation” is conducted by Department of Health Services upon four of its own programs. Data collection needs to be taken more seriously, and evaluation should be removed to a private – or at least independent – entity outside of the agencies administering programs.

■ Access to health care services has been increased.

Although individual program performance data leave much to be desired, the demographic information gathered by many programs indicates that the Medically Needy Account is making new health care services available to the working poor and other in-between populations. For example, the Premium Sharing Program has eligibility requirements that make service available to persons at or below 200 percent of the federal poverty level. In addition, some of the demographic information indicates that services are increasing to the groups specifically targeted by the initiative: namely the medically needy, medically indigent and low-income children. Since 1995, Medically Needy Account funds have provided at least 150,000 medical services in Arizona.

■ Although the effectiveness of Arizona's “smelly, puking habit” smoking cessation program has not yet been quantified, similar anti-tobacco efforts have worked well elsewhere.

While Arizona's “smelly, puking habit” tobacco cessation campaign has proven popular with the public, evaluations have been mixed. A September 1999 report by the Arizona Auditor General was critical of the campaign's failure to

conduct a baseline survey of youth smoking before initiating the campaign. Despite the quantification difficulties in Arizona, both California and Massachusetts have seen substantial decreases in their tobacco consumption following the imposition of similar cessation campaigns. Based on these two states, the U.S. Centers for Disease Control (CDC) has concluded that the combination of tobacco cessation and an increase in tobacco tax is the most effective way to reduce tobacco consumption. Because of the passage of Proposition 200 in 1994, both factors are now in place in Arizona.

WHAT LESSONS CAN BE LEARNED FROM PROPOSITION 200 FOR SPENDING ARIZONA'S SHARE OF THE MULTI-STATE SETTLEMENT?

■ First, decide on a desired impact or impacts.

As with the Proposition 200 revenues, the nearly \$3 billion in settlement monies scheduled to come to Arizona over the next 25 years represent an enormous opportunity for the state. Considering how special interest politics and a lack of policy resulted in a scattering of programs and expenditures from Proposition 200, the question of how to spend the settlement perhaps becomes a rather simple one: Would the state be better served spending the settlement money via the Prop. 200 “shotgun blast” model, or a simpler approach? Based on the Proposition 200 experience, the state would be well served to consider the large sum of money to be an opportunity to do something significant – perhaps one, two, or several things – not thirty things. Should the state decide that the monies or a large portion of the funds are best spent on health care, a comprehensive state needs assessment should be performed before allocation of the money begins.

■ Keep it simple and implement it well.

The implementation of Proposition 200 has resulted in a complex web of fragmented programs and expenditures. With potentially three billion dollars at stake over 25 years, Arizona would be wise to make sure that someone is minding the tobacco settlement store, and properly looking after it. If the state looks upon the settlement as a unique opportunity to do one or two significant things, it will go a long

EXECUTIVE SUMMARY

way toward both making a large impact and simplifying implementation. The trust fund, endowment, or foundation concept being used in other states might work well to further simplify things in Arizona. By adopting this type of structure, disbursement of the monies can be centralized and easily tracked, and program implementation and an overarching purpose for data collection can be housed in one location, instead of several, or even dozens. In addition, this type of structure can take responsibility for looking after the “big picture” of the tobacco settlement in Arizona.

When the tough job of how to spend and implement the settlement is decided, however, the work is only beginning. Arizona cannot afford to do a half-hearted job of implementing the settlement funds, as occurred with the Proposition 200 funds. The state would be well served to decide today that 25 years from now, Arizona should be held up as the model for the impact the tobacco settlement had on a state. Such a commitment will ensure not only that the money is well invested, but that it will have an impact.

■ Be smart about data collection and evaluation.

Whatever the state decides to do with the settlement fund opportunity, data collection and evaluation should be included prominently. It is critical that the Legislature regards performance measurement as an integral part of any spending plan.

So, what is “smart” data collection and evaluation? To be most effective, data gathering and evaluation must be addressed during program design by all stakeholders: legislators, program operations persons, and anyone else interested in outcomes. Above all, the data should measure

results, not just processes, and the data should focus on what the project or projects are accomplishing, especially in terms of impact on people. The primary focus should be to not only know what programs are doing, but to know whether they are doing any good. But make no mistake: good evaluation takes time. It is difficult to tell in just one or two years whether a program is effective or not.

Finally, “smart” evaluation involves private – or at least independent – evaluation. It is best not to assign government agencies to evaluate the programs they administer, as has occurred with several of the Proposition 200-funded programs.

■ Watch implementation closely.

One final lesson learned from the Proposition 200 experience is that regardless of the ground rules set out for implementation or how carefully the language of a ballot initiative is written, politics will almost certainly find a way into the process. According to interviews for this project, the supporters of Proposition 200 believed that they had drafted an initiative that was essentially “self-enacting” with language that would avoid the Legislature, and therefore, avoid politics. Ultimately, they were proven wrong.

Thus, perhaps a key lesson for Arizona voters, consumer and public law advocates, and the media is to keep a close eye on how any law or initiative passed in Arizona is implemented over time by the Legislature. Keeping watch over how the money is spent and implemented will not only ensure that the will of the people is validated, but will probably also increase the impact of the funds and increase the public’s trust in their elected officials.

EXECUTIVE SUMMARY

SUMMARY OVERVIEW OF ARIZONA'S PROPOSITION 200 AND THE SETTLEMENT AGREEMENT

1994 ARIZONA PROPOSITION 200

INTENT

- Provide health care services to persons who are medically needy, medically indigent, and low-income children.
- Encourage people to stop smoking or not start smoking and educate Arizona residents about the dangers of smoking.
- Provide funding for research of tobacco-related diseases.
- Raise new revenue for the above causes without impacting the Department of Corrections' share of existing tobacco tax revenues.

IMPLEMENTATION

- 70% of the new tax revenues dedicated to the "Medically Needy/Medically Indigent Account."
- 23% to "Health Education Account."
- 5% to "Health Research Account."
- <2% to Department of Corrections' "Adjustment Account."
- Funds shall not be subject to legislative "appropriation."
- Funds may only supplement, not "supplant" current levels of state health care spending.

1998 MULTI-STATE SETTLEMENT AGREEMENT

INTENT

According to the suit filed by the Arizona Attorney General:

- Recover dollars lost from the state's general fund due to increased health care costs brought about by tobacco-related illness and increased health care insurance premiums paid by the state for state employees.
- Fund a public education campaign related to smoking and health.
- Fund smoking cessation programs in the State of Arizona.

IMPLEMENTATION

- "State Specific Finality" (state court approval with no pending appeals) is required before funds begin to flow to the state.
- No action required by the state legislature in order to take effect.
- No restrictions on spending. States may use the funds for any purpose.

In November 1994, Arizona voters approved Proposition 200, the Tobacco Tax and Health Care Act, raising the tax on all tobacco products in the state, including a 40-cent per pack increase on cigarettes. According to the proposition, 98 percent of the revenue generated by the tax increase would be dedicated to three purposes: 1) health care for the medically needy and indigent, 2) programs for the prevention and reduction of tobacco use, and 3) research on the prevention and treatment of tobacco-related diseases.² Between 1995 and 1999, the new tobacco tax raised roughly \$520 million, and the Arizona Legislature created more than 30 programs and line-item expenditures for these three purposes, the majority related to health care for the medically needy and indigent.

In November 1998, four years to the month after Arizona passed Proposition 200, a four-year legal battle between the tobacco industry and the Attorneys General from 46 states ended when representatives of both sides signed a historic settlement agreement. The five largest U.S. tobacco companies agreed to pay out a total of roughly \$206 billion over 25 years in exchange for a promise from the states not to pursue future lawsuits against the tobacco companies to recover state costs of providing health care for ailing smokers.

Based on a disbursement formula developed for the settlement, Arizona's portion of the settlement agreement is estimated to be roughly \$3 billion, paid out over two and a half decades. In contrast to the voter-approved Proposition 200, the multi-state tobacco agreement is silent on how individual states can spend their settlement dollars. States face no restrictions on how the money can be spent.

Following the November 1998 announcement of the multi-state settlement agreement, political interests and leaders in Arizona began to step forward with their ideas for how Arizona should spend its share of the settlement. Some proposals, citing the Attorneys General reasons for bringing their lawsuits, called for the money to be dedicated to either

health-related or smoking-prevention expenditures. According to their logic, the lawsuits were brought to recoup health care costs, and thus the money should be spent on health care.

Others, however, began talking about “returning the money to the state’s taxpayers” in the form of tax cuts. After all, they argued, it was the taxpayers that – at least in theory – paid the state’s tobacco-related health care bills in the first place, so they should get their money back. Still others viewed the settlement as a windfall for the state to spend however it wanted on urgently needed items in non-health areas such as education, transportation, and infrastructure.

WHY THIS RESEARCH WAS CONDUCTED

As elected officials and special interests continued to bring forward their diverse ideas for spending the settlement in Arizona, it was obvious that consensus would be difficult, if not impossible. Interestingly, among the variety of settlement proposals, there seemed to be one common thread: virtually all ignored the state’s existing tobacco tax.

Perhaps it was for good reason. At face value, it seemed the only things that Arizona’s four-year old state tobacco tax and the brand new multi-state tobacco settlement had in common were two politically-volatile issues: tobacco and large sums of public money. But, there were larger, logical, and potentially more important questions that nobody seemed to be asking:

Where has the Proposition 200 money gone, and what – if anything – might be learned from Arizona’s four-year tobacco tax experience that could inform what the state should or should not do with its share of the tobacco settlement?

Though there was only limited history and experience of tobacco settlement spending (a handful of states had settled prior to November 1998 and were beginning to receive and spend their funds), by early 1999, there were four years of history regarding Arizona’s Proposition 200 tobacco tax increase and the programs created from it.

² The final two-percent was dedicated to an “adjustment account” in the Department of Corrections that was receiving a portion of the existing tobacco tax. It was thought that an increase in tobacco taxes would lower the revenues received by the existing account, and thus, this final two-percent was dedicated to maintain the Department of Corrections’ account.

INTRODUCTION AND BACKGROUND

With an eye toward a potential research project with implications for health policy, St. Luke's Charitable Health Trust and ASU's Morrison Institute for Public Policy began to dialogue about issues related to Arizona's tobacco tax, the multi-state settlement agreement, and public policy. Among the questions raised:

- What kinds of programs has Arizona's Proposition 200 tobacco tax created?
- What populations and issues have the programs served?
- What – if anything – can be said about the programs' performance or "quality"?
- Have the funds been spent in a manner consistent with the voter-approved Proposition 200? and,
- What can be learned from Arizona's tobacco tax experience that might inform the spending of the settlement?

METHODOLOGY OF THE PROJECT

With these questions as a point of departure, St. Luke's Charitable Health Trust entered into separate contracts in January 1999 with ASU's Morrison Institute for Public Policy and Phoenix-based research and consulting firm Cannon & Gill. Cannon & Gill was responsible for collecting information related to the programs funded by Proposition 200 revenues, including financial data, populations served, outputs and/or outcomes, and any available program evaluation information. The Morrison Institute assumed responsibility for exploring and analyzing the larger public policy issues surrounding the tobacco tax, the tobacco settlement, and the public policy lessons that might be learned from both.

During the first half of 1999, Cannon & Gill began compiling data and Morrison Institute staff conducted a series of interviews with key legislators and legislative staff, advocates and interested parties on all sides of the tobacco tax issue, and other persons knowledgeable about tobacco issues.³ In late-summer 1999, after completing the interviews, the Morrison Institute received the data and program information from Cannon & Gill and began reviewing the qualitative

and quantitative data to conceptualize the public policy analyses, overarching findings, and recommendations.

An advisory committee was assembled and called upon twice during the project to provide feedback and guidance. The first meeting, held at the outset of the project, was to discuss methodology and the prominent issues likely to be discussed. The second advisory group meeting was to review the draft findings and recommendations that appear in this report. In addition, in the fall of 1999, Morrison Institute staff conducted some follow-up interviews, primarily to present the preliminary findings and receive feedback from those who were unable to attend the second advisory committee meeting.

WHAT THIS REPORT IS...AND WHAT IT IS NOT

This report is about Arizona's 1994 tobacco tax increase, the funding and programs that have resulted from it, the 1998 multi-state tobacco settlement, and the public policy issues they share. The discussion centers upon Arizona's Proposition 200 tobacco tax increase, and in fact, the analysis is primarily focused on one specific portion of that tax increase: the Medically Needy Account, where 70 percent of all new Proposition 200 revenues have gone since 1994.

The decision to look primarily at the Medically Needy Account was made by the partnering organizations involved in the project because 1) it has received the most revenue from the new tax, 2) it has been where most of the legislative activity and controversy have occurred during the first several years of implementation, and 3) unlike the other accounts created by Proposition 200, it was established for the purpose of providing new health care services to persons who are medically needy, medically indigent, and low-income children. Because of these reasons, it was believed that a close examination of the Medically Needy Account would yield the most important, and most relevant, lessons for the tobacco settlement. Evaluation materials and data for the other three Proposition 200-created accounts – to the extent they exist – were also collected and examined during this project.

³ Appendix A contains a list of the persons interviewed for this project. Appendix B contains the names of persons who were invited to attend the project's advisory committee meetings.

INTRODUCTION AND BACKGROUND

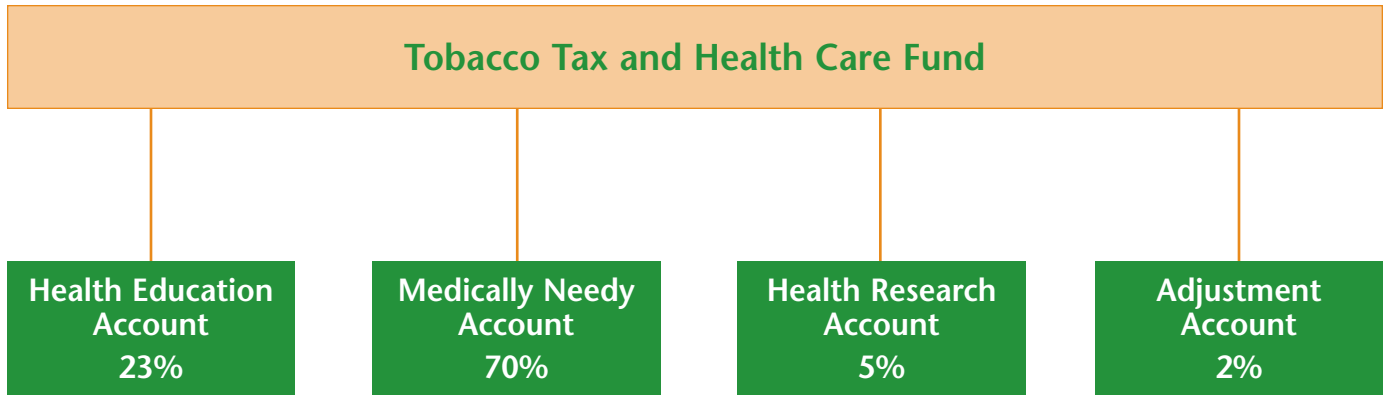
However, because these accounts are much smaller and have been the subject of only minimal legislative attention, they are mentioned primarily in passing, where relevant to the lessons offered by the Medically Needy Account.

Finally, a couple of words about what the report is not. This report is not a formal performance evaluation of the Tobacco Tax and Health Care Act (Proposition 200), nor does it offer specific recommendations for how the state should spend its portion of the multi-state tobacco settlement.

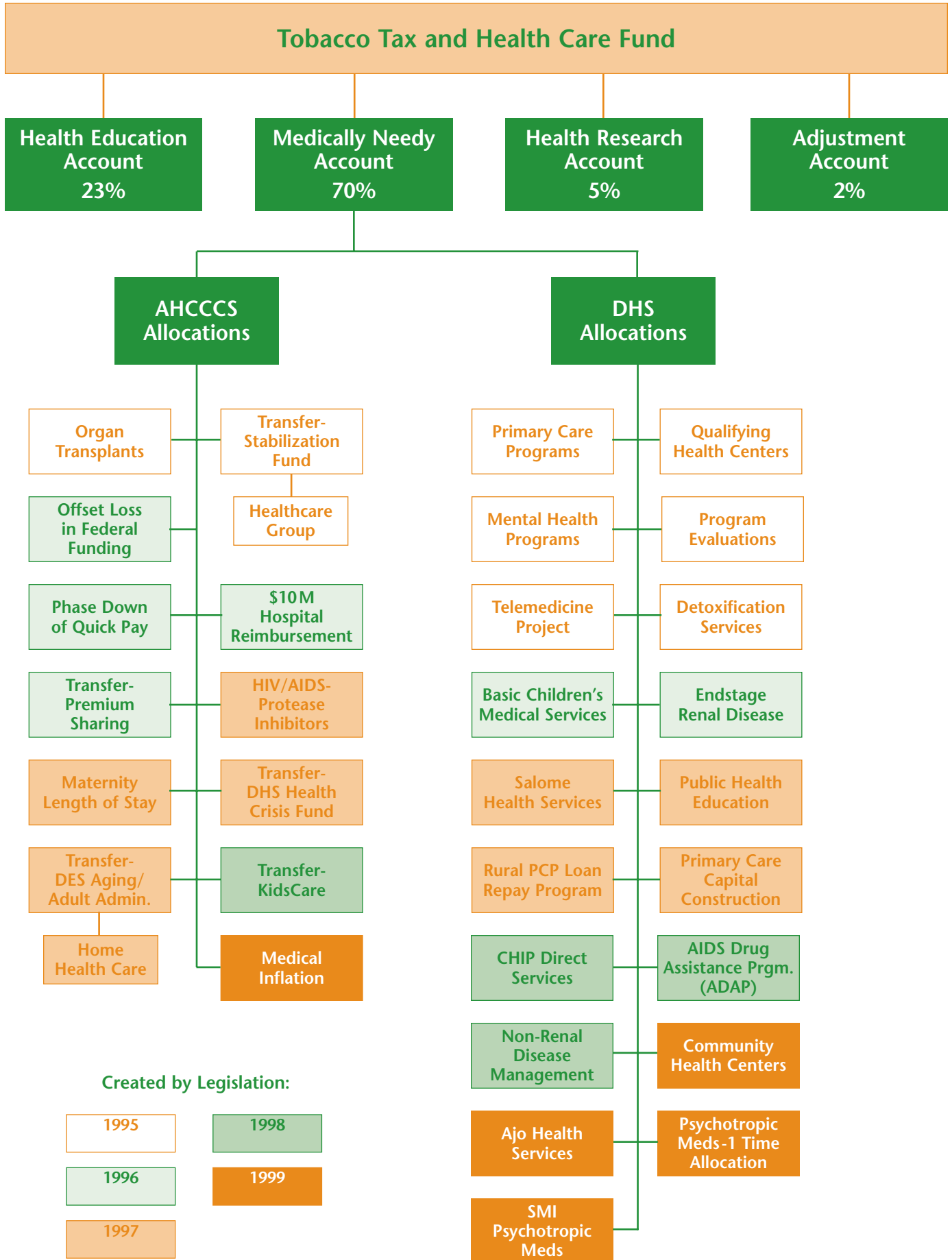
While it does look broadly across the implementation of Proposition 200, and closely at the Medically Needy Account and its programs and expenditures, the project was never intended to be a formal performance evaluation. It was designed to be an overview and analysis of the public policy

questions and implications of Arizona's existing tobacco tax and anticipated tobacco settlement. Also, although the report lists and discusses what a number of other states have chosen to do with their portion of the settlement, it does not recommend how Arizona should spend its tobacco settlement monies. Again, the project did not set out to do so. It goes without saying that an opportunity for Arizona to receive as much as \$3 billion over two decades with few restrictions is – justifiably – a public policy issue of the highest importance. However, we believe that decisions regarding the use of the settlement are best left to the citizens of Arizona and/or their elected representatives. This document is intended to provide information so that those decisions can be made thoughtfully.

**HOW PROPOSITION 200 WAS INTENDED:
THE TOBACCO TAX AND HEALTH CARE ACT OF 1994**



HOW PROPOSITION 200 HAS TURNED OUT: MEDICALLY NEEDY ACCOUNT PROGRAMS IN 1999



THE HISTORY OF ARIZONA'S TOBACCO TAX AND HEALTH CARE ACT

overview

In 1988, voters in California passed Proposition 99, increasing taxes on all tobacco products with a portion of the revenue dedicated to healthcare. Though not obvious at the time, the Golden State was once again at the forefront of what would become a significant public policy issue. Just a couple of years later, by the early 1990s, public sentiment toward tobacco in the U.S. – and in Arizona – was shifting notably.

In his 1993 budget, Arizona Governor Fife Symington proposed saving \$82 million by raising the eligibility bar for medically needy and medically indigent persons, a move that would have dropped thousands from the state's health safety net. The suggestion drew an immediate and strong opposition from the hospitals, who began looking at California's Proposition 99 and wondering if something similar might work in Arizona. After a survey of Arizona residents indicated they were favorable to the idea of raising tobacco taxes to pay for health care for the medically needy, the hospitals began to mobilize. Eventually, a diverse coalition of political interests came together and gathered enough signatures to place Proposition 200, the Tobacco Tax and Health Care Act, on the November 1994 ballot. After a somewhat testy campaign, Proposition 200 passed with a 50.8 percent majority.

Q: What brought Proposition 200 (the Tobacco Tax and Health Care Act) to the Arizona ballot in 1994?

A: A shifting political environment in the U.S. and Arizona combined with a series of events, including a controversial budget-saving proposal by the then-governor, allowed several forces to align which ultimately brought Proposition 200 to the ballot.

Political history tells us that taxation has never been a generally popular notion in America. However, while taxes, such as those on income, have consistently proven less-than-popular among the American populace, taxes on items such as tobacco and liquor have been more politically palatable, particularly during the last several decades. These so-called “sin taxes” (taxes on tobacco, liquor) have frequently passed at the state and federal level due to three factors:

- 1) The argument that those who do not use the product do not pay the tax;
- 2) The argument that an increase in the tax will reduce demand for the product, and thus reduce the societal ills caused by the “sin;” and,
- 3) The coming together of often-diverse coalitions to work for passage of “sin taxes.”

Tobacco has proven a popular “sin” to tax in the U.S. in recent decades for each of the above reasons. In the late 1970s, President Jimmy Carter supported a large federal excise tax on cigarettes after a coalition formed by the American Cancer Society and the American Medical Association endorsed the concept. President Clinton also proposed a new federal excise tax on tobacco products in 1993 to pay for his health care plan that was ultimately defeated in Congress.

In addition to the federal proposals to tax tobacco, the period of state government fiscal austerity during the 1980s and 1990s caused a number of states to impose sin taxes. It seemed as though demands for government services were increasing at the same time revenues were either stable or shrinking. As a result, many state legislatures turned to tobacco taxes as a less politically painful way to raise revenue.

In 1990, the Arizona Legislature raised the state's sales tax on cigarettes to 18 cents per pack as one piece of a large tax package designed to reduce a projected \$250 million budget shortfall.⁴ The 1990 legislative tobacco tax increase quickly started bringing in close to \$50 million per year to Arizona's general fund.

In addition to state legislatures looking to tobacco taxes for revenue, some states with the ballot initiative process

⁴ Foster, Ed “Tax Plans Would Nip Arizonans' Wallets” *The Arizona Republic* 2/23/90.

THE HISTORY OF ARIZONA'S TOBACCO TAX AND HEALTH CARE ACT

began to see proposition efforts to increase tobacco taxes in the late 1980s and early 1990s. In 1988, through Proposition 99, California voters passed a tobacco tax on themselves, increasing the tax on all packs of cigarettes sold in the state from 10 cents to 35 cents with a portion of the new revenues earmarked for healthcare. Voters in Massachusetts followed California's lead by passing a similar tobacco tax increase ballot initiative in 1992.

In 1993, the political environment in Arizona seemed to be ripening to the notion of a ballot initiative to raise tobacco taxes. In an effort to gain some \$82 million in budget savings, Governor Symington publicly proposed dropping roughly 35,000 medically indigent Arizonans from the state's Medicaid substitute program, the Arizona Health Care Cost Containment System (AHCCCS).⁵ The state's hospitals quickly protested Governor Symington's idea, saying that they would have to absorb heavy costs because they would be forced to continue to treat the uninsured, only now, uncompensated. The hospitals noted that dropping such a large portion of medically needy persons from the state's health safety net would only lead to higher hospital costs that would ultimately be passed on to the consumer and the private sector through higher insurance premiums.

Governor Symington's idea, saying that they would have to absorb heavy costs because they would be forced to continue to treat the uninsured, only now, uncompensated. The hospitals noted that dropping such a large portion of medically needy persons from the state's health safety net would only lead to higher hospital costs that would ultimately be passed on to the consumer and the private sector through higher insurance premiums.

In response to the governor's plan and what seemed to be the tip of a growing national tide against the tobacco industry, the Arizona Hospital Association commissioned a poll of state residents in 1993. The purpose was to gauge sentiment on the governor's plan, and also on the idea of an increase on tobacco taxes to pay for health care for Arizona's medically indigent and medically needy.⁶

Seventy-two percent of Arizonans in the poll, conducted statewide by the Gallup organization, said they opposed budget cuts that might reduce the availability of health services to medically needy or medically indigent persons. A 60 percent majority indicated a willingness to pay more taxes to support

health care for people who could not afford it. And finally, 82 percent of Arizonans said they would support increases in taxes on tobacco to pay for health care for the poor.

With these clearly favorable poll numbers and a highly objectionable plan by the Governor, the Arizona Hospital Association began studying the passage of California's Proposition 99. Over the next several months, into late 1993, the Hospital Association assembled a coalition of more than 20 Arizona health care groups (including the Cancer Society, the Lung Association, and the Heart Association) and began to prepare potential initiative language for the November 1994 ballot.

The outline of the proposed initiative was simple: allow Arizona residents to raise tobacco taxes from the existing 18-cent per pack to 58-cents per pack with the new revenue dedicated to health care services for the uninsured, youth smoking cessation programs, and research on tobacco-related diseases.

Q: What happened during the Proposition 200 campaign in 1994?

A: Allegations and counter-allegations flew between supporters and opponents about the other side's tactics and motives. Ultimately, Proposition 200 passed with a razor-thin majority.

On February 1, 1994, signature collectors began circulating petitions statewide on behalf of "Arizona for a Healthy Future," the growing coalition's chosen moniker. In the span of just a few months, the coalition had grown from 20 to more than 50 health care-related and educational groups, and had secured Arizona conservative icon and former U.S. Senator Barry Goldwater to chair the campaign. Having lost his wife ten years earlier to a smoking-related illness, Senator Goldwater agreed to be chair.

The campaign to pass the so-called "Tobacco Tax and Health Care Act" was launched. More than 105,000 signatures would have to be gathered by July 7, 1994 in order to place the proposition on the November 8 ballot.

With the issues of taxes, tobacco, and large sums of public money as a backdrop, it did not take long for the campaign to turn somewhat nasty, with allegations and counter-allegations from both sides throughout the summer of 1994.

⁵ Pitzl, Mary Jo. "Governor, Foes Meet On Health: Solutions, Not Debates, Sought By Symington." *The Arizona Republic*. January 9, 1993.

⁶ Ibid.

THE HISTORY OF ARIZONA'S TOBACCO TAX AND HEALTH CARE ACT

Opponents claimed the initiative was nothing more than self-enrichment for the hospitals. Arizona State Senate President John Greene told *The Arizona Republic*, “. . .they’re wanting to take \$100 million of tax money and put it in their pockets and say, ‘it’s ours and we can do with it what we want.’” Others in the Arizona Legislature came out in opposition because they saw it as “ballot-box budgeting” – usurping their right as elected members of the Legislature to appropriate monies.

Several anti-Proposition 200 groups quickly arose and presented additional arguments against the initiative. Among the arguments made: the proposition language was too vague as to how the money would be spent, the tobacco tax increase would create new entitlement programs that would be unfunded if the tax revenues declined and, the Department of Revenue would have to apply more resources and scramble to figure out how to collect the tax, which for the first time, would be collected on Indian reservations. Indian tribes publicly proclaimed that the proposed initiative would be an infringement upon their sovereignty. In an effort to paint the Prop. 200-supporting hospitals as greed-motivated, opponents publicized documents showing several Arizona hospitals earning large profits and paying generous salaries to their administrators while enjoying a tax-exempt status.

For their part, the supporting organizations claimed they were being “bullied and threatened” by opponents, including Governor Symington and Senate President Greene. During the

Proposition 200 passed in Arizona in 1994 by a margin of 50.8% to 49.2%, or about 18,000 votes out of the 1.1 million votes cast.

signature collection portion of the campaign, the proposition’s backers charged that an organized conspiracy between the insurance and tobacco industries was working to block them from getting signatures. One of the pro-Proposition 200 campaign

chairs produced affidavits from petition circulators stating they had been offered money to give up their petitions, allegations that if true, were clearly illegal.

Despite the bickering and allegations, representatives of Arizona for a Healthy Future submitted more than 200,000 petition signatures to the Arizona Secretary of State’s office on Friday, July 2, 1994. The number of signatures was nearly

twice as many as the 105,000 needed, which virtually nullified any idea by the opposition to challenge the signatures and have the proposition disqualified.

The campaign then moved toward November. During the campaign’s final months and weeks, the battle over Proposition 200 intensified. Both supporters and opponents took their arguments to the media. An opposition column in *The Arizona Republic* again cited the potential “windfall” for hospitals and discussed the supporters’ “façade” of a grass roots coalition that was almost entirely financed by several large hospitals. Proponents responded by criticizing the estimated \$4.7 million anti-Prop. 200 “war chest funded by the tobacco industry,” claiming they had been outspent by more than two-to-one.⁷ An early October poll by KAET-TV indicated that margin in favor of Proposition 200 was shrinking rapidly and stood at just 59 percent; apparently the opposition money was beginning to have an effect.

On election day, an exit poll of more than 1,000 voters showed Proposition 200 apparently going down to defeat. Both men and women, young and middle-aged voters, all income groups (except the highest income level), and – perhaps not surprisingly – a strong 88 percent of persons who said they were smokers all reported they were voting “no”. Despite this poll, proponents went to bed on Tuesday, November 8 with the election’s outcome still up in the air, with the initiative passing by just 51 percent to 49 percent. Opponents were counting on the late-arriving votes from Arizona’s northern reservation areas to push the “no” side to victory.

And indeed, Proposition 200 failed by a three-to-one margin in Apache and Navajo counties, but it was not enough to stop passage of Proposition 200 by the razor-thin statewide margin of 50.8 percent to 49.2 percent. The margin of victory was about 18,000 votes out of the 1.1 million votes cast in the election.

Twenty days after the November election, the Arizona Secretary of State officially canvassed the results of the election and Governor Symington signed a proclamation mandating the proposition be placed into law. The new, higher tax rates on all tobacco products began to be collected throughout the state roughly one month after the election.

⁷ The final official campaign filings made available in mid-December 1994, showed that the opposition organization actually spent closer to \$5.8 million, a state record for spending in an election. Murphy, Michael, “Tobacco Tax Foes’ Funding Set a Record,” *Phoenix Gazette*, December 14, 1994.

THE HISTORY OF ARIZONA'S TOBACCO TAX AND HEALTH CARE ACT

On December 19, 1994, *The Arizona Republic* published a remarkably prescient editorial:

“Arizona hasn’t seen a Legislature that appreciates being told how to make laws or how to spend money, particularly on a measure that it’s not fond of. Proposition 200 was not supported by the legislative leadership or the governor, so while the will of the people will not be circumvented, expect considerable time and money to be spent shaping the initiative into workable and politically acceptable public policy. . . . Also expect attempts to raid the healthy revenue pot the tax will generate, an estimated \$90 million the first year alone.”

Indeed, despite its passage and enactment, the fight over Proposition 200 was only beginning. Almost immediately, interests on all sides of the debate began to disagree over what the language of the proposition specifically mandated and how it mandated it. Indeed, the debate and dialogue have continued for most of the past five years, and continue today.

FIGURE 1 BASIC STRUCTURE OF THE TOBACCO TAX AND HEALTH CARE ACT

(as passed by Arizona voters in November 1994, and enacted in Laws, 1995, Chapter 275)

Arizona’s 18-cents per pack cigarette tax is increased to 58-cents (and taxes increase on all other tobacco products). The new tax revenue is divided as follows:

- 70% of the new revenue shall be deposited in the “Medically Needy Account” for health care services for persons determined medically indigent, medically needy, or low-income children.
- 23% of the new revenue shall be deposited in the “Health Education Account” for programs for the prevention and reduction of tobacco use.
- 5% of the new revenue shall be deposited in the “Health Research Account” for research on the prevention and treatment of tobacco-related disease and addiction.
- No more than 2% of the new revenue shall be deposited in the Department of Corrections’ “Corrections Fund,” to hold the fund harmless from decreases in revenue it might suffer from the tax increase causing existing tobacco tax revenue to decline.

Q: What happened to Proposition 200 after Arizona voters passed it in 1994?

A: Some legislators initially sought to make significant changes, but the Act was eventually codified into law.

Despite voter approval of Proposition 200, some in the Arizona Legislature sought to make changes to the new law almost immediately – even going so far as to suggest that it be repealed entirely. Two bills seeking to alter the Act were introduced early in the 1995 legislative session, roughly two months after passage. The first would have inhibited the spending of any new revenue until after an unspecified “study period.” The second would have swept all of the new revenue into the State’s general fund, where it could be used on virtually any expenditure.⁸

According to local news media, the motivation behind these moves was clear. In December, an *Arizona Republic* editorial indicated that the newspaper would be closely watching the implementation of Proposition 200 because some in the Legislature were openly hostile to the initiative. In January, the paper followed up with several articles tracking the legislative wrangling citing legislators’ arguments for their efforts to change the approved initiative. Two basic arguments were being made: 1) the proposition subverted the legislative process by directing public money without any legislative oversight, and 2) the public was misled by a distorted pro-200 campaign.

“Arizona hasn’t seen a Legislature that appreciates being told how to make laws or spend money...” editorial in The Arizona Republic, December 19, 1994

Despite the legislative tussle, the original framework of Proposition 200 was not substantially altered during the 1995 legislative session. One key reason was an appearance at the State Capitol by Proposition 200 campaign chairman Barry Goldwater, who forcefully persuaded a House Committee to uphold the voters’ wishes and reject the idea of sweeping the revenue into the general fund. Ultimately, near the end of the 1995 general session, the Tobacco Tax and Health Care Act was codified through House Bill 2275 as Laws 1995, Chapter 275.

⁸ Van Der Werf, Martin, “2 Bills Target Tobacco Tax Cash; Seek to Redirect Use of Revenues,” *The Arizona Republic*, January 21, 1995.

THE HISTORY OF ARIZONA'S TOBACCO TAX AND HEALTH CARE ACT

Although the Act was codified into law, the apparent disdain for it by at least a few members of the Legislature did not immediately go away. One piece of evidence of this disdain is the fact that the Legislative Oversight Committee on the Tobacco Tax and Health Care Fund, mandated by H.B. 2275, has never met. No meeting of the Oversight Committee has occurred despite the fact that the implementing law requires the Department of Health Services to report annually to this Committee regarding the availability of funds in the Medically Needy Account.

Q: What did Arizona's voters think they were voting for when they passed the Tobacco Tax and Health Care Act?

A: The proposition language made clear that the majority of new revenue would be dedicated to health care services for the state's medically needy and indigent.

As noted above, opponents of Proposition 200 sought to nullify the new law almost immediately after passage because they believed the voters had been duped by a slick campaign. However, advertisements aside, the summary of Proposition 200 that appeared on voters' ballots distilled the Act down to a single sentence:⁹

"A 'yes' vote shall have the effect of increasing the state tax on cigarettes, cigars and other tobacco products to provide for health care for the medically indigent, medically needy or low income children, tobacco related education and research."

On the six pages of legal language that followed this summary, the text of the Act spelled out specific provisions, including the establishment of several new "accounts" to be created for the revenue, and the proportions of the new revenue to be deposited within the accounts. The text of the Act states:

"The Tobacco Tax and Health Care Fund is established in the State Treasury. . . The Fund shall be deposited in four separate accounts and shall be administered as set forth below for the following purposes. . ."

"1. Twenty-three cents of each dollar in the Fund shall be deposited in the Health Education Account for programs for the prevention and reduction of tobacco use. . ."

"2. Five cents of each dollar in the Fund shall be deposited in the Health Research Account for the research on the prevention and treatment of tobacco-related disease and addiction. . ."

"3. Seventy cents of each dollar shall be deposited in the Medically Needy Account, for providing persons determined medically indigent. . . or medically needy. . . or low income children. . . with health care services. . ."

"4. Two cents of each dollar in the Fund shall be deposited in the Adjustment Account for transfer of appropriate amounts to the Corrections Fund. . . to compensate for decreases in the Corrections Fund resulting from lower tobacco tax revenues. . ."

To anyone who read the initiative, these provisions made clear the priorities of Proposition 200 and where its supporters wanted the new tax money to go. With its receipt of 70 percent of the funds, the provision of new health care services for the medically indigent, medically needy, and low-income children was obviously the highest priority of the initiative. The second priority, by virtue of the fact that it was assigned 23 percent of the new funds, was for spending on the prevention and reduction of tobacco use. The remaining relatively small amount of money was dedicated to research of tobacco-related diseases, and to ensure that a pot of tobacco tax money received by the Department of Corrections from previous legislation would be maintained should the new higher tax cause a reduction in revenue.

⁹ A copy of the entire text of Proposition 200, the Tobacco Tax and Health Care Act, is contained in Appendix C.

THE SPIRIT AND LETTER OF PROPOSITION 200

overview

Despite several early attempts in the Arizona Legislature to modify the framework of the voter-approved Tobacco Tax and Health Care Act (Proposition 200), the overarching intent of the original voter-approved Act has been largely maintained. That is, 1994's Proposition 200 was primarily intended to provide health care services to the state's medically indigent and medically needy, and that is what it has done through the accounts established by the initiative. However, not all of the funds collected under the 1994 tax increase have been spent, a situation which constitutes a violation of the spirit of the law.

It also appears that two specific provisions of Proposition 200 have been violated. One provision prohibits the Legislature from using the tobacco tax revenue to "supplant" existing healthcare services offered by the State, and the second provision states that the new funds not be "subject to appropriation." It appears that the Legislature has used Prop. 200 revenues to supplant previous expenditures for the "Quick Pay Discount Program," the "\$10 Million Hospital Reimbursement" and bail out of the "Healthcare Group." In addition, although the Legislature claims not to "appropriate" the funds, they do acknowledge "allocating" the funds, a distinction of terms that is very minor indeed.

Q: Has the overarching intent or "spirit" of the Tobacco Tax and Health Care Act been followed?

A: The answer is both 'yes' and 'no.' The four accounts created by Proposition 200 have been well maintained in the proportions spelled out in the initiative. However, large portions of the initiative's Medically Needy Account have not been spent and remain unspent, thus depriving the medically needy of services and undermining the intent of the initiative.

The four accounts and their designated allotments (percentages) of revenue have been well maintained since 1995. Only two relatively minor irregularities have appeared during the five-year period, and both irregularities were in fiscal year 1996.

As Figure 2 illustrates, in FY1996, the Health Research Account, scheduled to receive 5 percent of funds, ended up with nearly 7 percent, and the Health Education Account, mandated by law to receive 23 percent, received only about 21.5 percent. Thus, the overage in the Health Research Account seemed to be at the expense of the Health Education Account.

The Medically Needy Account appears to have received more than its allotted 70 percent in each of the other years examined, and the Department of Corrections Account seems to be receiving well below the "less-than-two percent" mandated annually. Figure 2 summarizes how well the Proposition 200-mandated percentages have been maintained through fiscal year 1999.

Based on the figures on the following page, the overarching priorities (the four primary "accounts") created by the ballot initiative have been maintained at the percentages approved by the voters in November 1994. The voters approved an increase in tobacco taxes to primarily finance health care for Arizona's medically needy/medically indigent population, and secondarily for health education and, for the most part, those accounts are where most of the revenue has gone.

However, while the money has been deposited into the accounts in proper proportions, the next chapter discusses the fact that much of the revenue in the Medically Needy Account has gone unspent. Thus, while the spirit of Proposition 200 has been maintained through the accounts, it has not provided all of the health care it potentially can for the medically needy and medically indigent because it has not been spent.

THE SPIRIT AND LETTER OF PROPOSITION 200

FIGURE 2 ARIZONA TOBACCO TAX REVENUE ALLOCATIONS BY ACCOUNT, FY95-FY99
(BASED ON FIGURES FROM THE JOINT LEGISLATIVE BUDGET COMMITTEE)

	FY 1995 (partial year)	FY 1996	FY 1997	FY 1998	FY 1999
Tobacco Tax and Health Care Fund Collections (not including interest and balances forward)	\$55,517,900 100%	\$124,987,200 100%*	\$116,545,300 100%*	\$114,448,500 100%	\$112,388,400 100%
Medically Needy Account 70%	\$39,174,100 70.5%	\$89,036,200 71.2%	\$82,829,400 71.0%	\$81,503,300 71.2%	\$79,825,300 71.0%
Health Education Account 23%	\$12,872,700 23.1%	\$27,093,000 21.6%	\$27,215,300 23.3%	\$26,779,600 23.3%	\$26,228,300 23.3%
Health Research Account 5%	\$2,798,300 5.0%	\$8,404,000 6.7%	\$5,916,300 5.0%	\$5,821,600 5.0%	\$5,701,800 5.0%
Department of Corrections <2%	\$514,100 0.9%	\$139,700 0.1%	\$280,400 0.2%	\$0** 0%	\$280,400 0.2%
Dept. of Revenue Admin. Costs (not specified)	\$158,700 0.2%	\$314,300 0.2%	\$303,900 0.2%	\$344,000 0.3%	\$352,600 0.3%

* The 7% drop in Tobacco Tax collections between FY96 and FY97 is difficult to explain. It may be at least partially due to the increase in the cost of tobacco products, although there are probably other factors.

** According to JLBC, the Arizona Department of Corrections did not receive any Tobacco Tax funds in FY98 because the criteria established for the transfer of funds were not met.

Q: Has the “letter” of Proposition 200 been followed?¹⁰

A: Several “letter of the law” violations have occurred. Specifically, it appears that prohibitions on using the money to “supplant” existing services and legislative “appropriation” have occurred.

Although the spirit of Proposition 200 – to provide funds for Arizona’s medically needy and medically indigent – has been marginally maintained during the first five years of implementation, other more specific “letter of the law” provisions in the Act appear to have been violated by the

Legislature. Specifically, provisions restricting “supplanting” and the “appropriation” of the funds.

It was primarily in these two provisions that the Proposition 200 proponents specifically sought to restrict Legislative control over the funds. It is also these provisions which – according to a number of interviews conducted for this report – caused much of the hostility toward the initiative from the Legislature.

¹⁰ Although the following analysis contains discussions of legal issues and principles, it is not a legal opinion. None of the issues discussed here has yet been the subject of litigation in Arizona.

THE SPIRIT AND LETTER OF PROPOSITION 200

Regarding Supplanting

Under the heading “use of funds,” language in Proposition 200 states:

“...Monies deposited in the Medically Needy Account shall only be used to supplement funds appropriated by the Legislature...”¹¹

“...Monies deposited in the Medically Needy Account shall not be used to supplant funds appropriated by the Legislature for the purpose of providing levels of service established pursuant to Title 35, Chapter 29, Article 1. For the purposes of this section, “levels of service” means the provider payment methodology, eligibility criteria and covered services established... (and) in effect on July 1, 1993.”

In the more than 20 interviews conducted for this project, a number of people – both those in favor and even some opposed to Proposition 200 – indicated that the Legislature had indeed violated the supplanting clause by using new tobacco tax revenue to fund existing services. In interviews, several members of the Legislature even acknowledged that some supplanting had probably gone on with the new tobacco tax funds. The items commonly mentioned in interviews as possible “supplantations” were:

- **“Phase Out of the Quick Payment Discount Program.”** During the first Special Session of 1997, the Arizona Legislature passed and the Governor signed the Omnibus Health Budget Reconciliation bill. Section 6 of the bill called for a withdrawal in the amount of more than \$26 million from the Medically Needy Account to pay for five items. The first item on the list was a \$7.9 million expenditure “to continue the scheduled phase-out of the quick payment discount required by Laws 1993...”
- **“\$10 Million Hospital Reimbursement.”** Another of the five items listed in a \$26 million withdrawal from the Medically Needy Account authorized during the Second Special Session of 1997 was “\$10,000,000 to discontinue the annual ten million dollar discount on private hospital reimbursement required by Laws 1993...” This expenditure apparently was initially

created in 1993 as a reimbursement fund for hospitals to recover the costs related to serving medically needy and medically indigent patients.

- **“Healthcare Group.”** Initiated January 1, 1988 and expanded statewide in March 1993, Healthcare Group allows small Arizona employers (less than 50 employees) to purchase health insurance for their employees through AHCCCS. In 1999, the Arizona Legislature modified some of the program’s eligibility criteria and transferred \$8 million in tobacco tax funds out of the Medical Services Stabilization Fund within the Medically Needy Account to assist the financially struggling Healthcare Group.

Other interviewees expressed the view that in addition to these apparently direct violations, there are several expenditures that seem to violate the “spirit” of the supplanting clause because they cause the Tobacco Tax and Health Care Fund to absorb an expenditure that – in the absence of the tobacco tax revenue – would have most likely been the responsibility of the state’s General Fund. Most commonly mentioned among this group were:

- **“Offset Loss in Federal Funding.”** The 1997 Omnibus Health Budget also included an expenditure of \$4.1 million from the Medically Needy Account to “replace federal funds reduced due to the lower federal matching assistance percentage...” A question remains, however, whether the supplanting language in Proposition 200 was intended to prohibit the supplanting of only state expenditures, or both state and federal expenditures.
- **“Medical Inflation.”** During the 1999 legislative session, the Joint Legislative Budget Committee’s recommendation for the AHCCCS budget called for increased funding for projected inflation of 3.5 percent in capitation rates for FY00 and FY01. JLBC formally recommended that the cost of this inflation be shared 50 percent by the state’s General Fund and 50 percent by the Medically Needy Account of the Tobacco Tax and Health Care Fund because inflation “represents a new cost” and thus, is not supplanting. This proposal was discussed and adopted in the Health and Welfare Subcommittee hearing on the AHCCCS budget in early 1999. The Arizona Hospital and Healthcare Association argued that this spending for inflation was supplanting because in all prior years, 100 percent of the cost of inflation had been paid out of the Arizona General Fund.

¹¹ Although this quote only mentions the Medically Needy Account, similar language appearing earlier in the Act also prohibits supplanting through use of any from any of the other accounts.

THE SPIRIT AND LETTER OF PROPOSITION 200

It should also be mentioned that at least two other programs or expenditures funded by Proposition 200 revenues probably would not have occurred in Arizona had the tobacco tax increase of 1994 not passed. Arizona's KidsCare health plan uses a large chunk of tobacco tax dollars for the mandated federal match, and the 48-hour maternity length of stay passed by Congress and signed by President Clinton in 1997 would have been an unfunded federal mandate had the Proposition 200 dollars not been available.

Regarding Appropriations

In addition to the language regarding “supplanting” contained in Proposition 200, there were several paragraphs in the Act that discussed the Legislature’s prohibition of “appropriating” the new tobacco tax funds. The provisions appeared twice in the initiative:

“The fund and its accounts are not subject to appropriation. Expenditures from each account are not subject to additional approval, notwithstanding any statutory provision to the contrary.”

“It is the intention and desire of the people of Arizona in enacting this measure by initiative that the funds provided hereby are in addition to and separate from other funds that are now and shall be annually appropriated by the legislature. The funds provided hereby shall not be deemed or classed to be appropriations by the legislature.”

During the campaign and just after passage, this language was at the center of controversy, as many opponents read the provisions to say that the Legislature was not to have any authority whatsoever over what the new incoming tax revenue could be spent on. In reality, however, this has not been the case. The Health Committees in the Arizona Legislature have had authority over the funds and have chosen where and when to spend – or not to spend – the Proposition 200 tobacco tax revenues.

However, the central issue regarding this language remains: Was this prohibition on “legislative appropriations” intended to make Proposition 200 essentially self-enacting so that the tax revenue would flow directly from the Arizona Department of Revenue to each of the four accounts, completely bypassing the Legislature?

Although some supporters of the initiative maintained in interviews that this was never the intent, others have said that the language was designed to keep the Legislature from spending the new revenue by having it bypass them completely and going directly to agency directors who would “administer” the accounts.

Despite the possible intent of the appropriations language and the reality of what has actually occurred, there is a practical problem with the aforementioned mechanism that is probably at the root of why it has never occurred.

The problem is this: What would happen if the Director of AHCCCS (the agency that is supposed to “administer” the Medically Needy Account, according to Proposition 200) began to spend the funds being deposited into the Medically Needy Account in any manner that he or she saw fit, without consulting the Governor or the Legislature? Obviously, because the AHCCCS Director is appointed by, and serves at the pleasure of the Governor, this type of action would probably result in his or her immediate dismissal.

So, how has the new tobacco tax money been spent without violating the specific “not subject to appropriation” clause? According to JLBC reports, the Legislature’s expenditures of the Tobacco Tax and Health Care Fund are officially “allocations,” not “appropriations.” Several persons interviewed for this project indicated that abandoning the “appropriations” language contained in Proposition 200 was a necessary and politically expedient solution to a problem with no good solution. They argued that if the language was read literally and acted upon, it might – as indicated above – either result in a political standoff, or the firing of an agency head. Neither of these events has ever occurred because the Legislature’s House and Senate Health Committees simply began to “allocate” the funds almost immediately after Proposition 200 passed.

How have the Prop. 200 funds been spent by the Legislature without being “appropriated”?

Technically, the expenditures have been “allocations,” not “appropriations.”

TRACKING PROPOSITION 200'S IMPLEMENTATION, FUNDING FLOWS, AND PROGRAMS

overview

For most Arizona State Legislators, the revenue and programs contained in Proposition 200's largest account (the 70 percent Medically Needy Account) have been neither high visibility nor high priority issues. Some lawmakers have been openly contemptuous; others have ignored it because they opposed the original initiative and fear that new "entitlements" might be created that will eventually have to be bailed out by the general fund. Still other legislators have been excluded from the dialogue over how to spend the Prop. 200 funds because of the funds' "off-budget" nature (that is, they are not a part of the normal general fund budget negotiations).

Because of these factors, spending in the Medically Needy Account began very slowly. It did not take long, however, for politics and special interests to begin the program creation process in earnest, with much activity occurring in 1997 and 1998. Although a great deal of spending in the Medically Needy Account has occurred recently, the lack of a state health needs assessment and the absence of overarching health policy goals has caused the funds to scatter to dozens of diverse expenditures.

Further, despite the significant program creation activity in recent years, large unspent carry-over balances are still being seen annually in the Medically Needy Account. As of the end of 1999, JLBC was projecting large balances – as much as \$90 million annually – to continue through fiscal year 2005.

Q: How has implementation of the Medically Needy Account gone?

A: Politics and a lack of overarching state health policy goals have left large unspent balances in the Medically Needy Account and created a "shotgun blast" of programs to address a variety of perceived gaps.

During the 1994 campaign, Arizona's Governor and several other state political leaders expressed open opposition to Proposition 200. After the initiative passed, much of the opposition turned to indignation and obstruction. Ultimately, however, after an attempt to sweep the funds into the general fund failed in early 1995, the Tobacco Tax and Health Care Act was codified in Laws 1995.

Substantial amounts of revenue immediately began to flow into the four accounts. More than \$55 million was deposited in the overarching Tobacco Tax and Health Care Fund during fiscal year 1995 (the new tax was collected for only about half of the fiscal year), and more than \$100 million in Proposition 200 tobacco tax revenue poured in

during fiscal year 1996. Because 70 percent of these funds were being deposited in the Medically Needy Account, it was growing quite large, with nearly \$40 million deposited in fiscal 1995, and roughly \$89 million deposited in 1996.

Responsibility for allocating these funds fell to the Legislature's Health Committees, who had oversight over AHCCCS and the Arizona Department of Health Services – the agencies designated in Proposition 200 to administer two of the accounts created. The spending of the tobacco tax revenues did not come quickly, however, especially those within the Medically Needy Account.

In early 1995, as the revenue began to flow into the Proposition 200 accounts, it appeared that a small group of legislators was going to try to block most of the new proposals for spending. The reason given by some for their opposition was the fear that new programs created in the Medically Needy Account would become "entitlements" that might eventually become the burden of the State's general fund – if the tax did as intended and caused less smoking over time, thus generating less tax revenue. More than one

TRACKING PROPOSITION 200'S IMPLEMENTATION, FUNDING FLOWS, AND PROGRAMS

person interviewed for this project speculated, however, that it was a goal of this faction to intentionally create large unspent balances in the accounts in order to demonstrate to Arizona taxpayers that the tax really was not necessary because the revenues were not being spent.

Another group of legislators began to make an honest attempt at implementing what the voters had passed. In the middle of this tug-of-war was the Arizona Governor, who opposed Proposition 200 during the campaign, but after passage became interested in using at least a portion of the money to create a “rainy day fund” for the state’s health-related expenses. Missing from this legislative dialogue over policy direction for the tobacco tax revenues, however, were two important items: information regarding the needs of Arizona’s medically needy and medically indigent (including an accurate calculation of the numbers in this group) and an overarching state policy regarding health and health care.

Thus, it was in a highly politicized environment and in the absence of any statewide assessment information that the Health Committees began to scatter new programs to address perceived healthcare needs. Although the needs addressed by these new programs can correctly be called “perceived” needs — because no formal assessment had been performed — some of the new programs have undoubtedly filled actual needs.

New and substantial expenditures were carved out of the Medically Needy Account for Primary Care Programs (\$5 million per year), Qualifying Community Health Centers (\$5 million per year), and Non-Title XIX Mental Health Pro-

grams (\$5 million per year). In addition, the Governor’s concept of a health rainy day or “stabilization fund” was established within the Medically Needy Account at \$15 million annually. Also in 1995, two small pilot programs — one for detoxification services and the other for telemedicine — were created. In addition, an authorization for “an amount necessary” was established in the Medically Needy Account for organ transplants for indigents.

In 1996, new programs were created to help patients with end-stage renal disease and to provide medical services to children, among others. The 1997 legislative session saw the creation of a modest \$1 million “health crisis” fund, funding for a program at the Department of Economic Security for low-income elderly persons, and a program to help primary care doctors in rural areas pay back their educational loans, among others. In 1998, the Legislature used tobacco tax monies as a match for a federal children’s health insurance program (CHIP, called KidsCare in Arizona), and to provide \$8 million to a state-sponsored small-business health insurance plan. Between the 1995 and 1999 legislative sessions, more than 30 line items were created in the Medically Needy Account for services ranging from organ transplants, to renal disease management, to HIV/AIDS drugs, to psychotropic medications for mentally ill persons.

As one person interviewed for this project said, a “shotgun blast” of programs has been created with the tobacco tax revenues in the Medically Needy Account. Figures 3 and 4 depict the so-called “shotgun blast” of programs.

FIGURE 3
TOBACCO TAX
MEDICALLY NEEDY ACCOUNT – FY 1995

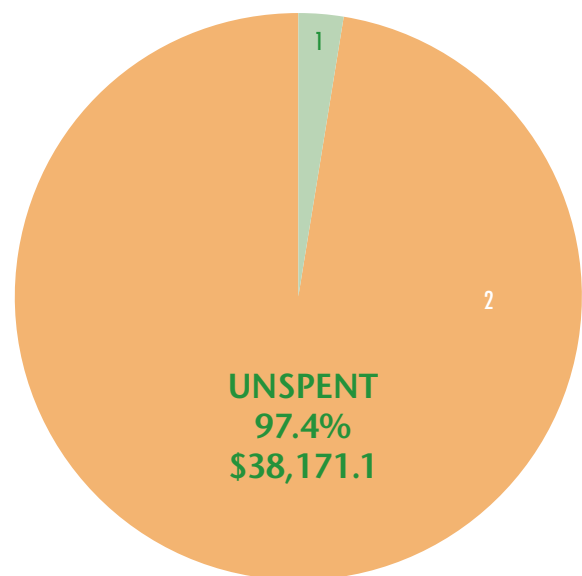
Total Funds Available: \$39,174.1

Total Expenditures: \$1,003

1	Organ Transplants	2.6%	\$ 1,003.0
2	Unspent	97.4%	\$ 38,171.1

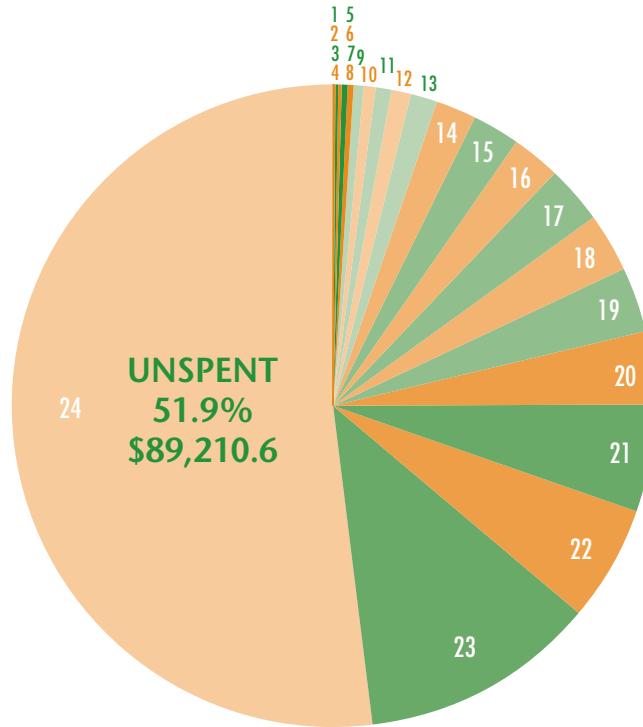
Expenditures in 000's

Source: JLBC



TRACKING PROPOSITION 200'S IMPLEMENTATION, FUNDING FLOWS, AND PROGRAMS

FIGURE 4 TOBACCO TAX MEDICALLY NEEDY ACCOUNT – FY 1999



Total Funds Available: \$171,680.3 • Total Expenditures: \$82,469.7

1 Nonrenal Disease Management	<0.25%	\$ 9.3	13 Basic Children's Medical Services	1.30%	\$ 2,294.3
2 CHIP Direct Services	<0.25%	\$ 31.7	14 Organ Transplants	2.00%	\$ 3,500.0
3 Rural PCP Loan Repay Program	<0.25%	\$ 37.5	15 Offset Loss in Federal Funding	2.40%	\$ 4,096.5
4 Telemedicine	<0.25%	\$ 126.3	16 Maternity Length of Stay	2.50%	\$ 4,213.3
5 Renal Disease Management	<0.25%	\$ 239.1	17 Qualifying Community Health Centers	2.90%	\$ 4,998.6
6 Evaluations	<0.25%	\$ 298.4	18 Mental Health Programs	3.00%	\$ 5,096.8
7 DES Aging and Adult Administration	<0.50%	\$ 500.0	19 Primary Care Programs	3.30%	\$ 5,619.7
8 Detoxification Services	<0.50%	\$ 513.6	20 Phase-Down of Quick Pay	3.70%	\$ 6,300.6
9 DHS Health Crisis Fund	<1.00%	\$ 862.8	21 CHIP-KidsCare	5.40%	\$ 9,251.1
10 HIV/AIDS Treatment	<1.00%	\$ 1,025.8	22 \$10 M Hospital Reimbursement	5.80%	\$ 10,000.0
11 Primary Care Capital Construction	<1.00%	\$ 1,356.2	23 Premium Sharing Project	11.80%	\$ 20,400.0
12 HIV/AIDS Drug Assistance Program (ADAP)	1.00%	\$ 1,698.1	24 Unspent	51.90%	\$ 89,210.6

Expenditures in 000's

Source: JLBC

TRACKING PROPOSITION 200'S IMPLEMENTATION, FUNDING FLOWS, AND PROGRAMS

The Medically Needy Account funds and programs have been scattered in many directions. Perhaps the more important issue, however, is whether the Prop. 200-created programs are helping the people they are targeting. Almost certainly, the variety of services in the programs created have provided medical care to persons and places which would not have received them had Proposition 200 not been passed in 1994 (including KidsCare). But, the larger question of how “effectively” they have done this is more difficult to answer. That question is the primary focus of Chapter Three.

Q: Has all of the Proposition 200 tobacco tax revenue been spent every year?

A: No, spending started slowly and large account balances began to appear annually. Today, large unspent balances – as much as \$90 million annually – are still projected far into the future.

Despite the creation of several large programs in 1995 and the creation of more in 1996 and 1997, only a small proportion of the money being deposited in the Medically Needy Account was actually being spent. In the first year that revenue began to flow (FY1995) only 3 percent of the \$38 million deposited in the Account was spent. Considering that it takes time to create programs and get them up and running, this is perhaps understandable. But large carry forward balances have been maintained annually in the Medically Needy Account since FY1995. In FY1996, despite the creation of a new \$20 million annual expenditure in the Account, more than \$100 million went unspent.

As the years have progressed, more programs and line-item expenditures have been created, and more funds have been allocated. Despite this progression, substantial carry-over balances have also remained. Figure 5 presents the revenue flow into the Medically Needy Account between fiscal years 1995 and 2000, including funds unallocated (bottom line). In FY1997, more than 50 percent of the total funds available in the Medically Needy Account went unspent (\$89 million out of \$189 million). In FY1998, another \$87.5 million went unspent. By fiscal year 1999, some 24 line item expenditures and programs had been created in the Medically Needy Account, but still greater than 40 percent of the Account was going unallocated (\$89 million).

Figures from JLBC (presented in Figure 5) project large unallocated balances through FY2005. These figures contrast with JLBC projections released in early 1999 which showed negative balances in the Medically Needy Account by 2005 because of significant growth in the KidsCare program and reductions in revenue due to lower demand for tobacco products. The revised estimates reveal lower KidsCare expenditures because of a lack of expected enrollment and a significantly lower decline in tobacco tax revenues, thus ensuring large balances well into the future.¹²

In FY 1996, despite the creation of a new \$20 million annual expenditure in the Medically Needy Account, more than \$100 million went unspent.

¹² JLBC revised figures near the end of 1999 because of slow enrollment in the federally assisted, low-income health care insurance program, Child Health Insurance Program (CHIP).

FIGURE 5
DETAIL OF PROGRAM AND LINE-ITEM EXPENDITURES AND REVENUE FLOW¹⁴
MEDICALLY NEEDY ACCOUNT, FY 1995-2005
 (actuals through FY 1999, estimates thereafter)¹³

	FY 1995 (partial year)	FY 1996	FY 1997
FUNDS AVAILABLE			
Balance Forward		\$39,369,600	\$101,271,100
Transfer in from Tobacco Tax and Health Care Fund	\$39,174,100	89,036,200	82,829,400
Interest and Revertments			4,974,400
Total Funds Available	\$39,174,100	\$128,405,800	\$189,074,900
ALLOCATION			
AHCCCS Medically Needy Allocations:			
Offset Loss in Federal Funding			\$ 2,021,200
Phase-Down of Quick Pay Discount			4,522,800
\$10 M Hospital Reimbursement			10,000,000
Maternity Length of Stay			
HIV/AIDS Treatment			
Medical Inflation			
Organ Transplants	\$1,003,000	\$ 734,800	\$ 1,707,900
Medical Stabilization Fund		14,065,400	45,000,000
Premium Sharing Fund			20,075,000
CHIP (KidsCare)			
DHS Health Crisis Fund			
DES Aging and Adult Administration			
DHS Medically Needy Allocations:			
Primary Care Programs		\$ 3,600,000	\$ 4,134,700
Qualifying Community Health Centers		3,600,000	4,404,100
Telemedicine		255,000	255,000
Mental Health Non-Title XIX		3,489,800	5,000,000
Detoxification Services		500,000	500,000
Renal Disease Management			150,000
Basic Children's Medical Services			1,429,600
Evaluations			282,000
Total Funds Allocated	\$1,003,000	\$26,245,000	\$99,482,300
TOTAL FUNDS UNALLOCATED	\$38,171,100	\$102,160,800	\$89,592,600

¹³ These figures from the Joint Legislative Budget Committee, annual appropriation reports (published) and other JLBC projections.

¹⁴ These figures from the Joint Legislative Budget Committee, annual appropriation reports (published) and other JLBC projections (provided to Morrison Institute for Public Policy). These figures were updated by JLBC in November 1999 to reflect modifications to future year projections.

FIGURE 5
DETAIL OF PROGRAM AND LINE-ITEM EXPENDITURES AND REVENUE FLOW¹⁴
MEDICALLY NEEDY ACCOUNT, FY 1995-2005

(actuals through FY 1999, estimates thereafter)¹³

	FY 1998	FY 1999	FY 2000	FY 2001
FUNDS AVAILABLE				
Balance Forward	\$89,592,600	\$87,552,800	\$89,210,600	\$83,989,100
Transfer in from Tobacco Tax and Health Care Fund	81,503,300	80,526,900	79,117,700	77,924,100
Interest and Revertments	4,648,000	3,600,600	3,926,300	4,047,800
Total Funds Available	\$175,743,900	\$171,680,300	\$172,254,600	\$165,961,000
ALLOCATION				
AHCCCS Medically Needy Allocations:				
Offset Loss in Federal Funding	\$ 4,145,000	\$ 4,096,500	\$ 4,542,200	\$ 4,542,200
Phase-Down of Quick Pay Discount	7,978,800	6,300,600	6,794,600	8,206,700
\$10 M Hospital Reimbursement	10,000,000	10,000,000	10,000,000	10,000,000
Maternity Length of Stay	1,919,000	4,213,300	2,485,800	2,572,800
HIV/AIDS Treatment	1,223,900	1,025,800	1,229,900	1,349,600
Medical Inflation	—	—	5,276,000	5,276,000
Organ Transplants	1,619,200	3,500,000	3,590,000	3,590,000
Medical Stabilization Fund	15,000,000	—	—	—
Premium Sharing Fund	20,325,000	20,400,000	400,000	—
CHIP (KidsCare)	—	9,251,100	15,172,000	11,805,900
DHS Health Crisis Fund	1,000,000	862,800	21,000	—
DES Aging and Adult Administration	500,000	500,000	500,000	500,000
DHS Medically Needy Allocations:				
Primary Care Programs	\$5,983,200	\$5,619,700	\$6,240,000	\$6,240,000
Qualifying Community Health Centers	6,874,900	4,998,600	5,200,000	5,200,000
Community Health Centers	—	—	4,000,000	4,000,000
Telemedicine	368,300	126,300	260,000	—
Mental Health Programs for Non-Title 19	5,000,000	5,096,800	5,200,000	5,200,000
Detoxification Services	500,000	513,600	520,000	—
Renal Disease Management	250,000	239,100	260,000	260,000
Basic Children's Medical Services Program	4,086,300	2,294,300	—	—
Evaluations	242,600	298,400	854,200	854,200
Public Health Education	957,600	—	2,777,800	2,341,500
Rural Primary Care Provider Loan Repay Program	16,100	37,500	139,000	111,200
Primary Care Capital Construction	136,200	1,356,200	2,500,000	—
Salome Health Services	65,000	—	—	—
HIV/AIDS Drug Assistance Prog (ADAP)	—	1,698,100	1,000,000	1,000,000
Nonrenal Disease Management	—	9,300	208,000	208,000
CHIP Direct Services	—	31,700	1,000,000	1,000,000
Ajo Health Services	—	—	95,000	—
Psychotropic Medications for SMI Non-Title XIX	—	—	3,000,000	3,000,000
Psychotropic Medications – One-Time Allocation	—	—	5,000,000	—
Total Funds Allocated	\$88,191,100	\$82,469,700	\$88,265,500	\$77,258,100
TOTAL FUNDS UNALLOCATED	\$87,552,800	\$89,210,600	\$83,989,100	\$88,702,900

FIGURE 5
DETAIL OF PROGRAM AND LINE-ITEM EXPENDITURES AND REVENUE FLOW¹⁴
MEDICALLY NEEDY ACCOUNT, FY 1995-2005

(actuals through FY 1999, estimates thereafter)¹³

	FY 2002	FY 2003	FY 2004	FY 2005
FUNDS AVAILABLE				
Balance Forward	\$88,702,900	\$92,620,739	\$94,583,549	\$95,399,700
Transfer in from Tobacco Tax and Health Care Fund	76,755,239	75,603,910	74,469,851	73,352,804
Interest and Revertments	4,422,500	4,205,600	4,226,300	4,218,800
Total Funds Available	\$169,880,639	\$172,430,249	\$173,279,700	\$172,971,304
ALLOCATION				
AHCCCS Medically Needy Allocations:				
Offset Loss in Federal Funding	\$ 4,542,200	\$ 4,542,200	\$ 4,542,200	\$ 4,542,200
Phase-Down of Quick Pay Discount	8,206,700	8,206,700	8,206,700	8,206,700
\$10 M Hospital Reimbursement	10,000,000	10,000,000	10,000,000	10,000,000
Maternity Length of Stay	2,572,800	2,572,800	2,572,800	2,572,800
HIV/AIDS Treatment	1,349,600	1,349,600	1,349,600	1,349,600
Medical Inflation	5,276,000	5,276,000	5,276,000	5,276,000
Organ Transplants	3,590,000	3,590,000	3,590,000	3,590,000
Medical Stabilization Fund	—	—	—	—
Premium Sharing Fund	—	—	—	—
CHIP (KidsCare)	13,396,200	14,066,000	14,769,300	15,507,800
DHS Health Crisis Fund	—	—	—	—
DES Aging and Adult Administration	500,000	500,000	500,000	500,000
DHS Medically Needy Allocations:				
Primary Care Programs	\$6,240,000	\$6,240,000	\$6,240,000	\$6,240,000
Qualifying Community Health Centers	5,200,000	5,200,000	5,200,000	5,200,000
Community Health Centers	4,000,000	4,000,000	4,000,000	4,000,000
Telemedicine	—	—	—	—
Mental Health Programs for Non-Title 19	5,200,000	5,200,000	5,200,000	5,200,000
Detoxification Services	—	—	—	—
Renal Disease Management	260,000	260,000	260,000	260,000
Basic Children's Medical Services Program	—	—	—	—
Evaluations	854,200	854,200	854,200	854,200
Public Health Education	753,000	670,000	—	—
Rural Primary Care Provider Loan Repay Program	111,200	111,200	111,200	111,200
Primary Care Capital Construction	—	—	—	—
Salome Health Services	—	—	—	—
HIV/AIDS Drug Assistance Prog (ADAP)	1,000,000	1,000,000	1,000,000	1,000,000
Nonrenal Disease Management	208,000	208,000	208,000	208,000
CHIP Direct Services	1,000,000	1,000,000	1,000,000	1,000,000
Ajo Health Services	—	—	—	—
Psychotropic Medications for SMI Non-Title XIX	3,000,000	3,000,000	3,000,000	3,000,000
Psychotropic Medications – One-Time Allocation	—	—	—	—
Total Funds Allocated	\$77,259,900	\$77,846,700	\$77,880,000	\$78,618,500
TOTAL FUNDS UNALLOCATED	\$92,620,739	\$94,583,549	\$95,399,700	\$94,352,803

TRACKING PROPOSITION 200'S IMPLEMENTATION, FUNDING FLOWS, AND PROGRAMS

Q: Is it possible that the money has not been spent because of a lack of demand and/or need?

A: Although slow-starting, there are some indications that enrollment for several programs is increasing as information and marketing about the programs spread. Further, based on numerous studies, the unserved medically needy/medically indigent population in Arizona is substantial.

As noted previously, a number of factors have contributed to the fact that large portions of the Medically Needy/Medically Indigent money have not been spent. Prominent among these factors have been the slow creation of programs because of both initial political opposition and a lack of needs data, and inadequate outreach and marketing of several large programs.

When the Premium Sharing program was created out of the Medically Needy Account in 1997, a cap on total enrollment was established at 6,000 people. The cap was established because lawmakers and the program's administrators were simply unsure what demand for the program might be and they did not want to exceed the program's budget capacity. Just over a year into the program, however (in May 1999), enrollment stood at 4,046, well below the cap. Similarly, the KidsCare (SCHIP) program, designed to provide a health care safety net for as many as 60,000 of Arizona's children, has not seen the enrollment growth that was expected when the program was created.

According to the interviews conducted for this project, the explanation for these low enrollments is inadequate outreach and marketing of the programs. In 1999, outreach increased significantly for both the KidsCare and Premium Sharing programs, and, according to both programs, enrollment is expected to grow in the coming years.

The larger question of whether there exists substantial and unmet health care needs in Arizona among the state's medically needy and medically indigent population is difficult to precisely quantify. However, annual data from reports such as the Anne E. Casey Foundation *Kids Count* data book and other sources indicate that Arizona has significant needs. Some national studies indicate that as many as 280,000 Arizona children are without health insurance – roughly one out of every six. The 1999 *Kids Count* placed Arizona 49th out of the 50 states in the percentage of babies born to mothers who receive late or no prenatal care. In 1997, roughly 74 percent of Arizona's 2-year olds were immunized, below the overall U.S. estimate of 78 percent. Further, three years of data collection in Maricopa County indicate that roughly 14 percent of the population in the state's largest metropolitan county are uninsured.¹⁵

Some national studies indicate that as many as 280,000 Arizona children are without health insurance – roughly one out of every six. The 1999 Kids Count placed Arizona 49th out of the 50 states in the percentage of babies born to mothers who receive late or no prenatal care.

¹⁵ Data from Anne E. Casey Foundation. Maricopa County uninsured number from *What Matters in Greater Phoenix*, Morrison Institute 1998.

PEOPLE AND PROGRAMS SERVED BY PROPOSITION 200

overview

An attempt to evaluate the overall or aggregate performance of the Medically Needy Account is difficult because of the variety of programs and inconsistent data available from them. In the final analysis, although some conclusions can be drawn about increased access to services in general, few conclusions can be drawn about the quality or performance of the programs operating within the Medically Needy Account. This is because a majority of the data is merely demographic information regarding the clientele served.

Evaluations of tobacco tax programs should be conducted by a private entity, or at least an independent entity outside of the agency charged with running and administering the programs.

The basic “numbers served” information collected by many programs tells us that expenditures in the Medically Needy Account are increasing access to healthcare services in Arizona. In addition, the demographic data from a number of programs indicate that services are mostly being provided to the groups intended by the initiative (the medically needy, medically indigent and low-income children). Since 1995, Medically Needy Account funds have provided at least 150,000 medical services.

While Arizona’s “smelly, puking habit” tobacco cessation campaign has proven popular with the public, a September 1999 report by the Arizona Auditor General was critical. The report stated that the campaign has done a poor job of quantifying its effectiveness among youth because it failed to conduct a baseline survey before initiating the campaign. Other evaluations have been more positive. However, despite Arizona’s difficulties in quantifying the cessation program’s effectiveness, both California and Massachusetts have seen substantial decreases in their per capita tobacco consumption following the imposition of a similar cessation campaign. Based on case studies of the California and Massachusetts experiences, the U.S. Centers for Disease Control (CDC) has concluded that the combination of a tobacco cessation program and an increase in taxes is the most effective way to reduce tobacco consumption. Both factors are in place in Arizona following the 1994 passage of Proposition 200.

Q: What do we know about the programs created and the people being served by the Medically Needy Account?

A: For a handful of programs in the Medically Needy Account, client and demographic data have been collected well. For other programs, however, data collection is lacking. In aggregate, little can be said about the programs and people served by the Medically Needy Account.

One of the primary challenges of this project was to compile data on the programs created by Proposition 200 tobacco tax revenue and the people affected by them in order to generally assess the expenditures and their performance. A casual perusal of the more than two-dozen past and present line-item expenditures listed in the Medically Needy Account (see Figure 5) begins to reveal the potential complexities of data collection with this set of diverse programs. Indeed, when this project began to focus on each of the Account’s programs, line items, and the multitude of laws that created

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them, the inconsistency of the data collection and evaluation quickly appeared.

One of the first problems encountered with Medically Needy Account program data is that some of the expenditures simply defy data collection. Of the 26 program line items listed in the Medically Needy Account¹⁶ (Figure 5), only 14 are expenditures or programs that provide some type of direct medical or health care-related service to a client.¹⁷ The other 12 are expenditures that provide client service only indirectly, such as the rural physician loan-payback program.

Obviously, for the programs through which clients only receive indirect benefits, the only possible information to know is who is being served *categorically*. For example, because of eligibility criteria, we know that medically needy or medically indigent mothers are the primary beneficiaries of the funds allocated to the program to pay for the 48-hour maternity length of stay program. Similarly, we can be sure that rural citizens are the beneficiaries of the rural physician loan payback program. But other line-item expenditures — such as funds to offset the increases in costs due to inflation — simply have no program performance data to collect.

For many of the direct service programs created under the Medically Needy Account, program performance data collection is sparse. At worst, data collection is nothing more than a head count of persons served by the program. Within the variety of programs, however, there are examples on both ends of the spectrum: good and not so good. The common denominator across the board seems to be decent output data, but an overall lack of performance data and a lack of consistency with data collection.

An example is the organ transplant program. Created in 1995, the transplant program was the first and only program to spend Medically Needy Account funds in 1995. Because there was no required data collection mandated in the enacting law, however, AHCCCS has collected information

for its own purposes from the nine facilities that conduct the transplant procedures. After four years of operating the program, what can be said about the program? Between fiscal year 1996 and the end of fiscal 1999, a total of 52 transplants were conducted: 36 bone marrow, 6 liver, 5 heart, 3 lung, and 2 heart/lung. Basically, AHCCCS keeps track of how many transplant operations have been conducted, the type of transplantation operations conducted, how many persons were Title XIX eligible and how many were medically needy/medically indigent, and how many are approved and waiting. What is not revealed about the transplant program is the “success” of the transplants, the health status of the persons who received transplants, or anything else that might provide insight into the “quality” or performance of the program. In all fairness to AHCCCS, it was not their mandate to collect this type of information, and it is extremely difficult to do so.

The Arizona Department of Health Services annually produces a 200-plus page, statutorily-mandated “evaluation” report regarding four programs under its administration: Primary Care Program (parts a and b), the Children’s Hospital Program (also known as the Basic Children’s Medical Services Program), the Telemedicine program, and the Behavioral Health Program. The executive summary of the thick report contains summary information on demographics and numbers served for each of the programs. The text of the report contains geographic information regarding services rendered (i.e., how many services delivered per county, etc.), the most common services, and some client

One of the first problems encountered with Medically Needy Account program data is that some of the expenditures simply defy data collection.

¹⁶ Figure 5 actually lists 31 line items, but 5 are transfers to other funds and programs.

¹⁷ For the purposes of this discussion, an example of a “direct client service” program is one that provides a specific service to a specific client, for example, a heart transplant.

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satisfaction data. Although some of the data in the report are useful in understanding the type of person who is being served by the program, there is little information one can use to assess the performance or quality of the programs and/or what modifications might be undertaken to improve the services.

In addition, interviews conducted for this project revealed that many persons find the DHS evaluation report of only marginal use because of 1) the poor readability of the document, and 2) the fact that ADHS is evaluating its own programs. Perhaps not surprisingly – given the fact that it is in effect a self-evaluation – the report contains numerous key accomplishments and success stories.

It appears from interviews that only a relatively limited audience outside of the Legislature read the report, and perhaps even fewer inside of the Legislature read it as well. In addition, as was mentioned earlier, the Legislative oversight committee that is supposed to receive this evaluation report annually in November, has reportedly never met.

The line-item allocation to DHS for this self-evaluation report has been more than \$240,000 annually for fiscal years 1997-99, and has increased to \$854,000 annually beginning in FY2000. Clearly, to maximize this significant expenditure and to improve usage and validity of this report, the evaluation should be moved out of the agency to a private, or at least independent, evaluator.

Other programs funded out of the Medically Needy Account have better program data. The Premium Sharing Project, which began as a pilot program, has been funded with \$20 million during each of fiscal years 1997-99. Premium Sharing has statutorily mandated data collection and evaluation, which is conducted independently by Arizona Legislative Council. According to the law, a semi-annual report must contain information about client satisfaction, program enrollment information, average annual income of the enrollee, total monies collected from enrollees, and other information “necessary to analyze and evaluate the project’s effectiveness or impact.”

The bottom line regarding data gathering for Medically Needy Account expenditures is this: because of the wide disparities among enacting statutes, some programs collect comprehensive data and provide some type of reporting regularly, while others mandate less collect data collection, less frequently. Still other programs, with virtually no guidance from their enacting statutes, collect the kind and amount of data they want to, when they want to. There is little coordination or consistency among the data collection for Medically Needy Account programs. Further, several programs are self-evaluated by the agency which administers them – a situation which creates obvious credibility problems.

Q: What then can be said – in aggregate – about the people and programs served by the Medically Needy Account expenditures?

A: About 150,000 medical services have been rendered since 1995, although an average of \$96 million has annually gone unallocated.

Between FY1995 and the end of FY1999, just under \$298 million was allocated in the Medically Needy Account and more than 150,000 medical services were provided.¹⁸ As was mentioned earlier in the document, an average of \$90 million has gone unallocated every year since 1995.

Although one might be tempted to immediately divide the amount spent by the number of services rendered to obtain a cost “per medical service,” several things should be kept in mind when doing so. First, roughly \$75 million of the \$298 million allocated during the first five years was deposited into the rainy-day Medical Services Stabilization Fund, where it has gone mostly unspent until \$8 million was withdrawn in 1999. Second, not all services provided by the programs are anywhere close to equal. For example, the cost of a life-saving operation such as a heart or lung transplant is – understandably – much more significant than the cost of a child’s dental check-up at a community health center. Figure 6 depicts the total allocations by programs within the Medically Needy Account and the persons served by the programs, through FY1999.

¹⁸ It is potentially inaccurate to say that 150,000 “persons” have been served under the Medically Needy Account because many medically needy/medically indigent persons could qualify as eligible for several programs and potentially could have received service from more than one program.

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**FIGURE 6 MEDICALLY NEEDY ACCOUNT
TOTAL PROGRAM ALLOCATIONS AND PERSONS SERVED THROUGH FY99¹⁹**

PROGRAM/EXPENDITURE	YEARS OF ALLOCATIONS	TOTAL ALLOCATIONS	TOTAL NUMBER OF SERVICES PROVIDED THROUGH FY99
Transfer to Medical Services Stab. Fund	FY96, FY97, FY98, FY99	\$73,315,400	No direct client service ²⁰
Transfer to Premium Sharing Project	FY97, FY98, FY99	60,800,000	4,596
\$10M Hospital Reimbursement	FY97, FY98, FY99	30,000,000	No direct client service
Qualifying Community Health Centers	FY96, FY97, FY98, FY99	20,079,000	64,963
Phase-Down of Quick Pay Discount	FY97, FY98, FY99	20,048,000	No direct client service
Primary Care Programs	FY96, FY97, FY98, FY99	19,957,900	39,200
Mental Health Programs for Non-Title XIX	FY96, FY97, FY98, FY99	18,869,800	29,116
Offset Loss in Federal Funding	FY97, FY98, FY99	10,708,400	No direct client service
Transfer to CHIP Fund	FY99	9,251,000	11,452
Organ Transplants	FY95, FY96, FY97, FY98, FY99	8,564,900	52
Basic Children's Medical Services Program	FY97, FY98, FY99	8,115,900	2,178
CHIP Direct Services	FY99	8,000,000	(see CHIP Fund)
Maternity Length of Stay	FY98, FY99	6,132,300	No direct client service
HIV/AIDS Treatment	FY98, FY99	3,697,800	See footnote ²¹
Primary Care Capital Construction	FY98, FY99	2,636,200	No direct client service
Detoxification Services	FY96, FY97, FY98, FY99	2,020,000	2,215
Transfer to DHS Health Crisis Fund	FY98, FY99	1,862,800	No direct client service
HIV/AIDS Drug Assistance Program	FY99	1,700,000	Approx. 570
Evaluations	FY97, FY98, FY99	1,378,800	No direct client service
Telemedicine	FY96, FY97, FY98, FY99	1,138,300	232
Transfer to DES Aging and Adult Admin.	FY98, FY99	1,000,000	737
Public Health Education	FY98 (begins again in FY2000)	957,600	No direct client service
Renal Disease Management	FY97, FY98, FY99	660,000	Approx. 1,500 annually
Nonrenal Disease Management	FY99	208,000	6
Rural Primary Care Provider Loan Repay Prog.	FY98, FY99	69,000	No direct client service
Salome Health Services	FY98	65,000	No direct client service
Community Health Centers	Started FY2000		
Ajo Health Services	Started FY2000		
SMI Non-Title XIX Psychotropic Meds	Started FY2000		
Psychotropic Medications (One-Time Allocation)	Started FY2000		
TOTAL		\$311,236,100	159,817

¹⁹ Figures retrieved by Cannon & Gill; compiled and presented by Morrison Institute for Public Policy.

²⁰ In FY99, \$8 million of the Medical Services Stabilization Fund was allocated to Healthcare Group, a state-sponsored pre-paid medical coverage program for small businesses and political subdivisions of the state with fewer than 50 employees. There were 12,546 members enrolled in Healthcare Group in July 1999.

²¹ An unduplicated count of members by year receiving protease inhibitors is not available from AHCCCS. An average of 250 members per month are reported by the health plans to be receiving protease inhibitors for the Acute and the ALTCS programs.

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Q: Do we know if the populations targeted for service by the Medically Needy Account are measurably healthier because of the programs?

A: It is likely that some people are healthier (such as those who have received life-saving transplants) because the Medically Needy Account programs have increased the availability of a number of services.

Considering the tens of millions of dollars being spent annually on programs in the Medically Needy Account, a reasonable and logical question seems: are the people being served any healthier? Indeed, this basic question was among the highest on the list of this research project at the outset.

However, as indicated in the previous section, the data and evaluation information collected for this study make it difficult to say much of anything about the Medically Needy Account programs, aside from the numbers of people served and general demographic information about the persons served. That is, some conclusions about individual program *outputs* might be drawn, but little can be said about the *outcomes* produced in Arizona by the programs.

While the question of the level of “quality” or efficiency of the programs is difficult to answer, the question of the Medically Needy Account’s overall effectiveness might be considered from a different perspective. Proposition 200 was passed by the citizens of Arizona primarily to provide medical services to low income children, medically needy and medically indigent persons. We know, based on the basic head-count data provided by the programs in the Medically Needy Account, that thousands of low income children, medically needy and medically indigent persons have received services since 1995 because of the programs.

Thus, have Proposition 200 programs been “effective” in providing service to these needy populations? The only possible answer to that question is “yes” because an expansion of the availability of services has occurred.

And, based on that expansion of services, options, and the numbers of people that have been served in the programs (according to the program data), it is reasonable to assume

that a portion of the population defined as “medically indigent or medically needy” in Arizona are at least somewhat healthier by virtue of the fact that they are receiving services where they might not have before – although quantifying this supposition is difficult.

Q: One of the other stated goals of Proposition 200 in 1994 was to reduce smoking and prevent youth smoking in Arizona. Has it worked?

A: Evaluations of the Tobacco Education and Prevention Program (TEPP) have been mixed, and Arizona’s youth smoking cessation efforts have not yet been quantified. However, the combination of tax increases and cessation campaigns have worked well in other states.

During the past several years, tobacco consumption has generally been decreasing throughout the United States for a variety of possible reasons, including cessation efforts and increases in taxes and the cost of tobacco products.

Arizona’s now nationally-famous “smelly-puking-habit” smoking cessation campaign (the Tobacco Education and Prevention Program, or TEPP) is funded out of the second largest account created by Proposition 200, the 23 percent Health Education Account.²² While the creative anti-smoking ads have now become a proud part of Arizona popular culture, evaluations of it have been mixed.

A two-volume TEPP summary report was produced by a private evaluation team for the Arizona Department of Health Services. Generally, the report was complimentary to the local coalition building and participation of the TEPP, and suggested that these strong efforts would lead to tobacco cessation and prevention. A January 1999 report by a UofA/ASU team examined the media costs of the TEPP and concluded that the public was recalling many of the campaign’s advertisements, although a per-person cost per-ad-recall was quite high as well.

²² The tobacco-industry-funded Tobacco Institute reported in 1999 that Arizona per capita cigarette sales to those over age 14 dropped from 127 per year in 1980 to 66 per year in 1999.

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In September 1999, however, the Arizona Auditor General was critical of the TEPP for not adequately quantifying its effectiveness as a smoking deterrent. According to the report, a baseline of youth tobacco use in Arizona was never conducted prior to the launch of the campaign, thus making it difficult to assess whether or not the prevention program is working. The Auditor General report commented: “Evaluation efforts since the Program’s 1995 inception have yielded inconclusive results.”²³ The report also stated TEPP has been more successful at determining adult prevalence levels and has taken steps to improve evaluation efforts. Evaluations of the statewide advertising campaign and adult prevalence rates are expected to be available in early 2000.

Despite the problems with measuring the possible effectiveness of Arizona’s tobacco cessation campaign, several other states have tobacco-prevention education campaigns in place and have had success measuring decreases in tobacco usage.

California voters increased tobacco taxes with Proposition 99 in 1988 and Massachusetts voters did the same with a ballot initiative in 1992. The implementation of statewide anti-smoking campaigns in each state seems to have directly contributed to greater reductions in per capita tobacco use than the rest of the nation. From 1992 through 1996, per capita tobacco consumption declined 19.7 percent in Massachusetts and 15.8 percent in California, but only about 6 percent in the rest of the nation.²⁴

While the imposition of a tobacco tax has been proven effective in some states in reducing tobacco consumption, the Centers for Disease Control has concluded that a tax increase combined with an antismoking campaign can be more effective in reducing per capita tobacco consumption than just a tax increase alone.²⁵ Indeed, although a reduction in smoking prevalence in Arizona has yet to be strongly proven by evaluation, it appears that what Arizona did by passing Proposition 200 in 1994 – creating a tax increase and an antismoking campaign – is likely to produce results.

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²³ Arizona Auditor General, “Department of Health Services’ Tobacco Education and Prevention Program,” Report No. 99-17, September 1999.

²⁴ Centers for Disease Control. “Cigarette Smoking Before and After an Excise Tax Increase and an Anti-Smoking Campaign – Massachusetts, 1990-1996” 1996; 45:966-70.

²⁵ Ibid.

LESSONS LEARNED FROM ARIZONA'S TOBACCO TAX FOR SPENDING THE SETTLEMENT

What are the lessons to be learned from Arizona's five-year experience with Proposition 200 (the Tobacco Tax and Health Care Act) and the Medically Needy Account? Based on the findings of this report, there are four primary lessons that can be taken forward as Arizona considers various options for spending its share of the multi-state tobacco settlement.

FIRST, DECIDE ON A DESIRED IMPACT OR IMPACTS.

Almost immediately after passage of Proposition 200, millions of dollars began to pour into the Medically Needy Account. Initially, because of politics and the absence of a plan, spending started slowly. But it did not take long before politicians and special interests began to understand the opportunity created by the significant sums of money. Soon, the money was scattered in a complex patchwork of diverse programs created under the medically needy heading.

As with the Proposition 200 revenues, the nearly \$3 billion scheduled to come to Arizona over the next 25 years represents an enormous opportunity for the state. Considering the experience of Proposition 200, the question becomes a rather simple one: should the state duplicate the politics-plus-“shotgun blast” model that has occurred with the tobacco tax money, or would the state be better served spending the settlement in a more needs-based, “laser-guided” manner?

Although many have benefited from one or more of the programs created by Prop. 200, we believe the state would undoubtedly be better served by looking at the settlement as a chance to do one or several significant things, whether they are in health care or any of the other multitudes of possibilities proposed.

Should the state decide that the monies – or a large portion of the funds – would best be spent on the broad category of health care in Arizona, a comprehensive needs assessment should be performed before allocating or dedicating the money to specific purposes. Such a needs assessment will ensure that the revenue goes toward the state's actual needs, not just “pet” or perceived needs, as has occurred with many Prop. 200 programs.

Finally, when allocation of Arizona's settlement monies begins, the state should remain cognizant of the potential shriveling up over the long term of the funds due to tobacco company bankruptcy or substantial declines in tobacco consumption – both of which are possible, and indeed, likely.

MAKE IT SIMPLE AND IMPLEMENT IT WELL.

One of the difficulties encountered in this research paper with attempting to assess the overall performance of the Tobacco Tax and Health Care Act was its complexity, particularly in the Medically Needy Account. Funds are transferred from one account to another, from one agency to the next, and passed through different programs on their way to other programs that – as noted previously – are treated very inconsistently in areas such as data collection and reporting. During the information collection phase of this research, multiple contacts were necessary at multiple agencies and within dozens of programs which, it seems, do not communicate with one another.

In addition, because Legislative oversight has been lacking for a variety of reasons, there has been little attention paid to the tobacco tax's “big picture,” including the amount of revenues available, large amounts of which continue to be carried over from year to year. In many ways, it's been political business as usual.

With potentially \$3 billion at stake over 25 years, Arizona would be wise to make sure that spending the tobacco settlement isn't business as usual, and that the funds are continually monitored and looked-after. If Arizona looks at the tobacco settlement monies as a unique opportunity to do one or two significant things, it will go a long way toward 1) making a large impact and 2) simplifying implementation.

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But simplification might prudently go further. This is not to imply that the creation of a new “tobacco” bureaucracy is necessary in Arizona. Quite the contrary, it can simply mean the establishment of a central point of departure for tobacco settlement or the combination of tobacco settlement and tobacco tax dollars. The trust fund, endowment, or foundation concept being adopted in other states might work well for this purpose, so long as strict guidelines are established so that the funds cannot be simply raided the next time the state’s general revenues decline.

By adopting this type of structure, disbursal of the monies can be centralized, and program implementation and an overarching purpose for data collection can reside in one location, instead of several or even dozens. In addition, this single location can be responsible for watching after the “big picture” of the tobacco settlement in Arizona, something that is currently sorely missing with the millions of dollars of tobacco tax.

As was stated previously, many of Proposition 200’s problems came in its implementation, which was mostly half-hearted. Creating a plan and simplifying the structure of implementation will go a long way toward improvement. The last crucial step is implementation of the plan to an excellence standard. Arizona should strive for implementation that is the model for other states regarding how to spend tobacco settlement dollars. The plan and simplification of implementation are important, but the commitment to implementation excellence is also exceedingly important.

BE SMART ABOUT DATA COLLECTION AND EVALUATION.

Data collection and evaluation were both included (as noted, sporadically and inconsistently) at various times in implementation of the Tobacco Tax and Health Care Act. Often, however, it seemed to be merely data collection for the sake of data collection, inconsistent and barely usable. Indeed, data collection – as seen in the implementation of Proposition 200 – is too often seen as an adjunct to programs, in the same way that evaluation is frequently viewed as a requirement to be thought about after the more important work of implementation is done.

The clear lesson from Prop. 200 is that whatever the state decides to do with the settlement fund opportunity, data collection and evaluation should be included prominently, and thought about early on. It is critical that the Legislature regards performance measurement as an integral part of any spending plan.

What is “smart” data collection and evaluation? To be most effective, data gathering and evaluation must be addressed during program design by all stakeholders: legislators, program operations persons, and anyone else interested in outcomes. Simply telling or legislatively mandating programs to report data on their projects without actively involving them in the performance measurement process, without explaining how and by whom the data are going to be used can be counterproductive, and cause bureaucratic resistance and possibly data corruption.

Smart data collection design requires a discussion of:

- program or outcome objectives,
- the potential sources of data,
- potential problems that might be encountered,
- methods of data collection, and
- needed accuracy and reliability of the data.

A few considerations about data collection should guide the design of performance or data indicators. Above all, the data should measure results, not just processes, and the data should focus on what the project or projects are actually accomplishing. Stated simply, the primary focus should be to know 1) what the programs are doing and 2) whether they are doing any good.

Date collection for the sake of data collection does not benefit anyone or any program. The benefits of using performance data must at least equal the cost of collecting them. Some projects and programs can provide good information at a low cost by using existing data, sampling techniques, appraisal methods, and other creative collection methods. If possible, data monitoring and evaluation design should build on the reporting arrangements already in place.

Finally, providing funds to agencies to evaluate their own programs is not smart. Private, or at least outside data collection – as has occurred with the Tobacco Education and

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Prevention Program – has worked well so far and has been objective. In the end, data collection, studies and surveys, data analysis, and results reporting need to be independent and they need to occur in a format that is relevant, readable, and understandable by all stakeholders.

WATCH IMPLEMENTATION CLOSELY.

One final lesson learned from Arizona's Proposition 200 experience is that regardless of how the language of a ballot initiative is written or the law devised for implementation, politics will almost certainly find their way into the process. According to the interviews conducted for this project, the supporters of Proposition 200 believed that they had drafted an initiative that was essentially "self-enacting" with language that would completely bypass and avoid politics. Ultimately, they were proven wrong.

Thus, perhaps a key lesson for Arizona voters, consumer and public law advocates, and the media is to keep a close

eye on how any law or initiative passed in Arizona is implemented over time by the Legislature. If the Proposition 200 history is any guide, those who do not get what they want from the settlement might be tempted to stymie decision-making, or even undermine the final spending decisions. Keeping watch over how the money is spent and implemented will not only ensure that the will of the people is carried out, but it will probably also increase the impact of the funds, and in the long run, improve the public's trust in their elected officials.

While Arizona's temptations to spend the significant tobacco settlement money are many and varied, the State will do well to consider the experience of implementing 1994's Proposition 200 tobacco tax increase and the lessons that can be learned from it. By not paying attention to and learning these lessons, it is possible that Arizona will welcome the year 2025 without remembering the opportunity presented by the multi-state tobacco settlement of 1998.

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ARIZONA AND THE MULTI-STATE TOBACCO SETTLEMENT

overview

The multi-state settlement agreement signed in November 1998 was the culmination of several years of litigation and negotiation between the Attorneys General of 46 states and the major tobacco producers in the U.S. Arizona's share of the settlement is projected to be approximately \$3 billion over the next 25 years, with so-called "up front" payments of roughly \$171 million during the first five years. The amount of payments ultimately received in Arizona is subject to many variables, most of which would cause the settlement amount to be less than projected today.

The settlement requires states to achieve State Specific Finality (state court approval) before receiving any funds, and at least 80 percent of the states in the agreement representing 80 percent of the funds need to achieve State Specific Finality before any state receives any money. If a state does not achieve Finality by the end of 2001, it will receive no funds. Arizona's State Specific Finality is currently being held up by a pending lawsuit filed by the state's counties, who are seeking a portion of the funds.

Although Arizona has not yet decided how to spend its portion of the settlement, many other states have. A number have looked at or adopted an overarching structure such as a trust fund, endowment, or a foundation to receive and decide how the money is to be spent. Several states – including Michigan – have created funds that allow a non-legislative board discretion in spending some or a large portion of the money. As far as actually spending the money, the ideas brought forward in states range from broad healthcare and tobacco cessation to prescription drug assistance for the elderly, to college scholarships, to technology infrastructure, to a "troubled youth" program.

Q: How did the multi-state tobacco settlement come about?

A: After Mississippi and several other states filed and then settled liability lawsuits with several large tobacco companies in the mid-1990s, 46 states (including Arizona) filed suit and eventually reached a settlement in 1998.

In early 1994, a coalition calling itself "Arizona for a Healthy Future" began collecting signatures to place the Tobacco Tax and Health Care Act (Proposition 200) on the Arizona ballot in November. Although the potential ballot initiative signaled yet another threat to tobacco, the industry was facing several other threats, and at significantly higher stakes than what was being discussed in Arizona.

On April 14, 1994, representatives of the largest tobacco manufacturers in the U.S. stood before a Congressional committee and swore under oath that they did not believe

that nicotine in cigarettes was an addictive substance and that they did not actively market their products to young people. The testimony made front-page news. According to one commentator, the tobacco executives' testimony was "so incredible and unbelievable that the (tobacco) industry's traditional arguments – about the whole issue of choice – were tainted even in the eyes of people who wanted to be rational about cigarette companies."²⁶ After successfully fighting off numerous lawsuits over the decades, the tobacco industry suddenly seemed vulnerable.

On May 23, 1994, a little more than a month after the Capitol Hill hearing, Mississippi filed suit against the tobacco industry to recover Medicaid expenditures for tobacco-related illnesses. In filing this first-of-its-kind suit,

²⁶ Quote from John Scanlon, a long-time public relations official for the tobacco industry, as quoted in Policy.com, "The Tobacco Settlement," April 16, 1998.

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the Attorney General of Mississippi claimed his motivation was the state's taxpayers: "I (seek to) spare Mississippi taxpayers from paying medical bills that are the tobacco companies' responsibility."²⁷ The states of Florida, Texas and Minnesota quickly followed Mississippi's lead and filed their own suits, and the four eventually reached a \$40 billion settlement with the tobacco industry.

In 1996, Arizona Attorney General Grant Woods filed suit against the tobacco companies, and by 1997, a total of forty-six states and a number of U.S. territories had also followed the lead of Mississippi. All sought payment from the industry giants for the costs their states had absorbed for treating tobacco-related illness.

The protracted court battle and closed-door negotiations that ensued led to a historic November 1998 signing of a \$206 billion multi-state settlement agreement.

Q: Who are the parties to the agreement and what specifically does the settlement call for?

A: 46 states and four tobacco companies signed the agreement in November 1998. Among other things, the settlement calls for financial payments to the states in perpetuity.

The attorneys general of 46 states (including Arizona) and several U.S. territories signed the settlement agreement. The four tobacco companies who signed the original agreement account for more than 95 percent of total cigarette sales in the United States. They are Brown & Williamson, Lorillard Tobacco Company, Phillip Morris, and R.J. Reynolds Tobacco Company. Several smaller tobacco manufacturers have joined in the settlement since late 1998, such that the companies involved in the agreement now account for greater than 99 percent of total national cigarette sales.

While the details of the "Master Settlement" are somewhat complex, the overarching concepts of the settlement agreement are straightforward. The states' Attorneys General dropped more than 40 pending lawsuits and agreed not to sue to recover Medicaid-related expenses in the future. In exchange, the tobacco companies consented to pay roughly \$200 billion in payments to the states over the next 25 years, and agreed to restrict their tobacco marketing efforts and put new efforts into reducing tobacco consumption by youth.

FIGURE 7 MAJOR PROVISIONS OF THE SETTLEMENT AGREEMENT

PAYMENTS TO STATES

Tobacco manufacturers will make payments to the states in perpetuity, with a total of approximately \$206 billion during the next 25 years.

FOUNDATION AND PUBLIC EDUCATION

The tobacco industry will contribute \$1.4 billion over the next five years for a national advertising and education campaign about tobacco. In addition, the industry will fund and create a \$250 million foundation that will develop an advertising and education program to discourage tobacco use, especially among teens.

ADVERTISING AND EVENT SPONSORSHIP LIMITATIONS

Tobacco manufacturers will no longer use outdoor advertising or apparel and merchandise with product logos to market their brands. In addition, they will no longer target youth in advertising or use cartoon characters in ads. Sponsorship of events is limited to one brand-name sponsorship per year.

INDUSTRY RESTRICTIONS

The tobacco industry will discontinue funding the Tobacco Institute and disband it, and lobbyists for the industry are prohibited from opposing proposed laws intended to limit youth access or usage of tobacco.

DOCUMENT DISCLOSURE

The tobacco manufacturers will open a website that includes the full content of all documents released during or related to any smoking/health-related lawsuit.

Source: California Legislative Analyst's Office, "The Tobacco Settlement," January 14, 1999.

Q: What is Arizona's anticipated share of the tobacco settlement, and when will the money begin to flow into the state?

A: Arizona could receive as much as \$3 billion over 25 years. Because of a pending appeal by the state's counties, however, it is unclear when and/or if the money might start to flow.

²⁷ "Attorney General Files Groundbreaking Lawsuit Against Tobacco Cartel, Affiliated Organizations," Mississippi Office of the Attorney General (press release), May 23, 1994.

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Under the disbursement terms worked out by the collective group of Attorneys General, Arizona's portion of the settlement is scheduled to be roughly \$2.9 billion over the first 25 years of the agreement. The first series of disbursements, the so-called "up front" payments, will total roughly \$177 million during the first five years. A second stream of payments, which may begin sometime in 2000, will bring annual payments of \$59 million to the state. These annual payments are expected to grow to \$118 million per year by fiscal year 2018, to a total of \$2.8 billion by 2025. However, the settlement stipulates that payments to the states will continue indefinitely into the future, so long as tobacco products are consumed in the United States. Thus, it is possible that Arizona's settlement revenue may not end after 2025.

The beginning of financial payments to Arizona depends on a number of legal steps that are required both in Arizona

Arizona has not yet reached State Specific Finality. Any state not achieving finality by 12/31/01 will receive no settlement funds.

and the other states. Each state that is a party to the settlement is required to submit the agreement to state courts for approval, although the settlement does not require any explicit action be taken by the state legislature. When

the agreement is approved by the state courts, the state is said to have reached "State Specific Finality."

Funding does not automatically begin to flow at that point, however. Other provisions of the settlement provide that at least 80 percent of the states participating in the agreement representing at least 80 percent of total amount of funds in the settlement must reach "State Specific Finality" before the monies begin to be disbursed. However, the agreement also provides that the initial payments will begin to flow on June 30, 2000 to any state that has reached "State Specific Finality" even if the 80 percent/80 percent threshold is not met by that date. Any state without finality by December 31, 2001 will receive no settlement funds.

As of the end of September 1999, the 80/80 threshold cleared a significant hurdle when a group challenging the agreement in California decided not to appeal a lower court ruling against them. The decision cleared the way for finality in the largest state in the agreement. With California and New York at or near finality, it appears that funds will probably begin flowing prior to June 30, 2000.

As of the end of 1999, Arizona is one of eight states that have not yet reached finality. The states that have not reached "State Specific Finality" are Arizona, Alabama, Arkansas, Missouri, New Jersey, Pennsylvania, Tennessee and Virginia.

Q: Why has Arizona not yet reached State Specific Finality?

A: The lawsuit filed by a number of Arizona counties is holding up Arizona's State Specific Finality.

In early 1999, 14 of Arizona's 15 counties (excluding Pima) filed suit to claim an up-front share of the state's tobacco settlement funds. The counties claimed that most of the costs which the Attorney General sought to recover for the state in his original lawsuit against the tobacco industry had been paid for by the counties. In addition, they argued, when Attorney General Grant Woods filed his suit on behalf of the state and its "political subdivisions," the counties were implied as a party to the suit.

Therefore, the counties said they were entitled to a direct share of the state's settlement money, about 32 percent of the total settlement dollars. On March 3rd, 1999, however, a Maricopa County Superior Court Judge rejected the claims of the counties, saying, "One line (referring to political subdivisions) in a 300-paragraph complaint does not make the counties parties."²⁸

But the counties appealed the decision, and the unresolved appeal remains as the primary stumbling block in Arizona's quest for State Specific Finality. If the suit is not resolved by December 31, 2001, the state will not be a party to the settlement and will forfeit its entire portion of the settlement.

In California, a similar problem was averted because several county jurisdictions (including Los Angeles and San Francisco Counties) had filed their own lawsuits against the tobacco companies prior to the settlement agreement. Three months before the multi-state agreement was announced in November 1998, the California Attorney General entered into a Memorandum of Understanding (MOU) with the local

²⁸ Quote of Judge Barry Schenider. McCloy, Mike, "Tobacco Fund Plea is Denied; Maricopa County Loses Bid for Up-Front Money," *The Arizona Republic*, March 4, 1999.

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governments to coordinate their lawsuits and the potential settlement. As a result of that MOU, an even 50-50 split of the revenue will occur between the state and the local governments that sign on to the deal. Thus, of the estimated \$1 billion in annual payments expected, the state will receive \$500 million and the local governments will receive \$500 million.

Q: If and when the money does begin to flow into Arizona, are there any restrictions regarding how it can be spent?

A: There are essentially no restrictions regarding how the state can spend the money – it can be used for any purpose.

The settlement agreement imposes no restrictions regarding the use of the money by the states. The agreement did not mandate that the money be spent on public health programs, tobacco prevention, or any other specific purpose. The funds may be used as state matching funds for Medicaid.

In addition, under the terms of the agreement, no specific action is required by the state legislature to begin receiving the money. However, under law, the money will be deposited into each state's general fund, which is appropriated by the Legislature and the Governor.

As mentioned above, there are only two things required to begin receiving money in Arizona immediately: State Specific Finality (approval of the settlement in state court with no appeals pending) and completion of the 80/80 (80 percent of states/80 percent of the total monies) provision.

Q: Aside from achieving State Specific Finality, is there anything else that might reduce the amount of revenue scheduled to be received in Arizona?

A: There are some provisions of the settlement agreement that could substantially reduce how much money is ultimately received in Arizona.

In the short run, Arizona needs to resolve the dispute with the counties and then achieve State Specific Finality to begin receiving money. Over the long run, however, there are a number of possible factors that could reduce the amount of

money from the multi-state tobacco settlement that comes into Arizona, although there is one factor that could actually increase the amount. Nevertheless, it is possible – indeed probable – that much less than the estimated \$3 billion in total payments will materialize in Arizona.

According to the settlement agreement, smaller payments to the states could result if Congress enacts legislation prior to November 30, 2002 that mandates payments by the tobacco companies (through settlement or tax) which the federal government then makes available to the states for tobacco-related, health-related, or other unrestricted purposes. Thus, under this scenario, the net amount of revenue to Arizona might remain the same, but new federal restrictions could be imposed regarding the spending of the money.

The settlement also stipulates that if the federal government successfully seeks reimbursement from the tobacco companies for its tobacco-related Medicaid costs (either by seeking a piece of the states' settlement or by filing suit against tobacco companies in federal court), the amount of revenue to each state would be lowered.

The agreement also allows the tobacco companies to reduce the payments they make to the states if there is a significant drop in the nationwide sales of cigarettes. Each year, the amount of the payments to the states will be adjusted based on the volume of cigarettes shipped within the U.S. If the volume decreases, the amount of settlement will decrease. The likelihood of this provision affecting the total revenue disbursed is fairly high, particularly in light of recent increases in the price of tobacco products.

Further, in the event of a bankruptcy of one or more of the tobacco companies who signed the agreement, the payments to the states would decrease. It is important to note that several signers of the agreement are manufacturing subsidiaries of larger U.S. corporations. The larger parent corporations would not be responsible for settlement payments in the event that a subsidiary files for bankruptcy.

According to the agreement, there is one possibility that the payments to states could increase, although the actuality of more revenue is somewhat of a long shot considering the other provisions mentioned above. Payments are scheduled to be adjusted upward annually to inflation by either a flat three percent, or the national Consumer Price Index, whichever is greater. Thus, if the provision regarding the

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decreased volume of cigarettes shipped in the U.S. does not cause a decrease in the payments, it is possible that the states will receive more money due to an inflation adjustment.

Q: How might Arizona structure and spend the settlement?

A: The possibilities are many. Some states (such as Florida) are creating endowments or trust funds and spending only the interest. Others (such as Michigan) are making both one-time urgent need allocations, and on-going expenditures. In between, expenditures run the gamut.

Because the settlement places no restrictions on how individual states may spend the funds, how to spend the money has become a popular topic in virtually all states that are a party to the settlement agreement, Arizona included. Since the settlement was announced, Governor Hull's office has reportedly received several dozen recommendations for how to spend the settlement that, all totaled would reach several hundred million dollars.

A number of national and local-level advocates have worked hard to have the monies earmarked in each state for specific purposes such as health programs, cessation, prevention and education. In some instances the funds have been designated for these purposes, but in other states, unique approaches to spending the monies have emerged. Before reviewing how a number of other states have chosen to spend their portion of the money, however, some consideration should be given to possible overarching structures created to administer the funds when they are eventually spent.

A number of states are considering or already have established either a trust fund, an endowment, or a foundation to oversee and administer their expected tobacco settlement dollars.²⁹ Although similar in concept, trust funds, endowments and foundations can differ in intent and implementation. And indeed, definitions of each are often broad and imprecise, and the terms are sometimes used interchangeably. Each concept, however, can provide a way to manage and administer the funds outside of the regular state appropriations process, if that is what is desired.

Several states have created a trust fund for settlement dollars, generally to set aside some or all of the revenue for a specific purpose (Alabama has created the Children's First Trust Fund and Michigan has established the Merit Award Trust Fund). The purpose of the trust fund can vary according to the goals established by the state. Often, they are broadly defined and governed by an instrument with guiding principals that directs expenditures. In the case of Alabama, the state treasury will maintain the account, and the Juvenile Justice Coordinating Council will oversee disbursements. In Michigan, a 14-member board will guide expenditures from the Merit Award Trust fund, and the Michigan Strategic Fund Agency will administer the fund.

An endowment is generally used when attempting to preserve a base amount of funds over a long period of time, or in perpetuity. The goal is long-term stability and viability. Usually, an endowment is structured so that only the interest income is spent on a specific purpose or purposes, as specified in a charter or governing instrument. Endowments may be either a stand-alone entity, or part of an institution (such as a university). Florida has established the Lawton Chiles Tobacco Endowment for Children and Elders with its tobacco settlement monies, which have already begun to flow. The state's Board of Administration manages the funds and has the authority to spend the interest from the funds in a manner similar to how it invests the state's retirement funds on children's health, child welfare, and elder programs. Over the first four years, the endowment is expected to set aside more than \$2 billion. In Minnesota, where funds are also already flowing, Governor Ventura has created a foundation and three endowments in an effort to preserve the money in perpetuity.

Because the settlement places no restrictions on how individual states may spend the funds, spending the money has become a popular topic in virtually all states that are a party to the settlement agreement, Arizona included.

²⁹ Much of this discussion is from "The Tobacco Settlement: States Propose Trust Funds, Endowments and Foundations," by the National Governor's Association, 1999.

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FIGURE 8 TRUST FUNDS, ENDOWMENTS, AND FOUNDATIONS

TRUST FUND

Usually created to reserve or target revenue for specific purposes. There are multiple oversight and management options, from a separate, designated account in the state treasury that is appropriated through the annual appropriation process, or an account that is overseen by a board or commission outside of the appropriation process. The states of Alabama, Michigan, Virginia and Washington have all established trust funds for their tobacco settlement monies.

ENDOWMENT

Usually created to preserve a base of funds for a long period of time or in perpetuity. Generally, only the interest income or a portion of the income is spent, as designated in the charter or governing instrument. The states of Florida and Minnesota have created endowments with tobacco settlement revenues.

FOUNDATION

A non-profit entity usually created to aid and maintain charitable activities. A foundation can be established to disburse the funds of a trust fund or an endowment. Alabama and Virginia have created foundations to oversee the trust funds established, and Minnesota created a foundation to manage almost half of the state's up front payments.

Source: National Governor's Association, 1999

While trust funds and endowments are often the equivalent of “special reserve” accounts, a foundation is an actual non-profit, philanthropic entity, frequently established to manage trust funds or endowments. Often, a foundation provides grants to other nonprofit organizations to carry out its specific goals. In Virginia, the Tobacco Settlement Foundation has been created to oversee the trust fund established to prevent youth tobacco use. Alabama's Children's First Trust Fund is managed by the Children's First Foundation. The Juvenile Justice Coordinating Council and the foundation jointly are trustees for the fund.

With the uncertainty of the future payments to states due to the factors mentioned previously, trust funds, endowments and foundations are becoming increasingly popular ideas because they have the potential of protecting some of the

funds for future uses. In the absence of one of these structures or another similar concept, the settlement revenues – by provision in the agreement – will be deposited in the state's general fund.

With many states having achieved State Specific Finality, the debate over how to spend the settlement monies is quite advanced or even completed in many places. The states' responses to the settlement opportunity have been as diverse as the states themselves. In addition to the common expenditures on health care and tobacco cessation, some have considered using the tobacco settlement to pay for college scholarships (Michigan), water projects (North Carolina), debt reduction (Louisiana), sidewalk repair (Los Angeles), juvenile detention facilities (Alabama), and reductions in automobile, property, and income taxes. A sampling of what a number of states have already decided to do with their settlement revenue follows.³⁰

FLORIDA

In May 1999, the Lawton Chiles Endowment Fund was created. \$1.7 billion will be deposited into the fund over four years, and only the interest will be spent on children's health care, child welfare, and community-based service initiatives for the elderly.

HAWAII

In July 1999, the Hawaii Tobacco Settlement Special Fund was created to receive all settlement revenues. Emergency and Budget Reserve Fund (a rainy day reserve) will receive 40 percent of funds; the Department of Health will receive 35 percent for health related programs, including the children's health insurance program; and the Tobacco Prevention and Control Trust Fund will receive 25 percent for youth and adult education, prevention, and cessation programs, and chronic diseases.

MICHIGAN

In 1999, a number of one-time and on-going appropriations were agreed to. One-time appropriations include: \$75 million for “Michigan Technical Education Center Expansion” for vocational education training; \$10 million for “Long-Term Health Care Innovation Grants” for quality of life enhancements for residents in nursing homes. On-going appropriations include \$86.3 million for “Michigan Merit

³⁰ Much of the following information came from two sources: www.tobaccofreekids.org and the National Governor's Association (www.nga.org).

ARIZONA AND THE MULTI-STATE TOBACCO SETTLEMENT

Awards” from the Michigan Merit Award Trust Fund. The Michigan Merit Awards provide for scholarships for Michigan students who achieve a designated test score of the Michigan EAP test during their junior year in high school. A qualifying student will receive a \$2,500 one-time scholarship. \$50.0 million to be administered by the Michigan Strategic Fund Agency. The funds are to be distributed by an appointed board of 14 members who will distribute 40 percent to basic research in health-related areas, 50 percent to collaborative research, and 10 percent to support commercial development of health research in the State. Also created: \$30 million “Senior Prescription Drug Program” to provide prescription drug coverage for senior citizens whose household income is below 200 percent of the federal poverty level; \$5 million “Personal Needs Allowance” raises from \$30 to \$60 per month the amount of income a Medicaid-eligible senior citizen can keep for personal expenditures in a nursing home; and, \$3 million for a “Long-Term Care Advisor” to better assist senior citizens in making choices concerning long-term health care.

MISSISSIPPI

In April, 1999, the Mississippi Health Care Trust Fund and the Health Care Expendable Fund were created. The Expendable Fund may only be spent on health-related purposes, including Medicaid; SCHIP; community-based care for the elderly; and improvement of the health of school-age children. A board of directors will monitor and advise investments and expenditures.

MONTANA

The State of Montana’s settlement funds were allocated by the 1999 Legislature for the 2000-2001 biennium. 25 percent of the funds will be allocated to health-related issues, including the SCHIP, the Tobacco Use Prevention Program, and the Montana Comprehensive Health Association (a high-risk insurance pool). The remaining 75 percent of the funds are authorized for a “reserve fund,” the Montana National Guard Challenge Program for troubled youth, and the state’s general fund.

NEBRASKA

The State of Nebraska has created a Tobacco Settlement Trust Fund, where all tobacco settlement funds are to be deposited and invested. Interest from the trust fund is paid into the Excellence in Health Care Trust Fund, and a six-member Excellence in Health Care Trust Fund Council,

appointed by the Governor and approved by the Legislature, is authorized to make grants for any of the following purposes 1) public health services, 2) the statewide trauma system and emergency medical services, 3) education, retention and recruitment of primary care professionals, behavioral health professionals, and nurses for medically underserved areas, 4) health infrastructure development supportive of telemedicine capability, 5) conversion of nursing facilities to assisted living or alternative care, 6) conversion of rural hospitals to limited-service hospitals, 7) development and expansion of community-based aging services, and 8) state matching share for CHIP. The Council’s loan guarantee and grant decisions are subject to the approval of the Director of Health and Human Services Finance and Support.

NEVADA

In 1999, the governor signed two bills related to the tobacco settlement. The first directs 40 percent of the settlement to the Millennium Scholarship program, which will provide \$2,500 per year for four years to students enrolled in a Nevada state university who graduated from a Nevada high school with a 3.0 GPA or higher. Smaller scholarships will also be provided to students choosing to attend one of Nevada’s community colleges. The second bill created two funds: the Fund for a Healthy Nevada, into which 50 percent of the tobacco money is deposited; and the Trust Fund for Public Health, into which the remaining 10 percent of the money is deposited. The Fund for a Healthy Nevada may be used for programs that improve health services for children, senior citizens, and persons with disabilities, to reduce or prevent the use of tobacco, alcohol, or drugs, and the Governor’s program for pharmaceutical assistance to low-income seniors. The Trust Fund for Public Health may be used for grants for health programs for children, seniors, and the disabled; and research on prevention and treatment of illness.

NEW JERSEY

In 1999, the governor’s FY 2000 budget proposal was approved by the state legislature, including direction of spending the tobacco settlement monies. Of the roughly \$93 million in settlement funds expected in year one, \$18.5 million will be dedicated to anti-smoking programs. The remaining revenues will be allocated to wellness programs, long-term care alternatives, enhanced mental health services, pharmaceutical assistance to the aged and disabled, and medical services for those on general assistance.

ARIZONA AND THE MULTI-STATE TOBACCO SETTLEMENT

NORTH CAROLINA

In March 1999, two trust funds and a non-profit corporation to assist farming communities were created. 50 percent of settlement payments will be allocated to the nonprofit Corporation for Economic Impact Assistance to Tobacco Dependent Regions of the State. 25 percent will go to a trust fund to be established by the General Assembly to assist tobacco producers, allotment holders, and persons engaged in tobacco-related businesses, and 25 percent will go to a trust fund to be established by the General Assembly for health-related purposes.

NORTH DAKOTA

In April 1999, the Tobacco Settlement Trust Fund was created. The principal and interest of the fund will be re-allocated to three other trust funds: 45 percent to the Resources Trust Fund “to address the long-term water needs of the state.” 45 percent to the Common Schools Trust Fund to provide additional state funding to local school districts, and the final 10 percent to the Community Health Trust Fund to be appropriated for community-based public health programs, including tobacco prevention.

OKLAHOMA

In July 1999, the governor announced his desire to use the state’s tobacco settlement on bolstering technology, infrastructure, and improvements in the education system including teacher pay raises, and tobacco prevention.

TEXAS

In June 1999, a permanent fund for tobacco education and enforcement was created, including a \$10 million per year appropriation to the Texas Department of Health for programs to reduce the use of cigarettes and tobacco products. Governor Bush also signed legislation in 1999 to create the Tobacco Settlement Permanent Trust Fund. An Investment Advisory Committee will be established to advise the state comptroller on managing the assets of the fund.

WYOMING

The Wyoming Tobacco Settlement Trust Fund was created in early 1999. All incoming tobacco settlement monies will be placed in an endowment and only the interest income will be spent on programs related to health or school- and community-based tobacco prevention programs.

appendices

APPENDIX A:

Persons Interviewed for this Project

APPENDIX B:

Tobacco Project Advisory Committee

APPENDIX C:

Text of Proposition 200

APPENDIX D:

Tobacco Tax-Related Legislation in Arizona, 1995-99

APPENDIX E:

Medically Needy Account Program Descriptions

APPENDIX F:

Tobacco Tax Medically Needy Account Funds, FY 1995-05

PERSONS INTERVIEWED FOR THIS PROJECT*

Persons interviewed:

SHIRLEY ANDERSON, former Senate Health Committee Analyst

JASON BEZOZO, Arizona State Senate

SEN. RUSSELL "RUSTY" BOWERS

SUPERVISOR JAN BREWER, District 4, Maricopa County

BARBARA BURKHOLDER, Arizona Public Health Association

PETER BURNS, PJB Wakonda Group

KEVIN DeMENNA, DeMenna & Associates

REP. LAURA KNAPEREK

ANDY GORDON, attorney

SEN. SUSAN GRACE

REP. HERSCHELLA HORTON

LAURIE LANGE, Arizona Hospital and Healthcare Association

MATT MADONNA, American Cancer Society

BRIAN McNEIL, Arizona Corporation Commission

DANA NAMARK, Children's Action Alliance

NORMAN PETERSEN, Arizona Department of Health Services

MARGARET STEMMLER, Children's Action Alliance

RICK POTTER, William M. Mercer, Inc.

ANDY RINDE, Arizona Association of Community Health Centers

JOHN RIVERS, Arizona Hospital and Healthcare Association

MONSIGNOR EDWARD RYLE

BETH SCHERMER, attorney

REP. DAN SCHOTTEL

MARTIN SCHULTZ, Arizona Public Service Company

SHELLI SILVER, Arizona Health Care Cost Containment System

DON THAYER, Arizona Legislative Counsel

MARTIN VAN DER WERF, *The Arizona Republic*

JENNIFER VERMEER, Joint Legislative Budget Committee

DEBI WELLS, Office of Governor Hull

* Interviews were completed either in person or over the telephone. Those who declined to be interviewed are not listed here.

TOBACCO PROJECT ADVISORY COMMITTEE

Persons invited to attend:

SEN. GUS ARZBERGER
SEN. RUSSELL "RUSTY" BOWERS
CAROLYN COSSON, Coalition for a Tobacco Free Arizona*
SEN. GEORGE CUNNINGHAM
REP. LORI DANIELS
SEN. ANN DAY
REP. SUE GERARD*
SEN. RANDALL GNANT
REP. HERSHELLA HORTON
REP. KAREN JOHNSON
DAVID LANDRITH, Arizona Medical Association*
LAURIE LANGE, Arizona Hospital and Healthcare Association*
REP. ANDY NICHOLS
REP. JIM WEIERS
DEBI WELLS, Office of Governor Hull*

* Indicates attended one or both meetings, or sent a representative to one or both meetings.
All others did not attend a meeting, but were invited.

TEXT OF PROPOSITION 200

PROPOSITION 200 PROPOSED BY INITIATIVE PETITION

OFFICIAL TITLE

AMENDING TITLE 42, CHAPTER 7, ARIZONA REVISED STATUTES, BY ADDING ARTICLES 1.2 AND 1.3; RELATING TO TOBACCO TAXES TO PROVIDE FOR HEALTH CARE SERVICES FOR THE MEDICALLY NEEDY, MEDICALLY INDIGENT AND LOW INCOME CHILDREN, TOBACCO RELATED EDUCATION AND RESEARCH AND ADJUSTMENT TO CORRECTIONS FUND, USE OF TAX MONIES TO SUPPLEMENT EXISTING FUNDS AND LEVELS OF SERVICE, TOBACCO TAX LEVY ON INDIAN RESERVATIONS AND RELATED EXEMPTIONS; AND PROVIDING FOR SEVERABILITY.

DESCRIPTIVE TITLE

AN ACT REQUIRING AN INCREASE IN STATE TAX ON CIGARETTES, CIGARS AND OTHER TOBACCO PRODUCTS, INCLUDING THOSE SOLD ON INDIAN RESERVATIONS, EXEMPTING THOSE SOLD TO ENROLLED MEMBERS OF THE INDIAN TRIBE, TO PROVIDE HEALTH CARE FOR MEDICALLY INDIGENT, MEDICALLY NEEDY OR LOW INCOME CHILDREN, TOBACCO RELATED EDUCATION AND RESEARCH.

PROPOSITION 200

A “yes” vote shall have the effect of increasing the state tax on cigarettes, cigars and other tobacco products to provide for health care for the medically indigent, medically needy or low income children, tobacco related education and research.

A “no” vote shall have the effect of not increasing the state tax on cigarettes, cigars and other tobacco products.

PROPOSITION 200 OFFICIAL TITLE AN INITIATIVE MEASURE

AMENDING TITLE 42, CHAPTER 7, ARIZONA REVISED STATUTES, BY ADDING ARTICLES 1.2 AND 1.3; RELATING TO TOBACCO TAXES TO PROVIDE FOR HEALTH CARE SERVICES FOR THE MEDICALLY NEEDY, MEDICALLY INDIGENT AND LOW INCOME CHILDREN, TOBACCO RELATED EDUCATION AND RESEARCH AND ADJUSTMENT TO CORRECTIONS FUND, USE OF TAX MONIES TO SUPPLEMENT EXISTING FUNDS AND LEVELS OF SERVICE, TOBACCO TAX LEVY ON INDIAN RESERVATIONS AND RELATED EXEMPTIONS; AND PROVIDING FOR SEVERABILITY.

TEXT OF PROPOSED AMENDMENT

Be it enacted by the people of the State of Arizona:

The following amendments to provide for a tobacco tax for health care purposes are proposed to become valid when approved by a majority of the qualified electors voting thereon and on proclamation of the governor:

Section 1. Declaration of policy

- A. The people of Arizona believe it is in the best interest of Arizona to establish state funds dedicated to provide health care programs and services, such as health care services for medically needy, medically indigent persons and low income children, education for the prevention and reduction of tobacco use and tobacco related disease and addiction research.
- B. It is the intention and desire of the people of Arizona in enacting this measure by initiative that the funds provided hereby are in addition to and separate from other funds that are now and shall be annually appropriated by the legislature. The funds provided hereby shall not be deemed or classed to be appropriations by the legislature.

Sec. 2. Title 42, Chapter 7, Arizona Revised Statutes, is amended by adding Article 1.2 to read:

ARTICLE 1.2 TOBACCO TAX FOR HEALTH CARE PURPOSES

42-1241. Levy and collection of tax; establishment of fund and accounts; purposes; administration; distribution

- A. IN ADDITION TO ALL OTHER TAXES, AND IN ADDITION TO THE TAX LEVIED AND IMPOSED BY SECTIONS 42-1204 AND 42-1231, THERE IS LEVIED AND SHALL BE COLLECTED BY THE DEPARTMENT AND PAID TO THE STATE TREASURER IN THE MANNER PROVIDED BY ARTICLE 1 OF THIS CHAPTER ON ALL CIGARETTES, CIGARS, SMOKING TOBACCO, PLUG TOBACCO, SNUFF AND OTHER FORMS OF TOBACCO THE FOLLOWING TAX:
1. ON EACH CIGARETTE, 2 CENTS.
 2. ON SMOKING TOBACCO, SNUFF, FINE CUT CHEWING TOBACCO, CUT AND GRANULATED TOBACCO, SHORTS AND REFUSE OF FINE CUT CHEWING TOBACCO, AND REFUSE, SCRAPS, CLIPPINGS, CUTTINGS AND SWEEPINGS OF TOBACCO, EXCLUDING TOBACCO POWDER OR TOBACCO PRODUCTS USED EXCLUSIVELY FOR AGRICULTURAL OR HORTICULTURAL PURPOSES AND UNFIT FOR HUMAN CONSUMPTION, 4.5 CENTS PER OUNCE OR MAJOR FRACTION THEREOF.

TEXT OF PROPOSITION 200

3. ON ALL CAVENDISH, PLUG OR TWIST TOBACCO, 1.1 CENTS PER OUNCE OR FRACTIONAL PART THEREOF.
 4. ON EACH TWENTY SMALL CIGARS OR FRACTIONAL PART THEREOF WEIGHING NOT MORE THAN THREE POUNDS PER THOUSAND, 8.9 CENTS.
 5. ON CIGARS OF ALL DESCRIPTIONS EXCEPT THOSE INCLUDED IN PARAGRAPH 4 OF THIS SUBSECTION, MADE OF TOBACCO OR ANY SUBSTITUTE THEREFOR, IF MANUFACTURED TO RETAIL AT NOT MORE THAN 5 CENTS EACH, 4.4 CENTS ON EACH THREE CIGARS, BUT IF MANUFACTURED TO RETAIL AT MORE THAN 5 CENTS EACH, 4.4 CENTS ON EACH CIGAR.
- B. THE TOBACCO TAX AND HEALTH CARE FUND IS ESTABLISHED IN THE STATE TREASURY. THE FUND SHALL CONSIST OF ALL REVENUES DEPOSITED THEREIN PURSUANT TO THIS ARTICLE AND ARTICLE 1.3 AND INTEREST EARNED ON THOSE MONIES. THE STATE TREASURER SHALL DEPOSIT ALL MONIES RECEIVED UNDER THIS SECTION INTO THIS FUND. THE STATE TREASURER SHALL INVEST MONIES IN THE FUND AND ALL ACCOUNTS THEREIN AS PROVIDED BY SECTION 35-311. THE STATE TREASURER SHALL CREDIT MONIES EARNED FROM THESE INVESTMENTS TO THE FUND.
- C. THE FUND SHALL BE DEPOSITED IN FOUR SEPARATE ACCOUNTS AND SHALL BE ADMINISTERED AS SET FORTH BELOW FOR THE FOLLOWING PURPOSES, SUBJECT TO THE PROVISIONS OF SECTION 42-1242:
1. TWENTY-THREE CENTS OF EACH DOLLAR IN THE FUND SHALL BE DEPOSITED IN THE HEALTH EDUCATION ACCOUNT FOR PROGRAMS FOR THE PREVENTION AND REDUCTION OF TOBACCO USE, THROUGH PUBLIC HEALTH EDUCATION PROGRAMS, INCLUDING, BUT NOT LIMITED TO, COMMUNITY BASED EDUCATION, CESSATION, EVALUATION AND OTHER PROGRAMS TO DISCOURAGE TOBACCO USE AMONG THE GENERAL POPULATION AS WELL AS MINORS AND CULTURALLY DIVERSE POPULATIONS. THE ACCOUNT SHALL BE ADMINISTERED BY THE ARIZONA DEPARTMENT OF HEALTH SERVICES.
 2. FIVE CENTS OF EACH DOLLAR IN THE FUND SHALL BE DEPOSITED IN THE HEALTH RESEARCH ACCOUNT FOR RESEARCH ON THE PREVENTION AND TREATMENT OF TOBACCO-RELATED DISEASE AND ADDICTION. THE ACCOUNT SHALL BE ADMINISTERED BY THE ARIZONA DEPARTMENT OF HEALTH SERVICES.
 3. SEVENTY CENTS OF EACH DOLLAR SHALL BE DEPOSITED IN THE MEDICALLY NEEDY ACCOUNT, FOR PROVIDING PERSONS DETERMINED MEDICALLY INDIGENT PURSUANT TO SECTION 11.297, MEDICALLY NEEDY PURSUANT TO SECTION 36-2905 OR LOW INCOME CHILDREN PURSUANT TO SECTION 36-2905.03, WITH HEALTH CARE SERVICES PROVIDED BY THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM, PURSUANT TO TITLE 36, CHAPTER 29, ARTICLE 1, OR ANY EXPANSION OF THAT PROGRAM, OR ANY SUBSTANTIALLY EQUIVALENT OR EXPANDED SUCCESSOR PROGRAM ESTABLISHED BY THE LEGISLATURE PROVIDING HEALTH CARE SERVICES TO PERSONS WHO CANNOT AFFORD THOSE SERVICES AND FOR WHOM THERE WOULD OTHERWISE BE NO COVERAGE. THESE SERVICES SHALL INCLUDE, BUT NOT BE LIMITED TO, PREVENTIVE CARE AND THE TREATMENT OF CATASTROPHIC ILLNESS OR INJURY, AS PROVIDED BY THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM. THE ACCOUNT SHALL BE ADMINISTERED BY THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION OR ANY SUCCESSOR THERETO.
 4. TWO CENTS OF EACH DOLLAR IN THE FUND SHALL BE DEPOSITED IN THE ADJUSTMENT ACCOUNT FOR TRANSFER OF APPROPRIATE AMOUNTS TO THE CORRECTIONS FUND ESTABLISHED BY SECTION 41-1641 TO COMPENSATE FOR DECREASES IN THE CORRECTIONS FUND RESULTING FROM LOWER TOBACCO TAX REVENUES AVAILABLE UNDER SECTION 42-1204, SUBSECTION B, PARAGRAPH 3 AS A RESULT OF THE TAX SET FORTH IN SECTION 42-1241. ANY FUNDS IN THE ADJUSTMENT ACCOUNT IN EXCESS OF THE AMOUNT NEEDED FOR SUCH ADJUSTMENT SHALL REVERT TO THE TOBACCO TAX AND HEALTH CARE FUND FOR DISTRIBUTION IN EQUAL PROPORTIONS TO THE ACCOUNTS DESCRIBED UNDER SUBSECTION C, PARAGRAPHS 1, 2 AND 3 OF THIS SECTION. THE FUNDS DEPOSITED IN THE ADJUSTMENT ACCOUNT UNDER THIS PROVISION SHALL BE ADMINISTERED BY THE DEPARTMENT.
- D. THE FUND AND ITS ACCOUNTS ARE NOT SUBJECT TO APPROPRIATION. EXPENDITURES FROM EACH ACCOUNT ARE NOT SUBJECT TO ADDITIONAL APPROVAL, NOTWITHSTANDING ANY STATUTORY PROVISION TO THE CONTRARY.
- E. IN NO EVENT SHALL ANY MONIES IN THE FUND OR ITS ACCOUNTS REVERT TO THE STATE GENERAL FUND. MONIES IN THE FUND AND ITS ACCOUNTS ARE EXEMPT FROM THE PROVISIONS OF SECTION 35-190, RELATING TO LAPSING OF APPROPRIATIONS.
- F. UNLESS OTHERWISE PROVIDED, THE ADMINISTRATION OF THIS ARTICLE IS VESTED IN AND SHALL BE EXERCISED BY THE DEPARTMENT ACCORDING TO CHAPTER 1, ARTICLES 1 AND 2 OF THIS TITLE, ARTICLE 1 OF THIS CHAPTER AND THIS ARTICLE.

42-1242. Use of funds

MONIES IN THE FUND SHALL BE EXPENDED ONLY FOR PURPOSES AUTHORIZED BY THIS ARTICLE. MONIES DEPOSITED IN THE HEALTH EDUCATION AND HEALTH RESEARCH ACCOUNTS SHALL ONLY BE USED TO SUPPLEMENT FUNDS APPROPRIATED BY THE LEGISLATURE FOR HEALTH EDUCATION AND HEALTH RESEARCH PURPOSES AND SHALL NOT BE USED TO SUPPLANT SUCH APPROPRIATED FUNDS. MONIES DEPOSITED IN THE MEDICALLY NEEDY ACCOUNT SHALL ONLY BE USED TO SUPPLEMENT FUNDS APPROPRIATED BY THE LEGISLATURE FOR THE PURPOSE OF PROVIDING LEVELS OF SERVICE

TEXT OF PROPOSITION 200

ESTABLISHED PURSUANT TO TITLE 36, CHAPTER 29, ARTICLE 1 TO ELIGIBLE PERSONS AS DEFINED UNDER SECTION 36-2901, PARAGRAPH 4, OR ANY EXPANSION OF SUCH LEVELS OF SERVICE, OR ANY SUCCESSOR PROGRAM ESTABLISHED BY THE LEGISLATURE PROVIDING LEVELS OF SERVICE SUBSTANTIALLY EQUIVALENT TO OR EXPANDING THOSE PROVIDED, PURSUANT TO TITLE 36, CHAPTER 29, ARTICLE 1 TO SUCH ELIGIBLE PERSONS. MONIES DEPOSITED IN THE MEDICALLY NEEDY ACCOUNT SHALL NOT BE USED TO SUPPLANT FUNDS APPROPRIATED BY THE LEGISLATURE FOR THE PURPOSE OF PROVIDING LEVELS OF SERVICE ESTABLISHED PURSUANT TO TITLE 36, CHAPTER 29, ARTICLE 1. FOR PURPOSES OF THIS SECTION, "LEVELS OF SERVICE" MEANS THE PROVIDER PAYMENT METHODOLOGY, ELIGIBILITY CRITERIA AND COVERED SERVICES ESTABLISHED PURSUANT TO TITLE 36, CHAPTER 29, ARTICLE 1 IN EFFECT ON JULY 1, 1993.

Sec. 3. Title 42, Chapter 7, Arizona Revised Statutes, is amended by adding Article 1.3, to read:

ARTICLE 1.3. INDIAN RESERVATION TOBACCO TAX

42-1251. Definitions

IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1. "INDIAN" MEANS ANY PERSON DULY REGISTERED ON THE TRIBAL ROLLS OF AN INDIAN TRIBE OCCUPYING AN INDIAN RESERVATION.
2. "INDIAN RESERVATION" MEANS ALL LANDS HELD IN TRUST BY THE UNITED STATES WITHIN THE LIMITS OF AREAS SET ASIDE BY THE UNITED STATES FOR THE EXCLUSIVE USE AND OCCUPANCY OF INDIAN TRIBES BY TREATY, STATUTE OR EXECUTIVE ORDER WHICH AREAS ARE RECOGNIZED AS INDIAN RESERVATIONS BY THE UNITED STATES DEPARTMENT OF THE INTERIOR.
3. "INDIAN TRIBE" MEANS ANY ORGANIZED INDIAN NATION, TRIBE, BAND OR COMMUNITY RECOGNIZED AS AN INDIAN TRIBE BY THE UNITED STATES DEPARTMENT OF THE INTERIOR.

42-1252. Levy of Indian Reservation tobacco tax; rate; distribution of revenues; civil penalty; exemptions

- A. IN ADDITION TO ALL OTHER TAXES, THERE IS LEVIED AND SHALL BE COLLECTED BY THE DEPARTMENT AND PAID TO THE STATE TREASURER A TAX ON THE PURCHASE ON AN INDIAN RESERVATION OF CIGARETTES, CIGARS, SMOKING TOBACCO, PLUG TOBACCO, SNUFF AND OTHER FORMS OF TOBACCO, AT THE RATES PRESCRIBED BY SECTION 42-1241, SUBSECTION A.
- B. THE TAXES LEVIED AND COLLECTED PURSUANT TO SUBSECTION A OF THIS SECTION SHALL BE DEPOSITED IN THE TOBACCO TAX AND HEALTH CARE FUND ESTABLISHED BY SECTION 42-1241 AND USED FOR THE PURPOSES PROVIDED THEREIN.
- C. THE TAXES LEVIED PURSUANT TO THIS SECTION ARE CONCLUSIVELY PRESUMED TO BE DIRECT TAXES ON THE CONSUMER BUT SHALL BE PRECOLLECTED AND REMITTED TO THE DEPARTMENT BY THE DISTRIBUTOR FOR THE PURPOSE OF CONVENIENCE AND FACILITY ONLY. THE TAXES THAT ARE PRECOLLECTED AND PAID TO THE DEPARTMENT BY THE DISTRIBUTOR SHALL BE CONSIDERED TO BE AN ADVANCE PAYMENT AND SHALL BE ADDED TO THE PRICE OF THE CIGARETTES, CIGARS, SMOKING TOBACCO, PLUG TOBACCO, SNUFF AND OTHER FORMS OF TOBACCO AND SHALL BE RECOVERED FROM THE CONSUMER.
- D. IF THE TAX IMPOSED BY THIS SECTION ON CIGARETTES, CIGARS, SMOKING TOBACCO, PLUG TOBACCO, SNUFF AND OTHER FORMS OF TOBACCO HAS NOT BEEN PRECOLLECTED OR REMITTED WHEN DUE BY THE DISTRIBUTOR, THE DISTRIBUTOR SHALL BE SUBJECT TO A CIVIL PENALTY EQUAL TO THE AMOUNT OF TAXES THAT SHOULD HAVE BEEN PRECOLLECTED OR REMITTED BUT WAS NOT.
- E. THE TAX LEVIED BY THIS SECTION DOES NOT APPLY TO CIGARETTES, CIGARS, SMOKING TOBACCO, PLUG TOBACCO, SNUFF AND OTHER FORMS OF TOBACCO:
 1. FOR WHICH THE TAXES IMPOSED BY ARTICLE 1.2 OF THIS CHAPTER HAVE BEEN PAID.
 2. SOLD BY AN INDIAN TRIBE, OR BY A FEDERALLY LICENSED INDIAN TRADER, ON AN INDIAN RESERVATION TO INDIANS WHO ARE ENROLLED MEMBERS OF THE INDIAN TRIBE FOR WHOSE BENEFIT THE INDIAN RESERVATION WAS ESTABLISHED.

42-1253. Precollection and remittance of tax by purchase of revenue stamps; procedure for claiming exemption

- A. FOR THE PURPOSE OF THE PRECOLLECTION AND REMITTANCE OF THE TAX IMPOSED BY SECTION 42-1252 ON CIGARETTES, CIGARS, SMOKING TOBACCO, PLUG TOBACCO, SNUFF AND OTHER FORMS OF TOBACCO, THE DISTRIBUTORS SHALL PURCHASE AND AFFIX REVENUE STAMPS PURSUANT TO ARTICLE 1 OF THIS CHAPTER.
- B. THE DEPARTMENT SHALL PROMULGATE REGULATIONS PRESCRIBING THE PROCEDURES FOR CLAIMING AND VERIFYING SALES EXEMPT UNDER SECTION 42-1252, SUBSECTION E.

42-1254. Criminal violation; classification

A DISTRIBUTOR OR ANY PERSON WHO SHIPS, TRANSPORTS, SELLS OR DISTRIBUTES CIGARETTES, CIGARS, SMOKING TOBACCO, PLUG TOBACCO, SNUFF AND OTHER FORMS OF TOBACCO ON WHICH THE TAX REQUIRED BY THIS ARTICLE HAS NOT BEEN PAID IS GUILTY OF A CLASS 3 MISDEMEANOR.

TEXT OF PROPOSITION 200

42-1255. Administration

UNLESS OTHERWISE PROVIDED, THE ADMINISTRATION OF THIS ARTICLE IS VESTED IN AND SHALL BE EXERCISED BY THE DEPARTMENT ACCORDING TO CHAPTER 1, ARTICLES 1 AND 2 OF THIS TITLE, ARTICLE 1 OF THIS CHAPTER AND THIS ARTICLE.

42-1256. Preemption by state

THE AREA OF INDIAN RESERVATION TOBACCO TAXATION IS PREEMPTED BY THIS STATE, AND A COUNTY, CITY, TOWN OR OTHER POLITICAL SUBDIVISION OF THIS STATE SHALL NOT LEVY SUCH A TAX. NOTHING IN THIS SECTION SHALL PRECLUDE AN INDIAN TRIBE FROM IMPOSING ITS OWN TOBACCO TAX OR SIMILAR LEVY.

42-1257. Indian reservation tobacco tax not to apply if similar tax is imposed by Indian tribe

IF AN INDIAN TRIBE IMPOSES A LUXURY, SALES, TRANSACTION PRIVILEGE OR SIMILAR TAX ON CIGARETTES, CIGARS, SMOKING TOBACCO, PLUG TOBACCO, SNUFF AND OTHER FORMS OF TOBACCO, BUT AT A RATE LESS THAN THAT PRESCRIBED BY SECTION 42-1252, SUBSECTION A, THE TAX IMPOSED BY SECTION 42-1252, SUBSECTION A SHALL BE LEVIED AT A RATE EQUAL TO THE DIFFERENCE BETWEEN THE RATE PRESCRIBED BY SECTION 42-1252, SUBSECTION A AND THE TAX IMPOSED BY SUCH INDIAN TRIBE. IF THE TAX IMPOSED BY SUCH INDIAN TRIBE IS EQUAL TO OR GREATER THAN THE TAX PRESCRIBED BY SECTION 42-1252, SUBSECTION A, THEN THE RATE PRESCRIBED BY SECTION 42-1252, SUBSECTION A SHALL BE ZERO.

Sec. 4. Severability clause

If any provision of this measure is declared invalid by a court of competent jurisdiction, such invalidity does not affect other provisions that can be given effect without the invalid provision and to this end the provisions of this measure are declared to be severable.

ANALYSIS BY LEGISLATIVE COUNCIL

(In compliance with A.R.S. section 19-124)

Proposition 200 proposes to increase the state tax on cigarettes, cigars, and other tobacco products and use the additional revenue generated for health care and for education and research related to preventing and reducing tobacco use. The following table shows the proposed tax rates on each class of tobacco product:

<u>ITEM</u>	<u>CURRENT TAX RATE</u>	<u>PROPOSED ADDITIONAL TAX RATE</u>	<u>PROPOSED TOTAL TAX RATE</u>
Cigarettes	.9 cents each (18 cents per pack)	2 cents each (40 cents per pack)	2.9 cents each (58 cents per pack)
Smoking tobacco, snuff, fine cut chewing tobacco, cut and granulated tobacco, shorts and refuse of fine cut chewing tobacco, and refuse, scraps, clippings, cuttings and sweepings of tobacco (except tobacco powder and tobacco products used exclusively for agricultural purposes and unfit for human consumption)	2 cents per oz.	4.5 cents per oz.	6.5 cents per oz.
Cavendish, plug or twist tobacco	.5 cents per oz.	1.1 cents per oz.	1.6 cents per oz.

TOBACCO TAX-RELATED LEGISLATION IN ARIZONA, 1995-99

1995: 42nd Legislature, First Regular Session, Third Special Session

MEDICALLY NEEDED ACCOUNT

- An “amount necessary” to pay the state share for persons eligible for **heart, liver, lung, heart-lung or bone marrow transplants**.
- \$1.25 million monthly, beginning August 1, 1995, to the **Medically Needy and Indigent Stabilization Fund** within Arizona Health Care Cost Containment System (AHCCCS), to be used to offset the cost of providing levels of services to persons determined medically indigent, medically needy, or low-income children.
- Up to \$15 million annually to the Arizona Department of Health Services (ADHS), as follows:
 - Up to \$5 million, but not less than 33% of the total amount transferred, for the **mental health program**;
 - Up to \$5 million, but not less than 33% of the total amount for **primary care services**; and
 - Up to \$5 million, but not less than 33% of the total amount for grants to **community health centers**.
- Up to \$500,000 annually to ADHS during FY96 and FY97 for **pilot programs for detoxification services**.
- Up to \$250,000 annually to ADHS during FY96, FY97, and FY98 for **telemedicine pilot programs**.

Also:

- An “amount necessary” to reimburse ADHS for administrative costs, not to exceed 2% of the transferred amount for each program, and an “amount necessary” for the required **evaluation**.

HEALTH EDUCATION ACCOUNT

Up to \$10 million in FY96, and up to \$20 million in FY97 and each year thereafter (but not more than 90% of the prior fiscal year’s Tobacco Tax and Health Care Fund’s allocation) to ADHS for:

- **Contracts** with county health departments, qualifying community health centers Indian tribes, accredited schools, community colleges and universities for education programs related to the prevention and reduction of tobacco use;
 - Related **administrative expenditures** for overseeing these contracts; and,
 - ADHS expenditures for **development and delivery of education programs** designed to prevent or reduce tobacco use including radio, television, or print media costs.
- Further, ADHS may spend 95% of the balance of this account as of October 1, 1997 over at least three fiscal years beginning in SFY98.

HEALTH RESEARCH ACCOUNT

Authorization for the Arizona Disease Control Research Commission to spend in FY95-96, from the monies contained in this account, up to 80% of the monies available through June 30, 1995 for research on the prevention and treatment of tobacco related diseases and addiction and for expenses incurred by the Commission in administering the health research program. Expenditures from the fund in subsequent fiscal years subject to the availability of funds.

ARIZONA DEPARTMENT OF CORRECTIONS ADJUSTMENT ACCOUNT

No legislative changes

TOBACCO TAX-RELATED LEGISLATION IN ARIZONA, 1995-99

1996: 42nd Legislature, Second Regular Session

MEDICALLY NEEDED ACCOUNT

Technical amendment regarding the transfer of \$15 million to ADHS, as follows:

- On-third of the total for the **mental health grant program**;
- One-third of the total for **primary care services**; and,
- One-third of the total for grants to **community health centers**.

In addition, the following new allocations:

- Up to \$150,000 annually to ADHS beginning in FY97 for **end stage renal disease** contracts with nonprofit organizations;
- Up to \$20 million annually beginning in FY97 through FY99 (plus an amount equal to 2% of the funds transferred for administrative costs) into the **Premium Sharing Demonstration Project Fund**, which is established by a transfer of funds from the Medically Needy Account, beginning on October 1, 1997. To be administered as a continuing expenditure. In addition, \$75,000 for administrative start-up funds.
- Up to \$5 million annually beginning in FY97 to ADHS for **basic children's medical services**;
- \$10 million in FY97 for the **discount on private hospital reimbursement**;
- \$4,522,800 in FY97 to continue the scheduled **phase-out of the quick payment discount**; and,
- \$2,021,200 to **replace federal funds** reduced due to the lower matching assistance percentage for federal FY97.

Medical Services Stabilization Fund

- Change the name from the Medically Needy and Indigent Stabilization Fund to **Medical Services Stabilization Fund**.
- Eliminate the requirement that funds could only be used for "unanticipated" increases in the cost of providing levels of services to the designated population, thus expanding it to be used for any type of increases.
- Further expand the use of the funds to offset increases in the cost of providing levels of service if the increase results from a decrease in federal funding, including match rate decreases.

HEALTH EDUCATION ACCOUNT

No legislative changes

HEALTH RESEARCH ACCOUNT

No legislative changes

ARIZONA DEPARTMENT OF CORRECTIONS ADJUSTMENT ACCOUNT

No legislative changes

1997: 43rd Legislature, First Regular and First Special Sessions

MEDICALLY NEEDED ACCOUNT

- \$200,000 increase to ADHS, beginning in FY99, for contracts with hospitals that perform **non-renal organ transplants**.
- \$7.5 million to ADHS for **public health education**.
- Increase from \$150,000 to \$250,000 annually, the amount transferred to ADHS for contracts related to **end-stage renal disease**.
- \$1 million to the **Health Crisis Fund** (established by Executive Order).
- Increase from \$5 million to \$6 million annually for **primary care programs**.
- \$500,000 to extend the **detoxification pilot** for one additional year.
- \$500,000 to Arizona Department of Economic Security (ADES) for services to persons meeting the low-income eligibility criteria of the **Aging and Adult Administration**.
- \$2.5 million to ADHS for **capital projects** in FY98 and FY99 to entities providing health services in rural areas or underserved areas.
- Increase the amount allowable transferred for **DHS administrative costs** from two percent to four percent.
- \$111,200 to ADHS to implement **Rural Private Primary Care Provider Loan Repayment Program**.
- \$65,000 to ADHS for primary care services in **Salome, Arizona**.
- \$14.8 million from the balance remaining at the end of FY97 to the **ADHS Construction Services Account**.
- \$ for Maternity Length of Stay
- \$ for HIV/AIDS Treatment

Premium Sharing Demonstration Program:

Allocate two percent of funds for administrative costs.

HEALTH EDUCATION ACCOUNT

Increase the expenditure limit from \$15 million to \$25 million and limit the expenditures to 90% of the previous year's revenue allocation. After a FY98 estimate is made, allow 95% of the remaining balance to be spent over the next three fiscal years.

HEALTH RESEARCH ACCOUNT

No legislative changes

ARIZONA DEPARTMENT OF CORRECTIONS ADJUSTMENT ACCOUNT

No legislative changes

TOBACCO TAX-RELATED LEGISLATION IN ARIZONA, 1995-99

1998: 43rd Legislature, First Regular and Fourth Special Sessions

MEDICALLY NEEDED ACCOUNT

- \$9,251,100 in FY99 to the **State Children's Health Insurance Program**, which will consist of these funds plus \$29,148,900 in federal funds (for a total of \$38.4 million). Program to be administered by AHCCCS.
- \$5 million in FY99 to ADHS for grants to contracting qualifying health centers and \$3 million for grants to contracting hospitals related to the **State Children's Health Insurance Program**.
- Decrease from \$5 million to \$2.5 million in FY99 for the ADHS **Basic Children's Medical Services Program**. Funding is eliminated in FY00.
- Repeal of \$14.8 million to ADHS for **construction of a health laboratory**.

Medical Services Stabilization Fund:

- Discontinue the \$1.25 monthly deposit to the Medical Services Stabilization Fund after July 1, 1999.
 - \$8 million from Medical Services Stabilization Fund in FY99 to provide reinsurance to **Healthcare Group** health plans.
-

HEALTH EDUCATION ACCOUNT

At least \$550,000 to ADHS, beginning in FY99, to implement a **pilot program for anti-smoking advertising on school buses**.

HEALTH RESEARCH ACCOUNT

\$5 million in FY99, \$2 million in FY00 and FY01, and \$1 million in FY02 for **Disease Control Research Commission**. The \$10 million (total) is for the support of cancer research projects at all phases of drug discovery, application, development, and clinical trials.

ARIZONA DEPARTMENT OF CORRECTIONS ADJUSTMENT ACCOUNT

No legislative change

1999: 43rd Legislature, Second Regular Session

MEDICALLY NEEDED ACCOUNT

- \$250,000 in FY00 to extend the **telemedicine pilot program**.
 - \$2.5 million to extend **Primary Care Capital Construction**.
 - \$500,000 to extend **detoxification services**.
 - \$95,000 to ADHS in FY00 for the provision of **primary care services** through an existing community health center located in a rural, medically underserved area of a county.
 - \$280,000 to ADHS in FY00 for **immunization services and outreach**.
 - \$661,800 to ADHS in FY00 and \$624,500 in FY01 for the **immunization information system** and associated operating costs.
 - \$350,000 to ADHS in both FY00 and FY01 for **Hepatitis C education**.
 - \$119,000 to ADHS in FY00 for **asthma program**.
 - \$450,000 to ADHS in both FY00 and FY01 for an **osteoporosis prevention and treatment education program**.
 - \$670,000 to ADHS from FY00 through FY03 for state match funds for the **federal Title V abstinence only education program**.
 - \$150,000 to ADHS in both FY00 and FY01 for **epidemiology programs**.
 - \$14,000 to ADHS in both FY00 and FY01 for **public health information**.
-

HEALTH EDUCATION ACCOUNT

No legislative change

HEALTH RESEARCH ACCOUNT

No legislative change

ARIZONA DEPARTMENT OF CORRECTIONS ADJUSTMENT ACCOUNT

No legislative change

MEDICALLY NEEDY ACCOUNT PROGRAM DESCRIPTIONS¹

Program name (AZ Revised Statutes)	ORGAN TRANSPLANTS (ARS 36-2921)
Brief description	A program administered by AHCCCS that pays for the state share of costs for providing health care services to persons who become eligible for a heart, lung, heart-lung, liver or autologous and allogenic bone marrow transplant as determined by the administrator.
Year created	1995
Year funding began	FY95
Admin %	Not tracked
Number of contractors/ programs	Four contracted transplant facilities and Five non-contracted facilities
Population served	AHCCCS eligible transplant patients (highly indicated)
Eligibility requirements	AHCCCS covers the following medically needy transplantation services, and related immunosuppressant drugs: bone marrow/stem cell, heart; lung and heart-lung; kidney; liver; and medically necessary services for members who receive transplants that are not covered by AHCCCS. The policies for each of the above transplantation services vary depending on the service. Transplantation services are not covered for non-categorically eligible members during prior period coverage except for those persons pursuant to Laws 1995, Ch. 1.
ARS data reporting or evaluation requirements	None
Other data collection or evaluation conducted	<p>The agency reports on the number of Title XIX approved and waiting by fiscal year and by type; the number of MN/MI approved and waiting and by type; the number of Title XIX completed transplants by fiscal year and type; and the number of MN/MI completed transplants by fiscal year and type.</p> <p>Title XIX Completed by Type (total, all years) Total Heart+Lung = 2 Total Lung = 2</p> <p>MN/MI Completed by Type (total, all years) Total Heart = 5 Total Liver = 6 Total Bone Marrow = 36 Total Heart+Lung = 0 Total Lung = 1</p> <p>In addition, an on-site visit is conducted for each facility prior to contracting.</p>

Program name (AZ Revised Statutes)	PRIMARY CARE PROGRAMS, PART A (ARS 36-2921, 36-2907.5)
Brief description	Established community-based primary care programs to provide comprehensive primary care services to indigent or uninsured Arizona residents. Specifically, funds are intended to develop contractors' capacity to provide medical care through employment of physicians, nurses, physician assistants or other health care personnel.
Year created	1995
Year funding began	FY96
Admin %	Initially 2%, changed to 4%
Number of contractors/ programs	Information not available
Population served	Uninsured low-income, at-risk individuals in identified communities (selected)
Eligibility requirements	<ul style="list-style-type: none"> • Arizona resident, and • Uninsured & ineligible for AHCCCS & Medicare, and • Income less than 200% federal poverty level (FPL)
ARS data reporting or evaluation requirements	<p>An annual program evaluation must be performed to examine the effectiveness and efficiency of the programs. It must include, but is not limited to the following information:</p> <ul style="list-style-type: none"> • Level and scope of services offered • Types of services offered • Frequency of services offered • Personal characteristics of the program participants who receive services • Demographic characteristics of the program participants who receive services • Number of program participants • Information on program contractors and providers • Program revenues and expenditures • Average cost per participant • Average cost of providing each service • Administrative costs for each program • Methods for selecting eligible contractors • Estimate of the benefits and effects of providing health care to persons who cannot get it or would otherwise be ineligible <p>The annual report must be submitted no later than November 1 of each year and ADHS shall receive funds annually to perform the evaluation.</p>
Other data collection or evaluation conducted	None

¹ Information and data retrieved by Cannon & Gill; compiled and presented by Morrison Institute for Public Policy.

MEDICALLY NEEDY ACCOUNT PROGRAM DESCRIPTIONS

Program name (AZ Revised Statutes)	QUALIFYING COMMUNITY HEALTH CENTERS, PART B (ARS 36-2921, 36-2907.06)
Brief description	Provides primary health care services to indigent or uninsured Arizona residents through qualifying community health centers in Arizona's Medically-Underserved Areas (AzMUA). Funding is for development and maintenance of an enhanced statewide capacity for cost-effective delivery of services to persons of all ages.
Year created	1995
Year funding began	FY96
Admin %	Initially 2%, changed to 4%
Number of contractors/ programs	Nine evaluation contractors; process and demographic information
Population served	Indigent and uninsured Arizona residents (selected)
Eligibility requirements	<ul style="list-style-type: none"> • Arizona resident, and • Uninsured and ineligible for AHCCCS & Medicare, and • Annual income of less than 200% of federal poverty level (FPL)
ARS data reporting or evaluation requirements	Same as Primary Care Programs
Other data collection or evaluation conducted	None

Program name (AZ Revised Statutes)	TELEMEDICINE (ARS 36-2921.5, 36-2352)
Brief description	A pilot program designed to facilitate the provision of medical services to persons living in underserved areas through the use of telecommunication between the urban and rural communities. Contractor focus is psychiatric services.
Year created	1995
Year funding began	FY96
Admin %	Initially 2%, changed to 4%
Number of contractors/ programs	Two contractors
Population served	Low-income, indigent, and/or uninsured persons in targeted communities (highly indicated)
Eligibility requirements	Selected pilot recipients determined by contractor
ARS data reporting or evaluation requirements	Same as Primary Care Programs
Other data collection or evaluation conducted	None

MEDICALLY NEEDY ACCOUNT PROGRAM DESCRIPTIONS

Program name (AZ Revised Statutes)	MENTAL HEALTH PROGRAMS FOR NON-TITLE XIX (ARS 36-3414, 36-2921)
Brief description	Each Regional Behavioral Health Authority (RBHA) developed a different set of services focused in five major areas: <ul style="list-style-type: none"> • Psychiatric crisis response systems • Programs for youth • Mental health support services for SMI persons • Mental health support services for elderly persons • Rural detoxification
Year created	1995
Year funding began	FY96
Admin %	Initially 2%, changed to 4%
Number of contractors/ programs	Five Regional Behavioral Health Authorities (RBHAs)
Population served	Persons with mental illness and substance abuse problems (selected)
Eligibility requirements	Depends on program. There are over 20 different programs administered by the five RBHAs using these funds and the detoxification program funds combined.
ARS data reporting or evaluation requirements	Same as Primary Care Programs
Other data collection or evaluation conducted	Same as Primary Care Programs

Program name (AZ Revised Statutes)	DETOXIFICATION SERVICES (ARS 36-2921.4)
Brief description	A pilot program designed to determine the appropriateness and effectiveness of having level II behavioral health facilities deliver detoxification treatment and services to indigent, or uninsured people who do not require the services of hospital or a level I behavioral health facility, and who do not require the use of restrictive behavior management practices. The law specified that the pilot programs be implemented and operated: <ul style="list-style-type: none"> • Only upon funding availability • Only in counties having a population of 500,000 persons or less • In at least one county, but in no more than three <p>The legislature requires ADHS to give priority to those RBHAs responsible for delivering behavioral health services in areas where there is a high demand for detoxification services and a lack of facility beds to meet the demand. ADHS is required to also give priority to those programs providing at least a 25 percent match.</p>
Year created	1995
Year funding began	FY96
Admin %	Initially 2%, changed to 4%
Number of contractors/ programs	Two of the five Regional Behavioral Health Authorities (RBHAs) with services provided in Page and Yuma
Population served	Persons with drug and alcohol addiction (selected)
Eligibility requirements	Over the age of 18
ARS data reporting or evaluation requirements	Same as Primary Care Programs. In addition, per 42-1242.02 Sec.10, the pilots shall be evaluated in a separate report to the Legislature. The report to the Legislature shall be a comprehensive assessment that covers the three years of the operation of the program.
Other data collection or evaluation conducted	None

MEDICALLY NEEDY ACCOUNT PROGRAM DESCRIPTIONS

Program name (AZ Revised Statutes)	PREMIUM SHARING DEMONSTRATION PROJECT (ARS 36-2923, 36-2921)
Brief description	Establishes a fund to “provide uninsured persons access to medical services provided by system providers” by helping them pay the premium. The fund consists of monies transferred from the Medically Needy Account. AHCCCS withdrew the sum of \$20,000,000 during each of FY97, FY98, and FY99 to establish the fund. AHCCCS prepays capitated rates to the three health plans and collects premiums from household enrolling in the program.
Year created	1996
Year funding began	FY97
Admin %	2%
Number of contractors/ programs	Three: Arizona Physicians, University Physicians, Mercy Care
Population served	Target population is the working poor, often referred to as the “notch” group. A secondary target population is the chronically ill. The project has been enrolling persons since February 1, 1998. The enrollment as of July 5, 1999 is 4,596. (highly indicated)
Eligibility requirements	For the working poor: income between 0-200% of the federal poverty level (FPL), without health insurance for at least six months, and an Arizona resident. For the chronically ill: income between 200-400% of the FPL and receiving services through the Medically Needy Account for at least 12 months. All enrollees with income below 200% of the FPL may not pay more than 4% of their annual income on premiums.
ARS data reporting or evaluation requirements	ARS 36-2921 and 36-2923 Requires that the Arizona Legislative Counsel submit a report semiannually to the premium sharing demonstration oversight committee. The report must contain the following information regarding the demonstration project: <ul style="list-style-type: none"> • An analysis of client satisfaction • Program enrollment information • Average annual income of the enrollee • Annual medical service expenditure • Total monies collected from enrollees • Information necessary to analyze and evaluate the project’s effectiveness or impact A review of the actual medical costs incurred and the premiums shared.
Other data collection or evaluation conducted	None

Program name (AZ Revised Statutes)	RENAL DISEASE MANAGEMENT (ARS 36-2921)
Brief description	ADHS contracts for end stage renal disease treatment services were completely funded out of state general funds through SFY 1997. In 1998, the State general funds for these contractual services were supplemented with funding generated from the tobacco tax. The purpose is to provide end stage renal disease treatment to patients who are residents of the State of Arizona who do not have adequate financial resources to pay for the services and supplies that may be required for treatment, and who are ineligible for funds from other sources. The services include medications, necessary transportation, dental care, and nutritional supplements. The annual budget consists of \$101,000 from the State general fund and \$250,000 from tobacco tax funds. The cost of obtaining such services for ineligible clients is borne by the Arizona Kidney Foundation.
Year created	1996
Year funding began	FY97
Admin %	0%
Number of contractors/ programs	One contractor – Arizona Kidney Foundation
Population served	Persons with end stage renal disease (highly indicated)
Eligibility requirements	Arizona residency and lack of financial resource to pay for services and supplies
ARS data reporting or evaluation requirements	None
Other data collection or evaluation conducted	No funding provided for evaluation. The Arizona Kidney Foundation monitors the number of clients that receive services and the cost per client per month. The number of clients receiving medication assistance, transportation assistance, dental care services, and the nutritional supplement program is tracked each quarter, including the average cost per client per month by each individual service.

MEDICALLY NEEDY ACCOUNT PROGRAM DESCRIPTIONS

Program name (AZ Revised Statutes)	BASIC CHILDREN'S MEDICAL SERVICES (ARS 36-2907.08)
Brief description	The program was created to provide grants to hospitals that exclusively serve the medical needs of children or that operate programs designed primarily for children. Provides specialized pediatric ambulatory and inpatient hospital services to eligible children through the age of 18. There are an estimated 4,500 children with special health care needs and estimated 200,000 uninsured children in Arizona. The funds allocated for this program are intended to improve access to pediatric care for underinsured/uninsured children not eligible for AHCCCS. It was envisioned that the program would become a component of the delivery system that would efficiently and effectively deliver specialized outpatient and inpatient hospital services, while the other programs coordinated primary and follow-up care. The program's goals relate to the larger health initiatives – Arizona 2000 Goal #2 – Universe access to health services.
Year created	1996
Year funding began	FY97
Admin %	4%
Number of contractors/ programs	Three contractors
Population served	Uninsured children 18 and under with specialized needs (selected)
Eligibility requirements	<ul style="list-style-type: none"> • 18 years of age or under • Resident of Arizona • No health insurance coverage or underinsured • Family income less than 200% of federal poverty level (FPL)
ARS data reporting or evaluation requirements	Same as Primary Care Programs
Other data collection or evaluation conducted	None

Program name (AZ Revised Statutes)	HIV/AIDS TREATMENT Laws 1997, First Special Session, Chapter 5
Brief description	A supplemental capitation payment made to AHCCCS health plans to augment the cost of serving eligible HIV/AIDS members
Year created	1997
Year funding began	FY98
Admin %	8%
Number of contractors/ programs	All 11 AHCCCS health plans plus the ALTCS program contracts, including DES/DDD, can serve people in the program.
Population served	AHCCCS eligible members being treated by the health plans for HIV/AIDS; AHCCCS pays a supplemental payment to the health plans for treating this population. (not segregated)
Eligibility requirements	The member must be receiving one of the approved protease inhibitors for at least 15 days in the given month, must be AHCCCS eligible through Title XIX, Title XXI, or state-only, and be assigned to a health plan or program contractor.
ARS data reporting or evaluation requirements	None
Other data collection or evaluation conducted	Audit reports from each of the individual health plans

MEDICALLY NEEDY ACCOUNT PROGRAM DESCRIPTIONS

Program name (AZ Revised Statutes)	PUBLIC HEALTH EDUCATION (ADMINISTRATION AND PROGRAM) (ARS 42-1242.01)
Brief description	Several Programs, as follows: <ul style="list-style-type: none"> • Abstinence Only Education – \$670,000 for state match to receive federal funding • Immunization Outreach – \$140,000 (one time for 6 months) • ASIIS – \$147,600 pass through to the Governor’s Division for Children (3 year program) of which \$25,000 for postage to send out immunization cards from the Governor. The remainder of the funds from this one-time allocation are as follows: <ul style="list-style-type: none"> • FY00-FT03 • Immunization Services (FY00) • ASIIS (FY00-01) • ASIIS Operational Costs (FY00-FY01) • Hepatitis C (FY00-FY01) • Osteoporosis Program (FY00-FY01) • Asthma Program (FY00) • Abstinence Education (FY00-FY03) • Medically Under-served of Minority Populations in Arizona (FY00-FY01) • Epidemiology Studies (FY00-FY01) • Perinatal Substance Abuse (FY00-FY02)
Year created	1997
Year funding began	FY98
Admin %	Percentage varies by individual program/line item
Number of contractors/programs	13 contractors for Abstinence Education, including one evaluation contractor, and one media campaign contractor
Population served	Abstinence Education: various (selected and universe)
Eligibility requirements	Families with incomes up to 150% of the federal poverty level (FPL) who are not Title XIX eligible. The income limit increases up to 175% of FPL in FY00 and to 200% from FY01, going forward.
ARS data reporting or evaluation requirements	None
Other data collection or evaluation conducted	The Abstinence Only Education Program is evaluated.

Program name (AZ Revised Statutes)	AGING AND ADULT ADMINISTRATION (ARS 36-2921)
Brief description	The legislation mandates the funds be used for services to persons who meet low-income eligibility criteria developed by the Aging and Adult Administration of Arizona Department of Economic Security (ADES). ADES, through a determination of unmet need, developed the services to be offered which include non-medical home and community-based services, such as adaptive aids and devices, home repair/adaptation/renovation, and emergency respite care and medically-related transportation for persons meeting low income eligibility criteria. ADES/A&AA made stipulations to the area agencies for the use of the funds: <ul style="list-style-type: none"> • Funds cannot be used to supplant existing resources. • Determination of medical need has to be established prior to provision of services regardless of the type of service. • Maximum limitation of \$125,000 per project • Special emphasis must be placed on community involvement in the development. • Programs must be innovative, considered “pilots,” and funds applied for annually. • Funds have to be case managed.
Year created	1997
Year funding began	FY98
Admin %	Information not available
Number of contractors/programs	Eight area agencies on aging
Population served	Persons determined eligible for specific services through an Area Agency on Aging (highly indicated)
Eligibility requirements	Income of less than 300% of the Supplemental Security Income (SSI) and a sliding fee scale for those with income above SSI. Those with income less than 100% of SSI are not charged for service, but are encouraged to make a donation. Those with income exceeding 300% of SSI must pay the full cost of the service.
ARS data reporting or evaluation requirements	None
Other data collection or evaluation conducted	A report is prepared by the Aging and Adult Administration in the Arizona Department of Economic Security (ADES) for the purpose of complying with the agreement between AHCCCS and ADES. The report is the Program and Administration Financial Report and includes detailed information about the program and the expenditures.

MEDICALLY NEEDY ACCOUNT PROGRAM DESCRIPTIONS

Program name (AZ Revised Statutes)	CHILDREN'S HEALTH INSURANCE PROGRAM; KIDSCARE (ARS 36-2982)
Brief description	Beginning in FY99, legislation requires that \$9,251,100 be transferred from the Medically Needy Account to the State Children's Health Insurance Program to be matched with \$29,148,900 in federal funds. These monies are administered by AHCCCS with an additional \$8,000,000 appropriated to DHS in FY1999 (see DHS KidsCare appropriation program description below). The program is commonly known as "KidsCare." The federal balanced budget act of 1997 provides the new federal funding to states for families with incomes up to 200% of the federal poverty level.
Year created	1998
Year funding began	FY99
Admin %	10% may be used for administration and outreach
Number of contractors/ programs	Uses existing infrastructure and authorizes AHCCCS to expand existing contracts with health care plans and contract with state employees health plans. All 11 AHCCCS health plans, plus the ADHS clinics serve the children in the program.
Population served	Low income uninsured children who are ineligible for Medicaid (highly indicated)
Eligibility requirements	Family incomes up to 150% of the federal poverty level (FPL) who are not Title XIX eligible. Income limit increases to 175% of FPL in FY00 and to 200% beginning in FY01, onward.
ARS data reporting or evaluation requirements	<p>Beginning January 1, 2000, AHCCCS must report annually to the Governor, President, Speaker of the House and Director of the Department of Library Archives and Public Records the following information:</p> <ul style="list-style-type: none"> • Number of children served • State and federal expenditures for the program for the previous state fiscal year • Comparison of expenditures for the previous fiscal year with the expected federal funding for the next year • Whether federal funding will be sufficient for the next year to provide services at the current percentage of the federal poverty level • Any recommendations for changes to the program <p>Also, a ten member joint legislative study committee on the integration of health care services to determine the feasibility of integrating the Children's Health Insurance Program, Premium Sharing, and Proposition 203 is created in ARS 36-2995. A federal report to the Secretary of Health and Human Services "State Assessment and Report" must be submitted on January 1, 2000, and annually thereafter. The elements assess the operation of the State plan, including the progress made in reducing the number of uncovered low-income children.</p> <p>A state evaluation must be filed with the Secretary of Health and Human Services on March 31, 2000 with prescribed federal data elements.</p> <p>Performance goals and strategic objectives to the Secretary of Health and Human Services on January 1, 2000, and annually with prescribed data elements.</p>
Other data collection or evaluation conducted	The federal reporting requirements contain an evaluation component including process and outcome information on the effectiveness of the program.

MEDICALLY NEEDY ACCOUNT PROGRAM DESCRIPTIONS

Program name (AZ Revised Statutes)	CHILDREN'S HEALTH INSURANCE PROGRAM (KIDSCARE) DIRECT SERVICES (ARS 36-2982)
Brief description	In addition to the AHCCCS administered portion of KidsCare, the legislation appropriates these funds to ADHS for direct services to be performed through grants to qualifying health centers.
Year created	1998
Year funding began	FY99
Admin %	10%
Number of contractors/ programs	Information not available
Population served	Low-income uninsured children who are ineligible for Medicaid (highly indicated)
Eligibility requirements	Families with incomes up to 150% of the federal poverty level (FPL) who are not Title XIX eligible. The income limit increases up to 175% of FPL in FY00 and to 200% from FY01, going forward.
ARS data reporting or evaluation requirements	Beginning January 1, 2000, AHCCCS must report annually the following information: <ul style="list-style-type: none"> • Number of children served • State and federal expenditures for the program for the previous state fiscal year • Comparison of expenditures for the previous fiscal year with the expected federal funding for the next year • Whether federal funding will be sufficient for the next year to provide services at the current percentage of the federal poverty level • Any recommendations for changes to the program <p>Also establishes a ten member joint legislative study committee on the integration of health care services to determine the feasibility of integrating the Children's Health Insurance Program, Premium Sharing, and Proposition 203.</p>
Other data collection or evaluation conducted	None

Program name (AZ Revised Statutes)	CHILDREN'S HEALTH CARE INSURANCE PROGRAM (KIDSCARE) DIRECT HOSPITAL SERVICES (ARS 36-2982)
Brief description	In addition to the AHCCCS administered portion of KidsCare, the legislation appropriates these funds to DHS for grants to qualifying hospitals.
Year created	1998
Year funding began	FY99
Admin %	10%
Number of contractors/ programs	Information not available
Population served	Low-income uninsured children who are ineligible for Medicaid (highly indicated)
Eligibility requirements	Families with incomes up to 150% of the federal poverty level (FPL) who are not Title XIX eligible. The income limit increases up to 175% of FPL in FY00 and to 200% from FY01, going forward.
ARS data reporting or evaluation requirements	Beginning January 1, 2000, AHCCCS must report annually the following information: <ul style="list-style-type: none"> • Number of children served • State and federal expenditures for the program for the previous state fiscal year • Comparison of expenditures for the previous fiscal year with the expected federal funding for the next year • Whether federal funding will be sufficient for the next year to provide services at the current percentage of the federal poverty level • Any recommendations for changes to the program <p>Also establishes a ten member joint legislative study committee on the integration of health care services to determine the feasibility of integrating the Children's Health Insurance Program, Premium Sharing, and Proposition 203.</p>
Other data collection or evaluation conducted	None

MEDICALLY NEEDY ACCOUNT PROGRAM DESCRIPTIONS

Program name (AZ Revised Statutes)	HIV/AIDS DRUG ASSISTANCE PROGRAM Laws 1998, Fourth Special Session, Chapter 5
Brief description	The Arizona Department of Health Services is responsible for the administration of the AIDS Drug Assistance Program (ADAP). ADAP provides access to medications used to treat and prevent the onset of related opportunistic infections for low-income individuals living with HIV/AIDS. It is funded from three sources: Ryan White CARE Act Titles I and II and state funding. The medications are purchased under a wholesale license issued by the Arizona State Board of Pharmacy and ADHS purchases medications from a wholesaler, stores inventory and distributes the medications. The medications are sent directly to the health care provider or pharmacy. There are currently 22 drugs available on the ADAP formulary.
Year created	1998
Year funding began	FY99
Admin %	0%
Number of contractors/ programs	None
Population served	Low-income individuals with HIV/AIDS in need of medication (highly indicated)
Eligibility requirements	Must be HIV-infected and a resident of Arizona. Annual income must be below 200% of federal poverty level. Must be ineligible for AHCCCS and not have any other benefits that can pay for the medications. Must file an application for AHCCCS and have a denial letter. Must file an application for ADAP.
ARS data reporting or evaluation requirements	None
Other data collection or evaluation conducted	None

Program name (AZ Revised Statutes)	NON-RENAL DISEASE MANAGEMENT (ARS 36-132, Subsection D and 36-2921)
Brief description	1998 Legislation transfers \$200,000 to ADHS for contracts with hospitals licensed by ADHS that perform non-renal organ transplant operations (currently only University Medical Center performs non-renal organ transplants). Contracts do not include payments for transportation to and from treatment facilities. Reimbursement is based on the average wholesale price, less 15%, plus a \$6.00 dispensing fee, plus postage/shipping costs not to exceed \$10.00.
Year created	1998
Year funding began	FY99
Admin %	4%
Number of contractors/ programs	One contractor – University Medical Center
Population served	Persons needing non-renal organ transplant operations and who need financial assistance with their medications (highly indicated)
Eligibility requirements	Non-renal, solid organ transplant recipients who are Arizona residents and meet at least one of the following criteria: <ul style="list-style-type: none"> • Medicare enrollees with exhausted prescription medication benefits • Primary and/or secondary insurance enrollees with exhausted or insufficient prescription medication benefits • Individuals without insurance coverage who are ineligible for AHCCCS coverage Individuals meeting at least one of these criteria must also have completed a self-reported financial screening that shows their monthly expenses, including transplant-related medications, exceed their current family income. Tobacco tax funds can only be used as a payer of last resort.
ARS data reporting or evaluation requirements	None
Other data collection or evaluation conducted	None

MEDICALLY NEEDY ACCOUNT PROGRAM DESCRIPTIONS

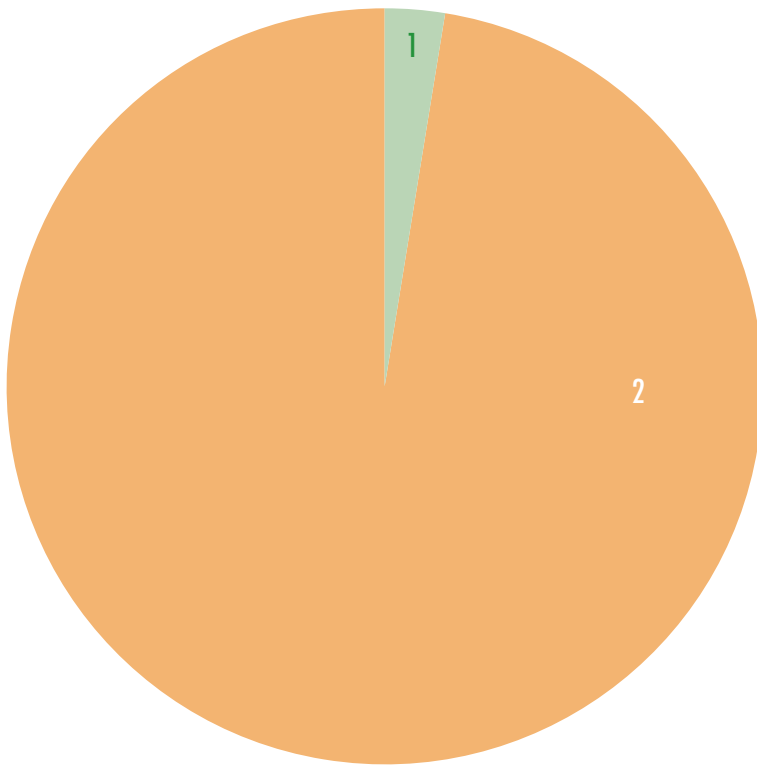
Program name (AZ Revised Statutes)	HEALTHCARE GROUP (AHCCCS Omnibus 1998)
Brief description	Healthcare Group is the registered name of a prepaid medical coverage program developed for small businesses with 50 or fewer employees and political subdivisions within the state. The purpose is to provide health care coverage for the working uninsured population. Healthcare Group is an entity within AHCCCS. In 1998, funds from the tobacco tax-created Medical Services Stabilization Fund were transferred to provide reinsurance to Healthcare Group health plans due to an increase in costs exceeding the amount in premiums received. The increase in cost appeared to be due to several factors, including changes in federal law and actions by private insurance companies which resulted in the pool of Healthcare Group participants containing fewer healthy members and more members with pre-existing conditions and high health care costs. To discourage the adverse selection, the legislation also changed the eligibility for small businesses to prevent businesses from only enrolling their less healthy full-time employees.
Year created	1998
Year funding began	FY99
Admin %	Not applicable
Number of contractors/ programs	Arizona Physicians IPA, Southwest Catholic Health Network (Mercy Healthcare Group), and University Physicians, Inc.
Population served	Enrollees in Healthcare Group; employees of small businesses with less than 50 employees or Arizona political subdivisions with fewer than 50 employees. As of July, 1999, total enrollment was 12,546. (highly indicated)
Eligibility requirements	Changed in 1998 to prevent businesses from enrolling less-healthy members. Small businesses or Arizona political subdivisions with fewer than five full-time employees who choose to enroll in Healthcare Group must now enroll all employees, and companies with between six and 50 full-time employees must enroll 80% of employees.
ARS data reporting or evaluation requirements	None
Other data collection or evaluation conducted	None

Program name (AZ Revised Statutes)	TOBACCO EDUCATION (Ars 42-1242)
Brief description	Media campaign intended to prevent youth and pregnant/postpartum women from smoking
Year created	1995
Year funding began	FY95
Admin %	4%
Number of contractors/ programs	Local Projects = 17 (15 counties plus Scottsdale School District and Intertribal Council) Media Campaign = 2 contractors Evaluation = 4 contracts Miscellaneous = 7 contracts (museums, school bus ads, etc.)
Population served	Media campaign intended to prevent youth and pregnant/postpartum women from smoking (universe)
Eligibility requirements	Because it is a media campaign, eligibility is not applicable.
ARS data reporting or evaluation requirements	ARS 42-1242 indicates that one of the purposes for the funds is for "evaluation and other programs to discourage tobacco use among the general populations." There is no specific statutory requirements related to the elements of the evaluation, however.
Other data collection or evaluation conducted	ADHS has contracted with the Behavioral Sciences Section of the Arizona Cancer Center at the University of Arizona to conduct an outcome and cost effectiveness evaluation of its anti-tobacco use media campaign. The evaluation will include: random sample telephone surveys, an in-depth survey of youth in schools, in-depth telephone interviews with pregnant and postpartum women, focus groups with youth, and a study of media campaign cost-effectiveness.

MEDICALLY NEEDY ACCOUNT PROGRAMS NOT PROVIDING DIRECT CLIENT SERVICE

PROGRAM OR ALLOCATION	BRIEF DESCRIPTION
Maternity Length of Stay	To provide coverage for an extended maternity length-of-stay of no less than 48 hours following a normal delivery or 96 hours following a cesarean section as required by law. This funding provided the additional funds needed for AHCCCS to comply with the law for AHCCCS eligible persons.
Offset Loss in Federal Funding	To replace federal funds reduced due to the lower federal matching assistance percentage for federal fiscal years 1996-97 and 1997-98 as reported by the U.S. Dept. of Health and Human Services.
Phase-Down of Quick Pay	To continue the scheduled phase-out of the quick payment discount required by Laws 1993, second special session, chapter 6, sections 27 and 29, as amended by Laws 1995, first special session, chapter 5, section 6 and 8.
\$10 Million Hospital Reimbursement	To discontinue the annual ten million dollar discount on private hospital reimbursement required by Laws 1993, second special session, chapter 6, section 39, as amended by Laws 1995, first special session, chapter 5, section 10.
AHCCCS Medical Services Stabilization Fund	Established as a transfer from the medically needy and indigent stabilization fund within AHCCCS to be used to offset the cost of providing levels of services to persons determined medically indigent, medically needy, or low-income children. Beginning on August 1, 1995 and on the first day of each month thereafter, \$1,250,000 to be transferred into the fund. Legislation during the 1998 session ceased the transfer of dollars into this fund.
Salome Health Services	A one-time appropriation awarded to Salome's non-profit medical association to provide services to residents in the Salome area during SFY 1998.
Rural Private Primary Care Provider Loan Repay Programs	Created in 1997 as a complement to the existing loan repayment program. It creates financial incentives to both recruit and retain primary care providers in designated medically underserved areas and increases the availability of primary health care providers.
Primary Care Capital Construction Projects	A transfer of funds to DHS for capital project grants to public and non-profit entities that provide health services in rural and/or medically underserved areas.

TOBACCO TAX MEDICALLY NEEDY ACCOUNT FUNDS – FY 1995



Total Funds Available: \$39,174.1

Total Expenditures: \$1,003

1 Organ Transplants	2.6%	\$ 1,003.0
2 Unspent	97.4%	\$ 38,171.1

Expenditures in 000's

Source: JLBC

TOBACCO TAX MEDICALLY NEEDY ACCOUNT FUNDS – FY 1996

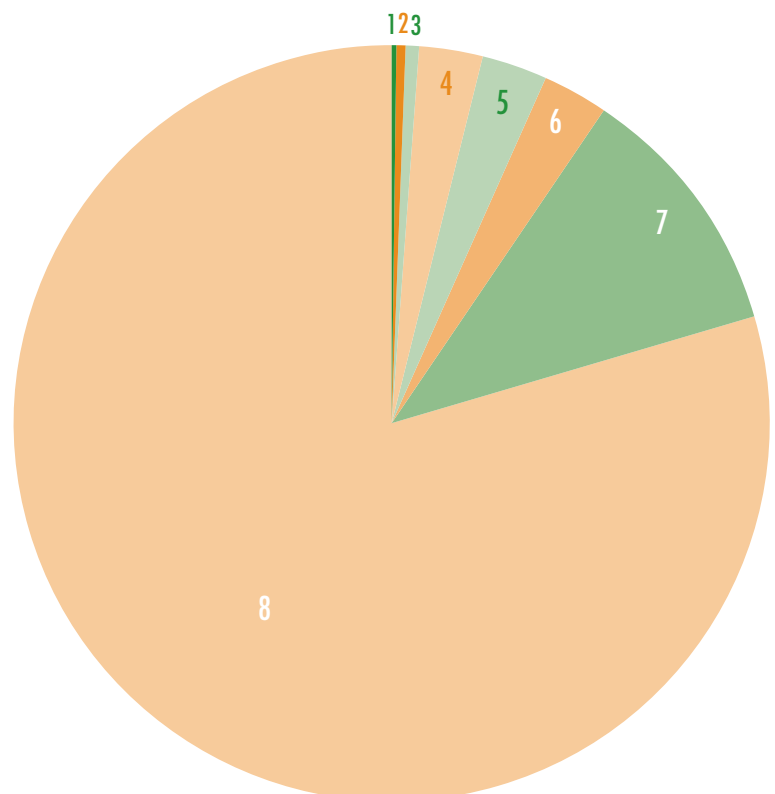
Total Funds Available: \$128,405.8

Total Expenditures: \$26,245

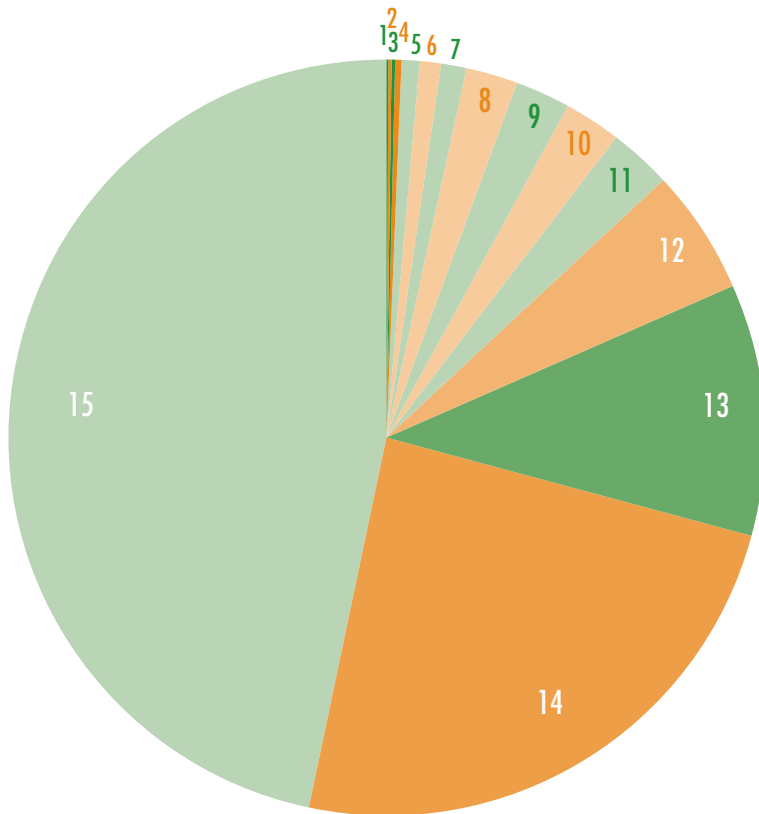
1 Telemedicine Project	<0.5%	\$ 255.0
2 Detox Pilot Program	<0.5%	\$ 500.0
3 Organ Transplants	<1.0%	\$ 734.8
4 Mental Health	2.7%	\$ 3,489.8
5 Qualifying Community Health Centers	2.8%	\$ 3,600.0
6 Primary Care Programs	2.8%	\$ 3,600.0
7 Medical Stabilization Fund	11.0%	\$ 14,065.4
8 Unspent	79.5%	\$102,160.8

Expenditures in 000's

Source: JLBC



TOBACCO TAX MEDICALLY NEEDY ACCOUNT FUNDS – FY 1997



Total Funds Available: \$189,074.9

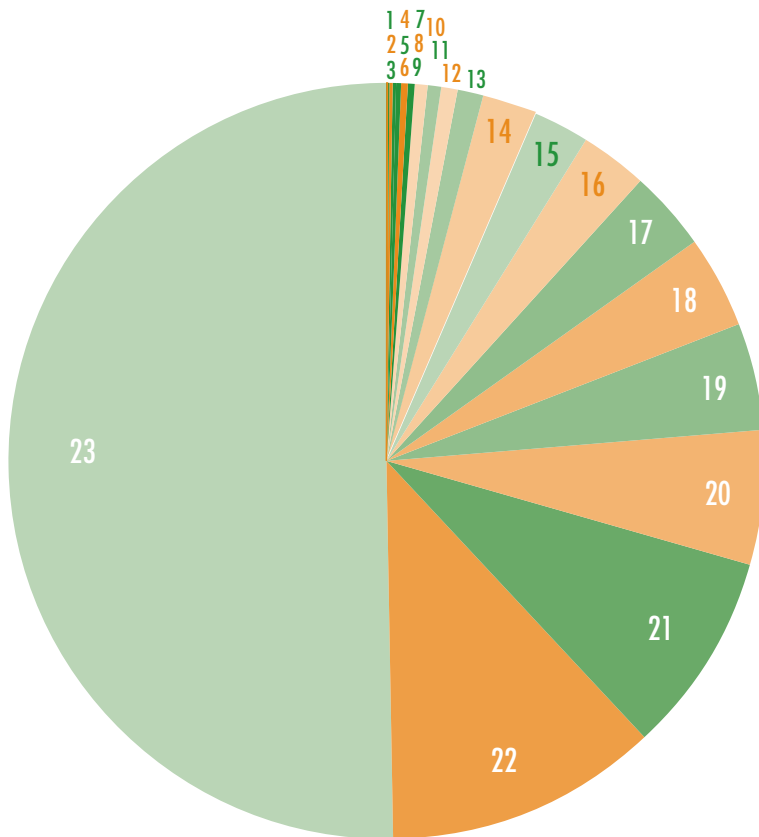
Total Expenditures: \$99,482.3

1	Renal Disease Management	<0.25%	\$ 150.0
2	Telemedicine Project	<0.25%	\$ 255.0
3	Evaluations	<0.25%	\$ 282.0
4	Detox Pilot Program	<0.50%	\$ 500.0
5	Basic Children's Medical Services	<1.00%	\$ 1,429.6
6	Organ Transplants	<1.00%	\$ 1,707.9
7	Offset Loss in Federal Funding	1.00%	\$ 2,021.2
8	Primary Care Programs	2.20%	\$ 4,134.7
9	Qualifying Community Health Centers	2.30%	\$ 4,404.1
10	Phase-Down of Quick Pay	2.40%	\$ 4,522.8
11	Mental Health	2.60%	\$ 5,000.0
12	10 M Hospital Reimbursement	5.20%	\$ 10,000.0
13	Premium Sharing Fund	10.60%	\$ 20,075.0
14	Medical Stabilization Fund	23.80%	\$ 45,000.0
15	Unspent	48.00%	\$ 87,187.1

Expenditures in 000's

Source: JLBC

TOBACCO TAX MEDICALLY NEEDY ACCOUNT FUNDS – FY 1998



Total Funds Available: \$175,743.9

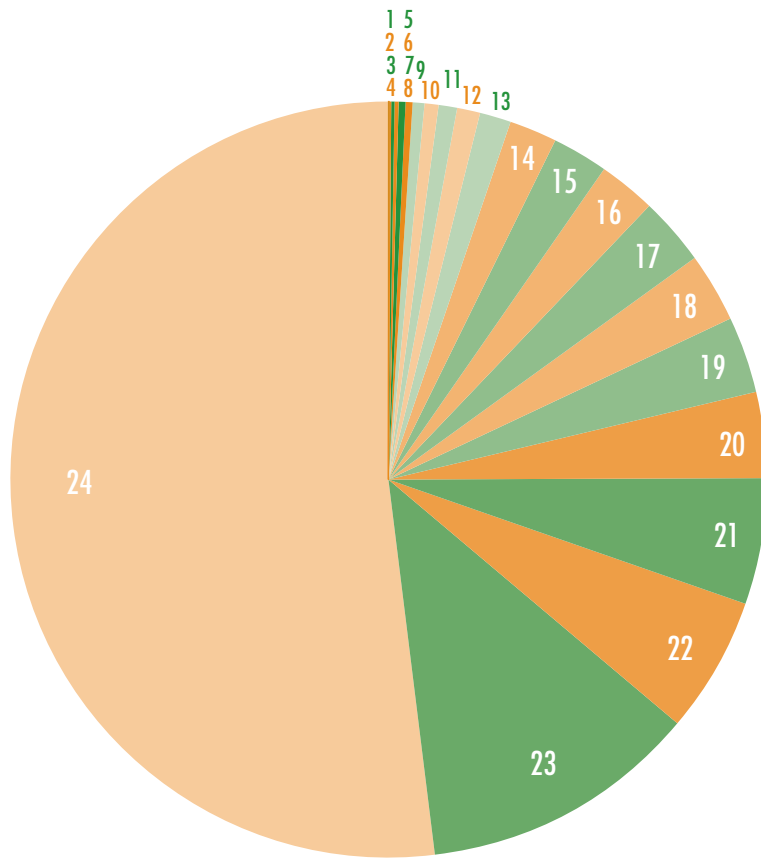
Total Expenditures: \$88,191.1

1	Rural PCP Loan Repay Program	<0.25%	\$ 16.1
2	Salome Health Services	<0.25%	\$ 65.0
3	Primary Care Capital Construction	<0.25%	\$ 136.2
4	Evaluations	<0.25%	\$ 242.6
5	Renal Disease Management	<0.25%	\$ 250.0
6	Telemedicine	<0.25%	\$ 368.3
7	DES Aging and Adult Administration	<0.50%	\$ 500.0
8	Detoxification Services	<0.50%	\$ 500.0
9	Public Health Education	<1.00%	\$ 957.6
10	Health Crisis Fund	<1.00%	\$ 1,000.0
11	HIV/AIDS Treatment	<1.00%	\$ 1,223.9
12	Organ Transplants	<1.00%	\$ 1,619.2
13	Maternity Length of Stay	1.10%	\$ 1,919.0
14	Basic Children's Medical Services	2.30%	\$ 4,086.3
15	Offset Loss in Federal Funding	2.40%	\$ 4,145.0
16	Mental Health	2.90%	\$ 5,000.0
17	Primary Care Programs	3.40%	\$ 5,983.2
18	Qualifying Community Health Centers	3.90%	\$ 6,874.9
19	Phase-Down of Quick Pay	4.50%	\$ 7,978.8
20	\$10 M Hospital Reimbursement	5.70%	\$ 10,000.0
21	Medical Services Stabilization Fund	8.40%	\$ 15,000.0
22	Premium Sharing Project	11.60%	\$ 20,325.0
23	Unspent	49.80%	\$ 87,552.8

Expenditures in 000's

Source: JLBC

TOBACCO TAX MEDICALLY NEEDY ACCOUNT FUNDS – FY 1999



Total Funds Available: \$171,680.3

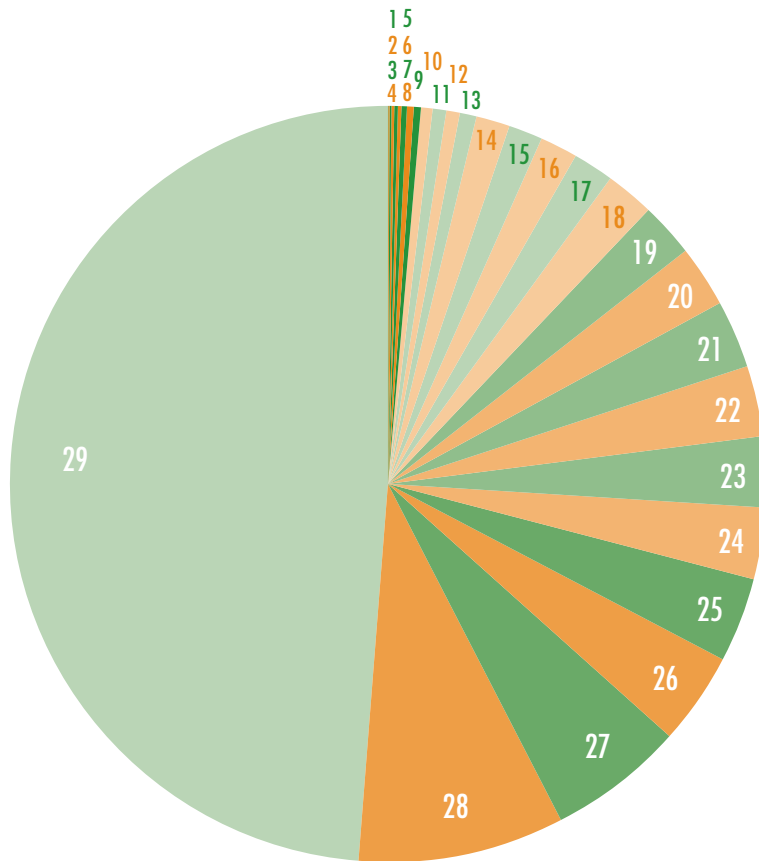
Total Expenditures: \$82,469.7

1	Nonrenal Disease Management	<0.25%	\$ 9.3
2	CHIP Direct Services	<0.25%	\$ 31.7
3	Rural PCP Loan Repay Program	<0.25%	\$ 37.5
4	Telemedicine	<0.25%	\$ 126.3
5	Renal Disease Management	<0.25%	\$ 239.1
6	Evaluations	<0.25%	\$ 298.4
7	DES Aging and Adult Administration	<0.50%	\$ 500.0
8	Detoxification Services	<0.50%	\$ 513.6
9	DHS Health Crisis Fund	<1.00%	\$ 862.8
10	HIV/AIDS Treatment	<1.00%	\$ 1,025.8
11	Primary Care Capital Construction	<1.00%	\$ 1,356.2
12	HIV/AIDS Drug Assistance Program (ADAP)	1.00%	\$ 1,698.1
13	Basic Children's Medical Services	1.30%	\$ 2,294.3
14	Organ Transplants	2.00%	\$ 3,500.0
15	Offset Loss in Federal Funding	2.40%	\$ 4,096.5
16	Maternity Length of Stay	2.50%	\$ 4,213.3
17	Qualifying Community Health Centers	2.90%	\$ 4,998.6
18	Mental Health Programs	3.00%	\$ 5,096.8
19	Primary Care Programs	3.30%	\$ 5,619.7
20	Phase-Down of Quick Pay	3.70%	\$ 6,300.6
21	CHIP-KidsCare	5.40%	\$ 9,251.1
22	\$10 M Hospital Reimbursement	5.80%	\$ 10,000.0
23	Premium Sharing Project	11.80%	\$ 20,400.0
24	Unspent	51.90%	\$ 89,210.6

Expenditures in 000's

Source: JLBC

TOBACCO TAX MEDICALLY NEEDY ACCOUNT FUNDS – FY 2000



Total Funds Available: \$172,254.6

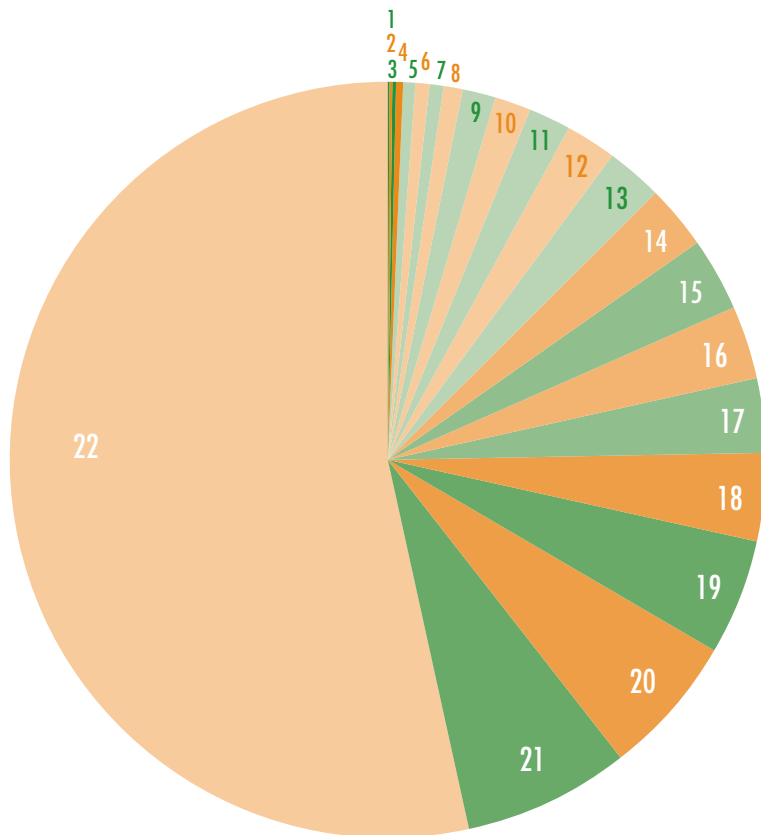
Total Expenditures: \$88,265.5

1	DHS Health Crisis Fund	<0.25%	\$ 21.0
2	Ajo Health Services	<0.25%	\$ 95.0
3	Rural PCP Loan Repay Program	<0.25%	\$ 139.0
4	Nonrenal Disease Management	<0.25%	\$ 208.0
5	Renal Disease Management	<0.25%	\$ 260.0
6	Telemedicine	<0.25%	\$ 260.0
7	Premium Sharing Project	<0.25%	\$ 400.0
8	DES Aging and Adult Administration	<0.50%	\$ 500.0
9	Detoxification Services	<0.50%	\$ 520.0
10	Evaluations	<1.00%	\$ 854.2
11	CHIP Direct Services	<1.00%	\$ 1,000.0
12	HIV/AIDS Drug Assistance Program (ADAP)	<1.00%	\$ 1,000.0
13	HIV/AIDS Treatment	<1.00%	\$ 1,229.9
14	Maternity Length of Stay	1.40%	\$ 2,485.8
15	Primary Care Capital Construction	1.40%	\$ 2,500.0
16	Public Health Education	1.60%	\$ 2,777.8
17	Psychotropic Medications – One-Time Allocation	1.70%	\$ 3,000.0
18	Organ Transplants	2.00%	\$ 3,590.0
19	Community Health Centers	2.30%	\$ 4,000.0
20	Offset Loss in Federal Funding	2.60%	\$ 4,542.2
21	Psychotropic Medications for SMI Non-Title XIX	2.80%	\$ 5,000.0
22	Mental Health Programs	3.00%	\$ 5,200.0
23	Qualifying Community Health Centers	3.00%	\$ 5,200.0
24	FY 2000 Medical Inflation	3.00%	\$ 5,276.0
25	Primary Care Programs	3.50%	\$ 6,240.0
26	Phase-Down of Quick Pay	3.90%	\$ 6,794.6
27	\$10 M Hospital Reimbursement	5.70%	\$ 10,000.0
28	CHIP-KidsCare	8.60%	\$ 15,172.0
29	Unspent	50.00%	\$ 83,989.1

Expenditures in 000's

Source: JLBC

TOBACCO TAX MEDICALLY NEEDY ACCOUNT FUNDS – FY 2001



Total Funds Available: \$165,961.0

Total Expenditures: \$77,258.1

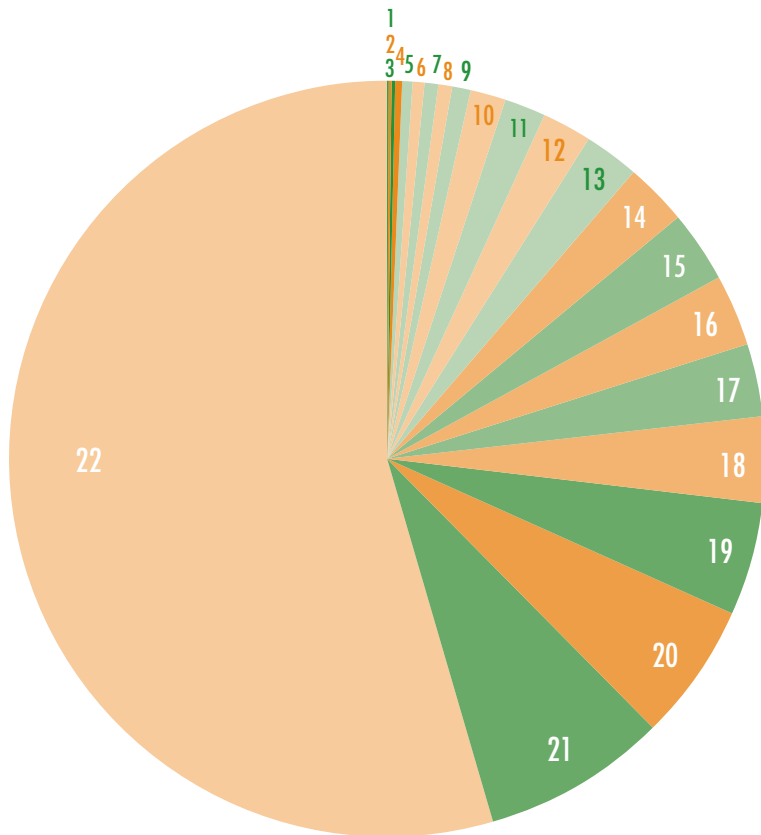
1	Rural PCP Loan Repay Program	<0.25%	\$ 111.2
2	Nonrenal Disease Management	<0.25%	\$ 208.0
3	Renal Disease Management	<0.25%	\$ 260.0
4	DES Aging and Adult Administration	<0.50%	\$ 500.0
5	Evaluations	<1.00%	\$ 854.2
6	CHIP Direct Services	<1.00%	\$ 1,000.0
7	HIV/AIDS Drug Assistance Program (ADAP)	<1.00%	\$ 1,000.0
8	HIV/AIDS Treatment	<1.00%	\$ 1,349.6
9	Public Health Education	1.40%	\$ 2,341.5
10	Maternity Length of Stay	1.50%	\$ 2,572.8
11	Psychotropic Medications One-Time Allocation	1.80%	\$ 3,000.0
12	Organ Transplants	2.20%	\$ 3,590.0
13	Community Health Centers	2.40%	\$ 4,000.0
14	Offset Loss in Federal Funding	2.70%	\$ 4,542.2
15	Mental Health Programs	3.10%	\$ 5,200.0
16	Qualifying Community Health Centers	3.10%	\$ 5,200.0
17	Medical Inflation	3.20%	\$ 5,276.0
18	Primary Care Programs	3.80%	\$ 6,240.0
19	Phase-Down of Quick Pay Discount	4.90%	\$ 8,206.7
20	\$10 M Hospital Reimbursement	6.00%	\$ 10,000.0
21	CHIP-KidsCare	7.10%	\$ 11,805.9
22	Unspent	53.50%	\$ 88,702.9

Expenditures in 000's

Source: JLBC

Projected based on current legislation.

TOBACCO TAX MEDICALLY NEEDY ACCOUNT FUNDS – FY 2002



Total Funds Available: \$169,880.6

Total Expenditures: \$77,259.9

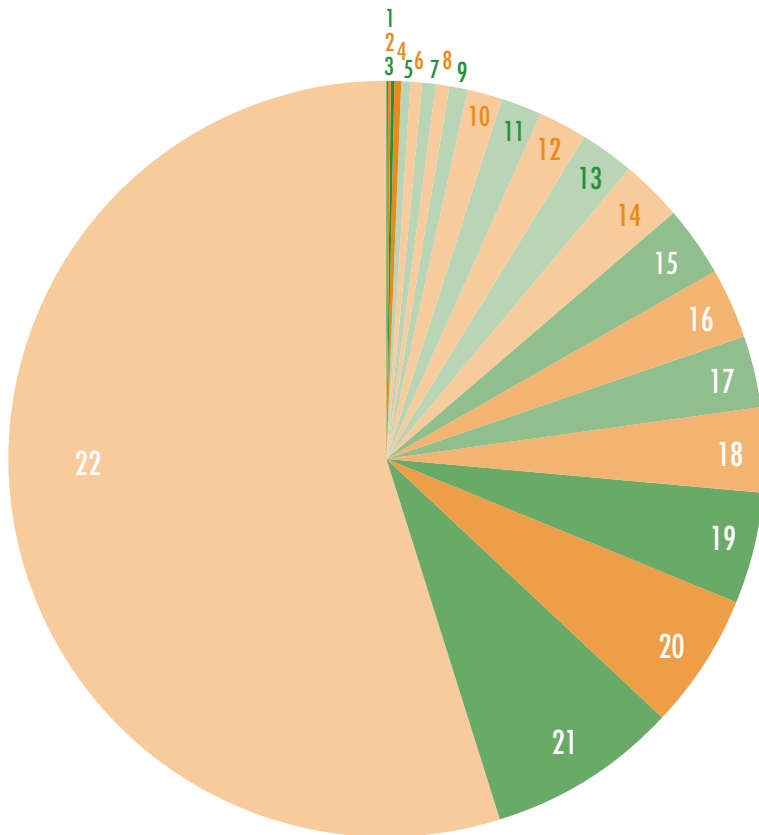
1	Rural PCP Loan Repay Program	<0.25%	\$ 111.2
2	Nonrenal Disease Management	<0.25%	\$ 208.0
3	Renal Disease Management	<0.25%	\$ 260.0
4	DES Aging and Adult Administration	<0.50%	\$ 500.0
5	Public Health Education	0.50%	\$ 753.0
6	Evaluations	<1.00%	\$ 854.2
7	CHIP Direct Services	<1.00%	\$ 1,000.0
8	HIV/AIDS Drug Assistance Program (ADAP)	<1.00%	\$ 1,000.0
9	HIV/AIDS Treatment	<1.00%	\$ 1,349.6
10	Maternity Length of Stay	1.50%	\$ 2,572.8
11	Psychotropic Medications One-Time Allocation	1.80%	\$ 3,000.0
12	Organ Transplants	2.10%	\$ 3,590.0
13	Community Health Centers	2.40%	\$ 4,000.0
14	Offset Loss in Federal Funding	2.70%	\$ 4,542.2
15	Mental Health Programs	3.10%	\$ 5,200.0
16	Qualifying Community Health Centers	3.10%	\$ 5,200.0
17	Medical Inflation	3.10%	\$ 5,276.0
18	Primary Care Programs	3.70%	\$ 6,240.0
19	Phase-Down of Quick Pay	4.80%	\$ 8,206.7
20	\$10 M Hospital Reimbursement	5.90%	\$ 10,000.0
21	CHIP-KidsCare	7.9%	\$ 13,396.2
22	Unspent	54.50%	\$ 92,620.7

Expenditures in 000's

Source: JLBC

Projected based on current legislation.

TOBACCO TAX MEDICALLY NEEDY ACCOUNT FUNDS – FY 2003



Total Funds Available: \$172,430.2

Total Expenditures: \$77,846.7

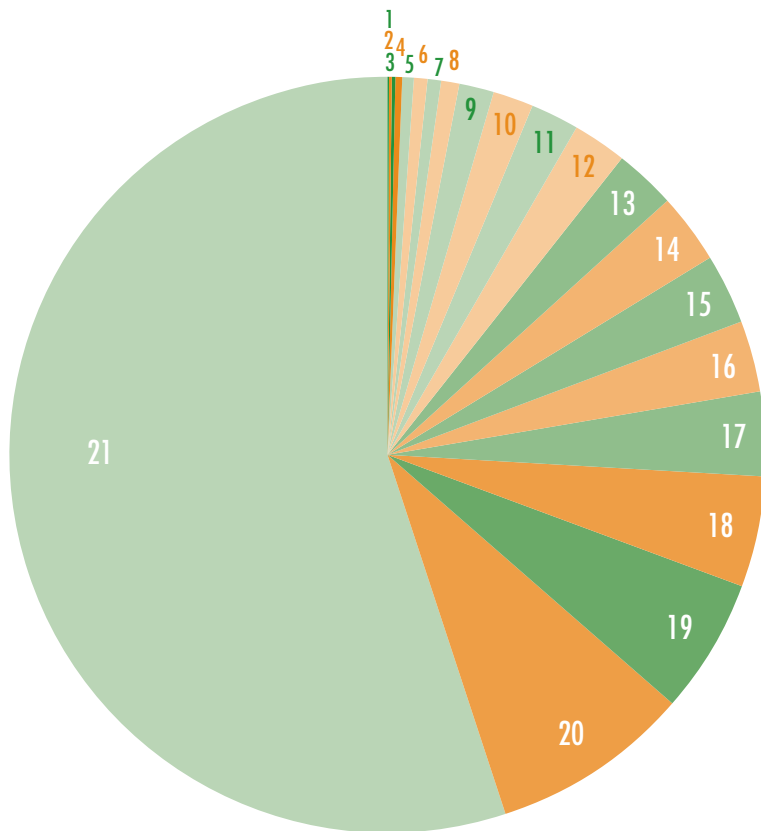
1	Rural PCP Loan Repayment	<0.25%	\$ 111.2
2	Nonrenal Disease Management	<0.25%	\$ 208.0
3	Renal Disease Management	<0.25%	\$ 260.0
4	DES Aging and Adult Administration	<0.50%	\$ 500.0
5	Public Health Education	<0.50%	\$ 670.0
6	Evaluations	<1.00%	\$ 854.2
7	CHIP Direct Services	<1.00%	\$ 1,000.0
8	HIV/AIDS Drug Assistance Program (ADAP)	<1.00%	\$ 1,000.0
9	HIV/AIDS Treatment	<1.00%	\$ 1,349.6
10	Maternity Length of Stay	1.50%	\$ 2,572.8
11	Psychotropic Medications One-Time Allocation	1.70%	\$ 3,000.0
12	Organ Transplants	2.10%	\$ 3,590.0
13	Community Health Centers	2.30%	\$ 4,000.0
14	Offset Loss in Federal Funding	2.60%	\$ 4,542.2
15	Mental Health Programs	3.00%	\$ 5,200.0
16	Qualifying Community Health Centers	3.00%	\$ 5,200.0
17	Medical Inflation	3.10%	\$ 5,276.0
18	Primary Care Programs	3.60%	\$ 6,240.0
19	Phase-Down of Quick Pay	4.80%	\$ 8,206.7
20	\$10 M Hospital Reimbursement	5.80%	\$ 10,000.0
21	CHIP-KidsCare	8.20%	\$ 14,066.0
22	Unspent	54.90%	\$ 94,583.5

Expenditures in 000's

Source: JLBC

Projected based on current legislation.

TOBACCO TAX MEDICALLY NEEDY ACCOUNT FUNDS – FY 2004



Total Funds Available: \$173,279.7

Total Expenditures: \$77,880.0

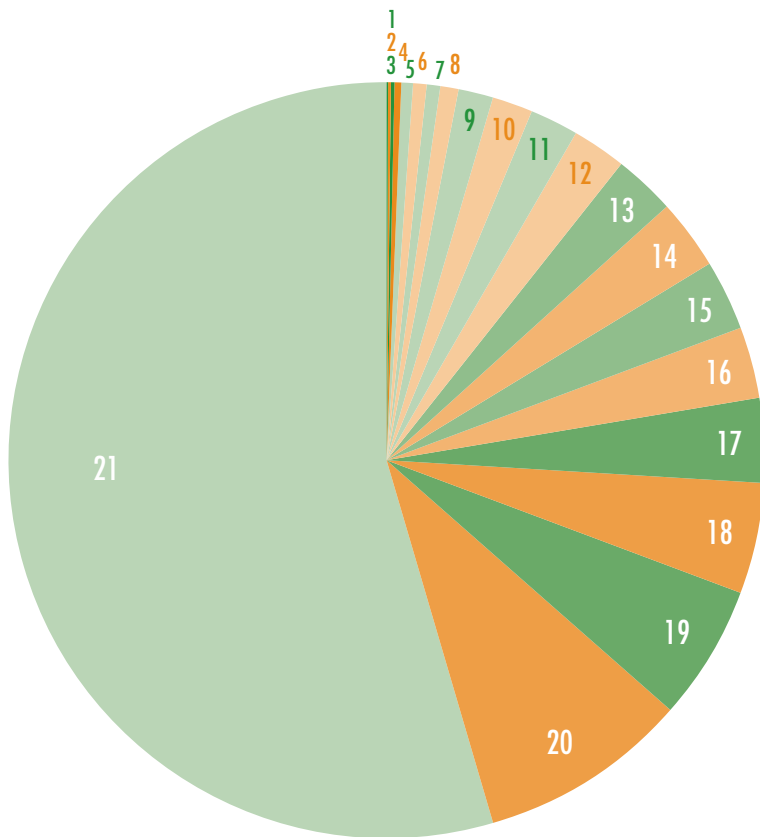
1	Rural PCP Loan Repayment	<0.25%	\$ 111.2
2	Nonrenal Disease Management	<0.25%	\$ 208.0
3	Renal Disease Management	<0.25%	\$ 260.0
4	DES Aging and Adult Administration	<0.50%	\$ 500.0
5	Evaluations	<1.00%	\$ 854.2
6	CHIP Direct Services	<1.00%	\$ 1,000.0
7	HIV/AIDS Drug Assistance Program (ADAP)	<1.00%	\$ 1,000.0
8	HIV/AIDS Treatment	<1.00%	\$ 1,349.6
9	Maternity Length of Stay	1.70%	\$ 2,572.8
10	Psychotropic Medications One-Time Allocation	1.70%	\$ 3,000.0
11	Organ Transplants	2.10%	\$ 3,590.0
12	Community Health Centers	2.30%	\$ 4,000.0
13	Offset Loss in Federal Funding	2.60%	\$ 4,542.2
14	Mental Health Programs	3.00%	\$ 5,200.0
15	Qualifying Community Health Centers	3.00%	\$ 5,200.0
16	Medical Inflation	3.00%	\$ 5,276.0
17	Primary Care Programs	3.60%	\$ 6,240.0
18	Phase-Down of Quick Pay Discount	4.80%	\$ 8,206.7
19	\$10 M Hospital Reimbursement	5.80%	\$ 10,000.0
20	CHIP-KidsCare	8.50%	\$ 14,769.3
21	Unspent	55.10%	\$ 95,399.7

Expenditures in 000's

Source: JLBC

Projected based on current legislation.

TOBACCO TAX MEDICALLY NEEDY ACCOUNT FUNDS – FY 2005



Total Funds Available: \$172,971.3

Total Expenditures: \$78,618.5

1	Rural PCP Loan Repayment	<0.25%	\$ 111.2
2	Nonrenal Disease Management	<0.25%	\$ 208.0
3	Renal Disease Management	<0.25%	\$ 260.0
4	DES Aging and Adult Administration	<0.50%	\$ 500.0
5	Evaluations	<1.00%	\$ 854.2
6	CHIP Direct Services	<1.00%	\$ 1,000.0
7	HIV/AIDS Drug Assistance Program (ADAP)	<1.00%	\$ 1,000.0
8	HIV/AIDS Treatment	<1.00%	\$ 1,349.6
9	Maternity Length of Stay	1.50%	\$ 2,572.6
10	Psychotropic Medications One-Time Allocation	1.70%	\$ 3,000.0
11	Organ Transplants	2.10%	\$ 3,590.0
12	Community Health Centers	2.30%	\$ 4,000.0
13	Offset Loss in Federal Funding	2.60%	\$ 4,542.2
14	Mental Health Programs	3.00%	\$ 5,200.0
15	Qualifying Community Health Centers	3.00%	\$ 5,200.0
16	Medical Inflation	3.10%	\$ 5,276.0
17	Primary Care Programs	3.60%	\$ 6,240.0
18	Phase-Down of Quick Pay	4.70%	\$ 8,206.7
19	\$10 M Hospital Reimbursement	5.80%	\$ 10,000.0
20	CHIP-KidsCare	9.00%	\$ 15,507.8
21	Unspent	54.6%	\$ 94,352.8

Expenditures in 000's

Source: JLBC

Projected based on current legislation.



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