

Executive Summary

Tobacco use is the single most preventable cause of death and disease in the United States. An estimated 46 million American adults currently smoke cigarettes and annually cigarette smoking causes approximately 443,000 deaths. For every person who dies from tobacco use, another 20 suffer with at least one serious tobacco-related illness. In 2004, this addiction cost the nation more than \$96 billion per year in direct medical expenses as well as more than \$97 billion annually in lost productivity.

We know how to end the epidemic of tobacco use and the staggering toll it takes on our families and communities. By putting into place proven tobacco policies and strategies, we have the ability to dramatically reduce the health and economic burden of tobacco use. When combined, these interventions – increasing the price of tobacco products, implementing smoke-free policies, reducing tobacco advertising and promotion, controlling access to tobacco products and promoting and assisting tobacco users to quit – have proven to significantly reduce tobacco use. In California, home of the longest-running comprehensive tobacco control program, adult smoking rates declined from 22.7% in 1988 to 13.3% in 2006. As a result, compared with the rest of the country, heart disease deaths and lung cancer incidence in California have declined at accelerated rates.

This report also highlights how far there is to go before all states have in place the full package of high-impact strategies and policies. And meanwhile, the prevalence of tobacco use has been essentially static for the last few years. Fully funding state tobacco control programs could make a dramatic difference. As Centers for Disease Control and Prevention's (CDC) *Best Practices for Comprehensive Tobacco Control Programs* guidelines demonstrate, this could be accomplished by dedicating just a small portion of what states collect in tobacco tax revenue and tobacco industry settlement payments to tobacco control activities. In 2007, no states were funded at the 100% level recommended by CDC in its 2007 *Best Practices*. Maine ranked first with 85.5% of recommended funding and Tennessee ranked last at 1.1%. Across all states, the median tobacco control funding was only 17.2% of the recommended level. State funding for tobacco control is one of the best predictors of success over time if funds are invested in evidence-based programs. Research shows that the more states spend on sustained comprehensive tobacco control programs, the greater the reductions in smoking – and the longer states continue to invest in such programs, the greater and faster the impact.

One of the ways in which states can increase funding for tobacco control programs is by increasing the price of tobacco products through higher excise taxes, with a portion of the revenue dedicated to tobacco control efforts. Not only does raising the price of cigarettes lead to a reduction in smoking – especially among young people – but it also benefits state governments by providing a way to fund essential services such as health care and tobacco prevention and control programs. While the national average for state cigarette taxes at the end of 2009 was \$1.34, the range was from \$3.46 per pack in Rhode Island to \$0.07 per pack in South Carolina. And while 2 states had taxes above \$3.00 per pack (Rhode Island, Connecticut), 12 states had taxes at or below \$0.60 per pack (Kentucky, Wyoming, Idaho, West Virginia, North Carolina, North Dakota, Alabama, Georgia, Louisiana, Virginia, Missouri, and South Carolina).

While adequate funding for comprehensive programs is crucial, there are policies and interventions that are possible to put into place with fewer resources but with significant potential impact. State-wide smoke-free laws are one example. Eliminating smoking in indoor spaces is the only way to fully protect nonsmokers from secondhand smoke exposure. Worksites are a major source of exposure for nonsmokers, and workers in restaurants and bars are especially likely to be exposed to secondhand smoke, often at high concentrations. Creating smoke-free policies in workplaces and other public places not only protects nonsmokers from involuntary exposure to the toxins in tobacco smoke, but also may have the added benefits of increasing the number of smokers who quit and reducing tobacco consumption by those who continue to smoke.

Existing state laws range from those that prohibit smoking in all indoor areas of workplaces, restaurants, bars and other public places to partial coverage in only one or two of these areas, to inadequate coverage (e.g. designated or ventilated smoking rooms) or no coverage at all. As this report indicates, in 2010 there are still 29 states that provide inadequate or no protection from secondhand smoke exposure. Seven of these states – Indiana, Kentucky, Mississippi, South Carolina, Texas, West Virginia and Wyoming – have no statewide smoke-free laws of any strength in place to protect their citizens from secondhand smoke.

A clear example of the importance of adequate funding for tobacco control programs is in the implementation of counter-marketing media campaigns. Evidence shows that to be effective, these types of campaigns must have sufficient reach, frequency and duration. Thus, without adequate funding, CDC recommends using funds for media advocacy and earned media opportunities rather than low-intensity paid campaigns. This report demonstrates that few states were able to mount adequate counter-marketing campaigns in 2008. Indeed, four states had no televised campaigns (Alabama, Georgia, Mississippi, and North Dakota) and two additional states had no televised campaigns targeting youth (Tennessee and Texas).

Increasing the number of states that provide Medicaid coverage for counseling and medications is another policy intervention with potential impact that isn't yet fully realized. Medicaid enrollees smoke at a substantially higher rate than the general population. The Public Health Service's *Clinical Practice Guideline* for cessation recommends comprehensive insurance coverage of tobacco dependence treatments without barriers that reduce utilization and subsequent success of these services by all health insurance providers, including Medicaid. This document reports that in 2007, only seven states (Indiana, Massachusetts, Minnesota, New Mexico, Oklahoma, Oregon, and Pennsylvania) provided insurance coverage to Medicaid enrollees for all FDA-approved medicines and counseling. Conversely, six states (Alabama, Connecticut, Georgia, Missouri, Nebraska, and Tennessee) had no coverage at all for their Medicaid population.

At the end of this document, there are tables showing the states' current status and rank (relative to other states) with respect to funding for tobacco control, cigarette excise tax, indoor smoke-free laws, counter-marketing media campaigns, and Medicaid coverage. These indicators all represent important policies and interventions that can be put in place to reduce tobacco-related morbidity and mortality.

In 2007, the Institute of Medicine (IOM) released *Ending the Tobacco Problem: A Blueprint for the Nation* with the goal of reducing smoking "so substantially that it is no longer a significant public health problem for our nation." The IOM Committee on Reducing Tobacco Use concluded that this ultimate goal could be achieved with a two-pronged strategy: strengthening and fully implementing traditional tobacco control measures like the ones mentioned above, and changing the regulatory landscape around tobacco products.

On June 22, 2009, the U.S. enacted Family Smoking Prevention and Tobacco Control Act (FSPTCA). This historic legislation grants authority to the U.S. Food and Drug Administration (FDA) to regulate tobacco products. Among other things, the FSPTCA provides FDA with authority to regulate marketing and promotion of tobacco products and to set performance standards for tobacco products to protect the public's health. Through this legislation, states and local communities are also granted the authority to impose restrictions that are in addition to or more stringent than FDA requirements, such as specific bans or restrictions on the time, place, and manner of cigarette advertising.

In conclusion, we know what to do to end this epidemic and we know how to do it. We need to invest, and we need to implement. If, within the next 3-5 years, all states were to fully implement the strategies described in this report, rates of tobacco use would decline precipitously. And, most important, we could prevent the staggering toll that tobacco takes on our families and communities.