

Executive Summary

Tobacco use continues to be the single most preventable cause of death and disease in the United States. Each year, approximately 443,000 people die from cigarette smoking or exposure to second-hand smoke, and another 8.6 million suffer from a serious smoking-related illness. While the percentage of American adults who smoke cigarettes has decreased and those who smoke are smoking fewer cigarettes per day, approximately one in five adults is still smoking cigarettes. Large disparities in smoking prevalence exist between population subgroups, with higher smoking prevalence among American Indians and Alaska Natives as well as those who live below the poverty level and those with less education. If current smoking trends continue, the national *Healthy People 2020* objective to reduce cigarette smoking prevalence to 12% will not be met.

In addition, disparities exist in tobacco use across the states. In 2011, adult cigarette smoking prevalence ranged from 11.8% in Utah to 29.0% in Kentucky, with a median prevalence of 21.2% across all states. In 2011, adult smokeless tobacco use prevalence also varied widely across all states, ranging from 1.4% in California and Rhode Island to 9.8% in Wyoming, with a median prevalence of 4.4% across all states. Similarly, among youth, a wide range in the proportion of high school students who reported using tobacco in the past 30 days exists across all states. In 2011, past 30-day cigarette smoking prevalence among high school students ranged from 5.9% in Utah to 24.1% in Kentucky. Smokeless tobacco use among high school students ranged from 3.5% in Hawaii to 16.9% in Kentucky, and cigar smoking among high school students ranged from 5.0% in Utah to 18.3% in South Carolina.

Tobacco use also exacts a huge economic toll. During 2000–2004, cigarette smoking was estimated to be responsible for \$193 billion in annual health-related economic losses in the United States, with \$96 billion in direct medical costs and approximately \$97 billion in lost productivity. Moreover, cigarette smoking results in 5.1 million years of potential life lost in the United States annually.

The scientific evidence is available that demonstrates what is needed to accelerate progress to drive down prevalence of tobacco use and how it can be done. The MPOWER framework, which was first released by the World Health Organization in 2008, describes the evidence-based, high-impact strategies that have proven to dramatically reduce the health and economic burden of tobacco use in many countries. These strategies, which include increasing the price of tobacco products, implementing smoke-free policies, reducing pro-tobacco advertising and promotion, controlling access to tobacco products, and assisting tobacco users to quit, have proven to significantly reduce tobacco use.

The Institute of Medicine concluded that fully funding comprehensive tobacco control programs is a critical component to support high-impact interventions that are known to decrease tobacco use, thereby improving public health. In fact, state funding for tobacco control is one of the best predictors of success over time when funds are invested in evidence-based tobacco control programs. Research shows that the more states spend on sustained, comprehensive tobacco control programs, the greater the reductions in smoking prevalence; also, the longer states continue to invest in such programs, the greater the impact. The Centers for Disease Control and Prevention's (CDC's) *Best Practices for Comprehensive Tobacco Control Programs—2007* not only outlines the program structure for implementing evidence-based comprehensive tobacco control programs but also provides recommended levels of state investment to reduce tobacco use in each state. In 2011, research by Chattopadhyay and Peiper indicates that if states were to follow *Best Practices* funding guidelines, they could potentially save between 14 and 20 times more money than the cost of implementing these programs.

Scientific evidence has demonstrated that statewide smoke-free policies are another high-impact strategy for helping smokers quit and reducing tobacco consumption by those who smoke. Furthermore, the Surgeon General concluded in 2006 that evidence is clear that 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 at high risk of being exposed to secondhand smoke, often at high concentrations. As of June 30, 2012, 25 states and the District of Columbia have comprehensive smoke-free laws that prohibit smoking in workplaces, restaurants, and bars, leaving residents in 25 states without adequate protection from the harmful effects of secondhand smoke.

Although close to 70% of current smokers say that they want to quit and approximately 50% try to quit each year, most smokers who want to quit must make multiple attempts before they are successful. Telephone quitlines and the use of Food and Drug Administration (FDA)-approved medications and counseling have proven to be effective in helping smokers quit successfully. For multiple reasons, including limited access to evidence-based cessation treatment, Medicaid enrollees continue to have a higher prevalence of smoking. While this report provides data for state Medicaid coverage for tobacco dependence treatment as of 2010, all states are in the process of transforming tobacco dependence coverage. For example, the Patient Protection and Affordable Care Act (Affordable Care Act) provides that all adults should be screened for tobacco use and tobacco cessation interventions be offered to those who smoke at no cost-sharing; in addition, the law provides that pregnant women should receive augmented, pregnancy-tailored counseling without cost-sharing. The Affordable Care Act mandates that beginning in 2014, states are precluded from excluding tobacco cessation drugs from coverage for Medicaid enrollees. As these and other cessation services expand, states will need to plan to adequately and appropriately promote their availability and encourage access to evidence-based cessation services.

Well-designed, “hard-hitting” countermarketing media campaigns with sufficient reach, duration, and frequency are an effective approach to decreasing the likelihood that people will begin smoking cigarettes, increasing smoking cessation, and reducing nonsmokers’ exposure to secondhand smoke. Countermarketing messages can also be used to educate the public about the dangers of tobacco use, encourage tobacco users to quit, and provide them with information about resources that are available to help them quit. Unfortunately, due to current funding for state tobacco control programs, most states do not have the resources necessary to mount a hard-hitting media campaign of sufficient reach, duration, and frequency. As this report describes, no states were able to mount a media campaign in 2010 that fulfilled the CDC *Best Practices* media funding recommendation of 800 youth targeted rating points (80% of the audience reached with 10 exposures each), and only 9 states were able to meet the recommendation of 1,200 general audience gross ratings points (80% of the audience reached with 15 exposures each) per quarter.

Controlling access to tobacco products by requiring businesses to obtain a license to sell tobacco products over the counter will aid in enforcement and compliance with local, state, and federal tobacco laws. This report indicates that as of June 30, 2012, 37 states require licensure for over-the-counter cigarette sales, and 29 states require licensure for smokeless tobacco product sales. The fee for licensure in the 37 states ranges from \$0 in Massachusetts and Nevada to \$200 in Indiana.

Scientific evidence found in *The Guide to Community Preventive Services: What Works to Promote Health* has shown that increasing the price of tobacco products is one of the most effective strategies for preventing and reducing tobacco use; the revenues from excise tax increases can provide a way for state governments to fund public health and health care programs, especially tobacco prevention

and control programs. As of June 30, 2012, the median state cigarette excise tax across all states was \$1.339, with a range of \$4.35 in New York to \$0.17 in Missouri. However, in 2011, there were no substantial increases in state cigarette excise taxes, and one state—New Hampshire—actually reduced the amount of its tax.

The enactment of the Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act) in 2009 granted FDA authority to regulate the manufacturing, marketing, and distribution of tobacco products and to set performance standards for tobacco products to protect the public's health. In addition, the Tobacco Control Act grants authority to state and local governments to regulate tobacco products in certain specific respects. For example, the Tobacco Control Act partially rescinded federal preemption and allows state and local restrictions on the time, place, and manner of cigarette advertising and promotion. As this report indicates, 12 states preempt local community retail display laws, 13 preempt promotion laws, and 14 preempt sampling laws.

The tobacco control community knows what to do to end the epidemic of tobacco use. The science supporting the effectiveness of interventions, such as implementing smoke-free policies, increasing the price of tobacco products, running hard-hitting countermarketing, reducing pro-tobacco promotion, and assisting tobacco users to quit, has existed for many years and continues to strengthen. According to CDC's *Best Practices*, if, within the next 5 years, all state tobacco control programs were funded at CDC-recommended levels and all were to fully implement evidence-based tobacco control strategies reaching all populations, prevalence of tobacco use would decline precipitously. Most importantly, we could prevent the staggering toll that tobacco takes on our families and communities.