

Introduction

“What will it take to end the tobacco epidemic in the United States?”

Each year, approximately 443,000 people die from smoking or exposure to secondhand smoke, and another 8.6 million suffer from a serious smoking-related illness.¹ Moreover, annual costs associated with tobacco-related illness amount to nearly \$96 million in medical expenses and \$97 million in lost productivity, resulting in 5.1 potential million years of potential life lost in the United States annually.¹ In 2011, 18.1% of high school students were current smokers.² Large disparities in tobacco use continue to exist among racial and ethnic groups and across socioeconomic positions. While the current prevalence of adult smoking is 19.0% overall, the smoking prevalence for American Indian and Alaska Native adults is 31.5%.³ Furthermore, while 26 states* now have comprehensive smoke-free air laws protecting citizens from the harmful effects of exposure to secondhand smoke, 52% of the U.S. population still is not protected.⁴

While data indicate that proportionately fewer adults are smoking today than 5 years ago and those who do smoke are smoking fewer cigarettes each day, tobacco use still is far from becoming a minor nuisance.⁵ Declining fiscal resources and public misperceptions that “the tobacco problem is solved” have contributed to a recent deceleration in tobacco control progress. Between 1998 and 2008, the adult cigarette smoking prevalence declined from 24.1% to 20.6%.⁶ Similar to adult prevalence, the recent rate of decline in youth cigarette smoking represents a much slower decline than experienced from 1997–2003,⁷ and year-to-year decreases in smoking prevalence have been observed only sporadically in recent years. While the majority of those who begin using tobacco are younger than 18 years of age, there has been an increase in initiation among those who are 18 years of age or older.⁸ Consequently, tobacco control programs need to effectively counter pro-tobacco messages by reaching all populations to prevent another generation of addicted adults.

Meanwhile, the tobacco industry continues to outspend tobacco control dollars by a ratio of more than 23 to 1. In 2008, major cigarette and smokeless tobacco companies spent approximately \$10.5 billion on marketing and promotion of their products while state tobacco control program budgets amounted to approximately \$456.7 million.⁹ While the tobacco industry continues to spend billions to promote its products, funding for comprehensive state tobacco control programs has declined significantly over the past several years—despite collection of state revenues of \$25.6 billion from the Master Settlement Agreement (MSA) and tobacco taxes. In fact, states have reduced funding for tobacco prevention and cessation programs by 12% between 2010 and 2011 and by 36% between 2007 and 2011, and current tobacco control funding is the lowest since 1999, when states first received tobacco settlement payments.^{9,10}

We know that the more states spend on tobacco control programs, the greater the reductions in smoking; also, the longer states invest in such programs, the greater the effect.¹¹ However, collectively, states are spending less than 2% of tobacco-related revenue on tobacco prevention and cessation programs.¹² In fact, recent research indicates that if states were to follow *Best Practices* funding guidelines, they could potentially save between 14 and 20 times more than the cost of implementing these programs.¹³

Funding the implementation of proven, high-impact strategies can dramatically reduce the health and economic burden of tobacco use. Increasing the price of tobacco products, implementing smoke-free policies, reducing pro-tobacco advertising and promotion, controlling access to tobacco products, and promoting and assisting tobacco users to quit are the interventions that

* In this report, “states” includes the 50 states and the District of Columbia.

most effectively drive down tobacco use. More than a decade ago, the independent Task Force on Community Preventive Services provided recommendations on the most effective community-based strategies for tobacco use prevention and control.¹⁴ The Centers for Disease Control and Prevention (CDC) has published two editions of *Best Practices for Comprehensive Tobacco Control Programs* (1999 and 2007) that provide the structure and recommended levels of state investment for comprehensive programs.¹¹ In 2007, the Institute of Medicine (IOM) released *Ending the Tobacco Problem: A Blueprint for the Nation*,¹⁵ 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 goal could be achieved with a two-pronged strategy: strengthening and fully implementing traditional tobacco control measures and changing the regulatory landscape to permit policy innovations¹⁵ such as the ones included in this report.

The time is now. With several recent major initiatives, there has never been a more opportune time for significant progress in reducing tobacco-related death and disease. In 2009, the United States enacted the Family Smoking Prevention and Tobacco Control Act¹⁶ that grants authority to the Food and Drug Administration (FDA) to regulate the manufacturing, marketing, and distribution of tobacco products. As part of its authority, FDA has banned deceptive marketing terms such as “light,” “low tar,” and “mild” on cigarettes and has required larger, more prominent cigarette health warnings on all cigarette packaging and advertising. (At the time of this report’s production, the implementation of the health warnings has been halted due to ongoing litigation.) If the proposed cigarette warning labels go into effect, they will represent the first change in cigarette warnings in more than 25 years and would represent a significant advancement in communicating the dangers of smoking. FDA will continue to consider additional regulatory requirements in the future.

Also for the first time in history, the Department of Health and Human Services has created a tobacco control strategic plan entitled *Ending the Tobacco Epidemic: A Tobacco Control Strategic Action Plan for the U.S. Department of Health and Human Services*.¹⁷ Based on strong scientific evidence supporting the effectiveness of mass media in reducing tobacco use initiation and assisting tobacco users in quitting, one of the four pillars of this plan is a recommendation for a national media and communications campaign to raise awareness and shift key attitudes and beliefs about tobacco use and exposure to secondhand smoke. In early 2012, CDC launched a national education campaign including print, radio, TV, billboard, Web, and social media elements to educate the public about the harmful effects of tobacco use and the consequences of living with a disease caused by tobacco smoke. This national campaign and other hard-hitting media campaigns will have significant potential for dramatically increasing the public’s understanding of the health risks associated with smoking and helping those who want to quit by providing information on cessation resources.

A third opportunity to accelerate progress results from the influx of funding to states, communities, and tribal entities through the American Recovery and Reinvestment Act of 2009 and the Patient Protection and Affordable Care Act of 2010.¹⁸ Communities Putting Prevention to Work and Community Transformation Grants enabled states, communities, tribes, and national organizations to work on proven, population-based strategies to reduce tobacco use and other behaviors that contribute to chronic diseases such as heart disease, cancer, stroke, and diabetes.

A fourth historic opportunity comes from the development and implementation of the 2009–2010 National Adult Tobacco Survey (NATS) that established a comprehensive framework for evaluating national and state-specific tobacco control programs. Also, through its National Tobacco Control Program (NTCP), CDC supports all 50 states and the District of Columbia as well as 8 U.S. territories or jurisdictions, 6 national networks, and 7 tribal support centers. The goals of NTCP are to prevent tobacco initiation among young people, promote quitting among adults and youth, elimi-

nate exposure to secondhand smoke, and identify and eliminate tobacco-related disparities among population groups. With the availability of both national and state-specific data from the 2009–2010 NATS, there is increased capacity to evaluate NTCP and better monitor the factors promoting and impeding progress in each state.

Given this time of multiple historic opportunities to improve health, it is crucial that federal, state, and local partners act now to end the epidemic of tobacco use and the resulting enormous toll it takes on individuals, families, and communities. Fully funding state tobacco control programs by investing a portion of the amount collected in tobacco tax revenue and tobacco industry settlement payments and putting in place high-impact tobacco policies and strategies such as those described in the MPOWER framework could make a dramatic difference in reducing the health and economic burden imposed by tobacco use.

MPOWER

M = **Monitor** tobacco use and prevention policies

P = **Protect** people from tobacco smoke

O = **Offer** help to quit tobacco use

W = **Warn** about the dangers of tobacco

E = **Enforce** bans on tobacco advertising, promotion, and sponsorship

R = **Raise** taxes on tobacco

Purpose of This Document

The purpose of *Tobacco Control State Highlights 2012* is to provide tobacco control programs in the 50 states and the District of Columbia with valid, reliable, state-specific data about the high-impact, cost-effective strategies they are currently using or could be implementing as well as measures to track their progress. This document is also intended to provide decision makers and tobacco control programs with useful and accessible state-level data to assist with decision making.

As in *Tobacco Control Highlights 2010*, CDC's *Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs* describes the rationale for many of the measures included in this publication. These are key indicators to monitor program success, and these indicators have been scientifically linked to positive outcomes.¹⁹ Some of the indicators also relate to the health objectives of *Healthy People 2020*.²⁰ Again, this report is organized according to the MPOWER framework to demonstrate the utility of MPOWER and the manner in which high-impact strategies are aligned with this framework.

Tobacco Control State Highlights 2012 has several new features. First, the availability of the 2009–2010 NATS data means that we can now examine short- and intermediate-term indicators of progress, such as attitudes, beliefs, and knowledge, across the states. Secondly, this edition includes data related to tobacco products other than cigarettes, such as smokeless tobacco and cigars. Finally, it also examines trends in cigarette smoking initiation among youth and young adults, which has not been compared across states in any other CDC report.

MPOWER Framework With Selected Indicators

What follows is a brief description and explanation of each of the MPOWER strategies and each of the indicators selected for this report. Next to each indicator is a parenthetical note of whether it is new, expanded, or updated from *Tobacco Control State Highlights 2010*.

Monitor tobacco use and prevention policies

A comprehensive tobacco control program has a system of surveillance and evaluation that can monitor and document short-, intermediate-, and long-term intervention outcomes in the population to inform program and policy directions and to ensure accountability to those with fiscal oversight. *Best Practices* recommends investing approximately 10% of a program's total annual intervention or programmatic budget in surveillance and evaluation efforts.

Adult Current Cigarette/Smokeless Tobacco Use (expanded)

Youth Current Cigarette/Smokeless Tobacco/Cigar Use (expanded)

Past-Year Cigarette Initiation (new)

Protect people from tobacco smoke

There is no safe level of exposure to secondhand smoke.²¹ Secondhand smoke contains about 70 carcinogens and causes heart disease and lung cancer in nonsmoking adults.²² Eliminating smoking in indoor spaces is the only way to fully protect people from exposure.²¹ Worksites are a major source of secondhand smoke exposure, and workers in restaurants and bars are especially likely to be exposed, often at high concentrations.²¹ 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 benefit of reducing tobacco consumption by smokers, increasing the number of smokers who quit, and preventing relapse among those who have already quit.^{14,23,24}

Adult Exposure to Secondhand Smoke (new)

Opinions About Smoking in the Workplace (new)

Smoke-Free Home Rules (new)

State Smoke-Free Policy (updated)

Offer help to quit tobacco use

Cessation of tobacco use can reduce the risk for tobacco-related disease, even among those who have used tobacco for decades.²⁵ Offering access to cessation programs to help those who want to quit is one effective tobacco control strategy to promote quitting. Among current U.S. adult smokers, 70% report that they want to quit completely, and millions have attempted to quit smoking.²⁶ In addition to effective clinical approaches to helping smokers quit, there are several population-based approaches that have proven to be effective, including price increases and smoke-free laws. These include telephone counseling (quitlines) and reducing patient out-of-pocket costs for effective cessation treatment.^{14,27}

Adults Who Made a Quit Attempt in the Last Year (new)

Quitline Utilization (new)

Medicaid Coverage for Counseling and Medications (updated)

Warn about the dangers of tobacco

Comprehensive efforts to educate and warn about the dangers of tobacco use are critical to changing social norms, preventing initiation, and promoting cessation. Effective messages that are targeted appropriately can increase public support for tobacco control interventions and create a supportive environment for policy and programmatic community efforts.²⁴ The Task Force on Community Preventive Services' *Guide to Community Preventive Services* strongly recommends sustained media campaigns combined with other interventions as an effective strategy to decrease the likelihood of tobacco initiation and promote smoking cessation.¹⁴ Experience from many states, including Arizona, California, Florida, Massachusetts, Minnesota, and Oregon, as well as the national Legacy campaign, suggests that message content is very important. Aggressive countermarketing campaigns that confront the tobacco industry's marketing tactics have demonstrated effectiveness.²⁸ Also, advertising campaigns with strong, hard-hitting messages about the health consequences of tobacco use perform better than humorous or emotionally neutral campaigns.

Tobacco Countermarketing Media Intensity (updated)
Knowledge of the Dangers of Tobacco (new)

Enforce bans on tobacco advertising, promotion, and sponsorship

Billions of dollars are spent annually by tobacco companies to make tobacco use appear to be attractive as well as an accepted and established part of American culture.^{11,29,30,31} Nonsmoking adolescents exposed to tobacco advertising and promotional campaigns are significantly more likely to become young adult smokers.^{29,32} The 1998 multistate MSA included specific tobacco industry restrictions related to youth access, marketing, lobbying, and certain types of outdoor advertising. However, following the settlement, tobacco marketing expenditures more than doubled over the next 5 years.^{11,29} Tobacco promotions have shifted away from media such as billboards and magazines and moved toward retail outlets.^{29,30,33} Furthermore, shifts away from cigarette advertising to other products, such as smokeless tobacco, has increased.³⁰ Research indicates that point-of-sale advertising encourages youth, particularly younger teens, to try smoking.^{11,29}

With the enactment of the Family Smoking Prevention and Tobacco Control Act on June 22, 2009,¹⁶ FDA was given authority to regulate the manufacturing, marketing, and distribution of tobacco products. This legislation also grants authority to states and local communities 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 tobacco advertising. It will be important to measure and monitor the establishment of, compliance with, and impact of federal, state, and local regulations and restrictions to assess the impact they have on reducing morbidity and mortality from tobacco use.

State Allows Local Advertising and Promotion Laws (new)
Over-the-Counter Retail Licensure (new)

Raise taxes on tobacco

Increasing the price of tobacco products reduces tobacco consumption and prevalence, especially among the most price-sensitive populations (e.g., young people).²⁹ Increasing cigarette taxes is an effective method of increasing the real price of cigarettes, but maintaining high prices requires continued tax adjustments to offset the effects of inflation and industry practices designed to control retail product prices.^{29,34} To illustrate the latter issue, in 2008, tobacco companies spent more than \$9.9 billion on advertising and promotional expenses for cigarettes³⁰ and more than \$2.7 billion for smokeless tobacco.³¹ The largest expenditure category by far comprised promotional allowance price discounts paid to retailers or wholesalers to reduce the price through buy one/get one types of offers and other types of sales.^{30,31}

*Amount of Tobacco Product Excise Tax (expanded)
Price Paid for Last Cigarettes Purchased (new)*

Summary of Findings and Indicators Definitions

While there are many indicators used by tobacco control programs to monitor and evaluate programs, those that were selected for this document are closely aligned with policy recommendations from *Best Practices* and have recent and reliable data available. What follows is a description of each indicator and its importance for measuring progress, followed by a brief description of the data sources and definitions. More detailed information on the data sources and definitions are given later in this document.

Monitor

Adult Current Cigarette/Smokeless Tobacco Use

Current cigarette use prevalence among adults is a fundamental indicator in monitoring the population impact of tobacco use (see key outcome indicator [KOI] 3.14.1).¹⁹ However, it is also important to track other tobacco products, such as smokeless tobacco. When assessing current cigarette and smokeless tobacco use prevalence, it is essential to consider the demographic subgroups within the population, because prevalence typically varies by age, gender, race/ethnicity, educational status, sexual orientation, and other factors.

The adult current cigarette smoking prevalence in 2011 ranged from 11.8% in Utah to 29.0% in Kentucky. Across the states, the median prevalence was 21.2%. Cigarette smoking was more prevalent among people with a high school or less than a high school education than those with college degrees or higher.

The adult current smokeless tobacco use prevalence in 2011 ranged from 1.4% in California and Rhode Island to 9.8% in Wyoming. Across the states, the median prevalence was 4.4%. Smokeless tobacco was most prevalent among white males in most states.

Definitions:

- Current Cigarette Smoking
 - ▶ Overall adult current cigarette smoking prevalence is the percentage of adults who are current smokers. Current smokers are defined as persons who reported smoking at least 100 cigarettes in their life and who currently smoke every day or some days.

- ▶ Adult current cigarette smoking prevalence by educational level is for persons 20 years of age and older. For the overall prevalence estimates and all other subgroups, the results shown are for persons 18 years of age and older.
- ▶ For the racial/ethnic subgroups, persons who reported Hispanic ethnicity are included in the Hispanic category and not in any of the other race categories.
- Current Smokeless Tobacco Use
 - ▶ Overall adult current smokeless tobacco use prevalence is the percentage of adults who are current smokeless tobacco users. Current smokeless tobacco users are defined as persons who currently use chewing tobacco, snuff, or snus every day or some days.
 - ▶ Adult current smokeless tobacco use prevalence by educational level is for persons 20 years of age and older. For the overall prevalence estimates and all other subgroups, the results shown are for persons 18 years of age and older.
 - ▶ For the racial/ethnic subgroups, persons who reported Hispanic ethnicity are included in the Hispanic category and not in any of the other race categories.

Source:

- Tobacco use data are from the Behavioral Risk Factor Surveillance System (BRFSS), a population-based survey that provides descriptive data on health risk behaviors for each state. Information on BRFSS can be found at <http://www.cdc.gov/brfss/>. Per the Centers for Disease Control and Prevention data suppression criteria for BRFSS, results are not shown for any demographic categories that included fewer than 50 respondents.³⁵
- See Appendix C for more detail on changes to the 2011 BRFSS methodology.

Youth Current Cigarette/Smokeless Tobacco/Cigar Use

Tobacco use prevention among youth is an important component of overall efforts to reduce future tobacco-related morbidity and mortality (see KOI 1.14.1),¹⁹ since more than half of those who smoked their first cigarette in 2008 were younger than 18 years of age.³⁶ It is imperative to monitor cigarette smoking and the use of other tobacco products among youth to best understand why declines in tobacco use are slowing down³⁷ and to be able to reach the targets established by *Healthy People 2020*.²⁰ The *Healthy People 2020* objectives for high school students are to reduce current tobacco product use to 21.0% (TU-2.1), current cigarette use to 16% (TU-2.2), current smokeless tobacco product use to 6.9% (TU-2.3), and current cigar use to 8.0% (TU-2.4).²⁰

Nationally, current cigarette smoking prevalence was 18.1% for high school students in 2011, ranging from 5.9% in Utah to 24.1% in Kentucky across 44 states. Nationally, current cigarette smoking prevalence was lowest among non-Hispanic Asians, highest among males, and highest in 12th grade.

Nationally, current smokeless tobacco use prevalence was 7.7% for high school students in 2011, ranging from 3.5% in Hawaii to 16.9% in Kentucky across 40 states. Nationally, current smokeless tobacco use prevalence was lowest among non-Hispanic blacks, highest among males, and highest in 12th grade.

Nationally, current cigar smoking prevalence was 13.1% for high school students in 2011, ranging from 5.0% in Utah to 18.3% in South Carolina across 37 states. Nationally, current cigar smoking use prevalence was lowest among non-Hispanic Asians, highest among males, and highest in 12th grade.

Nationally, current tobacco use prevalence was 23.4% for high school students in 2011, ranging from 7.8% in Utah to 31.9% in Kentucky across 36 states. Nationally, current tobacco use prevalence is lowest among non-Hispanic Asians, highest among males, and highest in 12th grade.

Definitions:

- **Current Cigarette Smoking**
 - ▶ Overall youth current cigarette smoking prevalence is the percentage of high school (grades 9–12) students who are current cigarette smokers. Current cigarette smokers are defined as high school students who had smoked cigarettes on at least 1 day during the past 30 days before the survey.
 - ▶ For the racial/ethnic subgroups, persons who reported Hispanic ethnicity are included in the Hispanic category and not in any of the other race categories.
- **Current Smokeless Tobacco Use**
 - ▶ Overall youth current smokeless tobacco use prevalence is the percentage of high school (grades 9–12) students who are current smokeless tobacco users. Current smokeless tobacco users are defined as high school students who had used chewing tobacco, snuff, or dip on at least 1 day during the past 30 days before the survey.
 - ▶ For the racial/ethnic subgroups, persons who reported Hispanic ethnicity are included in the Hispanic category and not in any of the other race categories.
- **Current Cigar Smoking**
 - ▶ Overall youth current cigar smoking prevalence is the percentage of high school (grades 9–12) students who are current cigar smokers. Current cigar smokers are defined as high school students who had smoked cigars, cigarillos, or little cigars on at least 1 day during the past 30 days before the survey.
 - ▶ For the racial/ethnic subgroups, persons who reported Hispanic ethnicity are included in the Hispanic category and not in any of the other race categories.
- **Current Tobacco Use**
 - ▶ Overall youth current tobacco use prevalence is the percentage of high school (grades 9–12) students who are current cigarette smokers, current smokeless tobacco users, or current cigar smokers. Current tobacco users are defined as high school students who reported current cigarette smoking, current smokeless tobacco use, or current cigar smoking. (Note: To be included, youth must have provided an answer to each of the questions regarding past 30-day use for cigarettes, smokeless tobacco, and cigars.)
 - ▶ For the racial/ethnic subgroups, persons who reported Hispanic ethnicity are included in the Hispanic category and not in any of the other race categories.
- Youth Risk Behavior Surveillance System (YRBSS) data may be missing for a state because the YRBSS was not conducted in 2011 or it was conducted but had a low response rate and thus did not receive weighted YRBSS data. Additionally, YRBSS data may be missing for a specific product, because not all tobacco products were included on the state-specific questionnaire. Furthermore, even though the YRBSS is used to track *Healthy People 2020* national goals, some states use other data systems to track indicators of youth tobacco use.

Sources:

- Data are from the Youth Risk Behavioral Surveillance System (YRBSS), a school-based (high school) survey that monitors six types of health-risk behaviors that contribute to the leading causes of death and disability among youth and adults and provides descriptive data on these health-risk behaviors for some states and the nation. Information on YRBSS can be found at <http://www.cdc.gov/healthyyouth/yrbs/index.htm>. Per CDC data suppression criteria for YRBSS, results are not shown for any categories that included fewer than 100 respondents.³⁵
- Results were obtained from the YRBSS Web analysis tool at <http://apps.nccd.cdc.gov/youthonline/App/Default.aspx?SID=HS> and from <http://www.cdc.gov/mmwr/pdf/ss/ss6104.pdf>.

Past-Year Cigarette Initiation

The majority of tobacco use begins before 18 years of age, though increasingly, initiation is beginning in young adulthood.^{29,38,39} The earlier young people begin using tobacco, the more likely they are to continue use in adulthood. Both the duration and amount of tobacco use are related to eventual chronic health conditions such as lung disease, heart disease, cancer, and stroke.²² This indicator is closely related to measurement of KOI 1.13.1, which assesses the age at which young people first smoked a whole cigarette.¹⁹ The *Healthy People 2020* goals are to reduce youth (aged 12–17 years) cigarette initiation from 6.2% to 4.2% (TU-3.2) and to reduce young adult (aged 18–25 years) cigarette initiation from 8.3% to 6.3% (TU-3.6).²⁰

In 2008–2009, the percentage of youth aged 12–17 years who smoked part or all of a cigarette for the first time in the past year ranged from 3.3% in Utah to 9.2% in West Virginia. The national average was 6.3%, and there has been no statistically significant change in youth initiation nationally since 2002–2003.

In 2008–2009, the percentage of young adults aged 18–25 years who smoked part or all of a cigarette for the first time in the past year ranged from 4.2% in Colorado to 14.7% in North Dakota. The national average was 8.5%, and the rate of young adult initiation has increased significantly nationally since 2002–2003.

Definition:

- Past-year cigarette initiation is defined as those who had not previously smoked in their lifetime who report smoking part or all of a cigarette for the first time in the past 12 months. Results presented are weighted percentages for youths aged 12–17 years and young adults aged 18–25 years.

Source:

- Estimates were produced by the Substance Abuse and Mental Health Services Administration (SAMHSA) using the National Survey on Drug Use and Health (NSDUH) analyzed in 2-year increments from 2002 to 2009. NSDUH is an annual survey sponsored by SAMHSA that provides data on illicit drugs, alcohol, and tobacco in the civilian noninstitutionalized population in the 50 states and the District of Columbia. Information on NSDUH can be found at <http://www.oas.samhsa.gov/NSDUH.HTM>.

Protect

Adult Exposure to Secondhand Smoke

There is no safe level of exposure to secondhand smoke, which causes lung cancer, heart disease, and acute respiratory disease in adults.²¹ A comprehensive smoke-free law is defined as a law that covers all worksites, restaurants, and bars and completely eliminates indoor smoking. Though many states and localities have smoke-free laws in place, they are not all comprehensive, and as a result, many people are left unprotected. Moreover, smoke-free environments help smokers who want to quit.²³ Additionally, compliance with existing policies is essential for the policy to have a public health impact.

Monitoring various venues of exposure is important in identifying where people remain unprotected. These indicators of exposure to secondhand smoke (KOI 2.7.1, 2.7.2, 2.7.3, 2.7.5) are influenced by the existence and enforcement of smoke-free policies.¹⁹ They also provide supplementary information to the related *Healthy People 2020* objective to reduce the proportion of adult nonsmokers exposed to secondhand smoke (TU-11.3).²⁰

Nationally, 47.7% of adults in 2009–2010 reported being exposed to secondhand smoke either at home, in vehicles, or in indoor or outdoor spaces at work or other public places. Across the states, this ranged from 35.7% in Montana to 67.4% in Nevada.

Definitions:

- The prevalence of exposure to secondhand smoke at indoor or outdoor workplaces was determined by adult (aged 18 years and older) survey respondents' reports of breathing the smoke from someone else's smoking tobacco at their workplace, either indoors or outdoors, within the past 7 days.
- The prevalence of exposure to secondhand smoke in homes was determined by adult (aged 18 years and older) survey respondents' reports of anyone else smoking inside their home (not including decks, porches, or garages) when they were home within the past 7 days.
- The prevalence of exposure to secondhand smoke in vehicles was determined by adult (aged 18 years and older) survey respondents' reports of riding in a vehicle in which anyone else was smoking within the past 7 days.
- The prevalence of exposure to secondhand smoke in indoor or outdoor public places was determined by adult (aged 18 years and older) survey respondents' reports of breathing smoke from someone else's smoking in an indoor or outdoor public place, not counting workplaces, within the past 7 days.
- The overall prevalence of exposure to secondhand smoke was determined by adult (aged 18 years and older) survey respondents' reports of exposure to secondhand smoke in one or more of the following locations within the past 7 days: their workplaces (indoors or outdoors), their homes, in a vehicle, or in indoor or outdoor public places.

Source:

- Data are from the 2009–2010 National Adult Tobacco Survey (NATS), which is a stratified, national, landline and cell-phone survey of noninstitutionalized adults aged 18 years and older. It was designed to yield representative data on key outcome indicators¹⁹ at both state and national levels for monitoring and evaluating progress toward the goals of the National Tobacco Control Program: preventing initiation of tobacco use among young people, eliminating nonsmokers' exposure to secondhand smoke, promoting quitting among adults and young people, and identifying and eliminating tobacco-related disparities. The NATS estimates in

this report are from landline respondents only. All state-level data are weighted to the respective state populations, and national data are weighted to the U.S. population. NATS suppression criteria are the same as for BRFSS, for which results are not shown when the sample included fewer than 50 respondents.

Smoke-Free Home Rules

The home is the primary source of exposure to secondhand smoke for infants and children and a major source for nonsmoking adults.²¹ Unfortunately, parents and other adults continue to smoke in homes, exposing children to secondhand smoke. This exposure leads to secondhand smoke mortality from sudden infant death syndrome and morbidity due to respiratory symptoms, slowed lung growth, ear problems, bronchitis, pneumonia, and worsened asthma.²¹ Because there is no safe level of secondhand smoke exposure, creating and enforcing a smoke-free home policy is one of the most important decisions a family can make to protect all household members, including pets,⁴⁰ from the dangers of secondhand smoke exposure. Monitoring this indicator (see KOI 2.4.4.)¹⁹ is important to the national objective to reduce the proportion of children, adolescents, and nonsmoking adults exposed to secondhand smoke (*Healthy People 2020* objectives TU-11.1–11.3).^{20,21}

Nationally, 81.8% of adults reported having rules that smoking was not allowed inside their home in 2009–2010, ranging from 92.9% in Utah to 67.5% in Kentucky. However, an estimated 32.0% of homes without smoke-free rules had children 17 years of age or younger living in them, with estimates ranging from 17.3% in Arizona to 44.6% in Delaware.

Definitions:

- The percent of adults whose homes had rules that smoking was not allowed inside the home was determined by adult (aged 18 years and older) survey respondents' reports that smoking is never allowed inside their home, not counting decks, porches, or garages.
- The potential for exposure to second hand smoke among children 17 years of age and younger was determined by the proportion of homes that did not have rules that smoking is never allowed inside the home (not counting decks, porches, or garages) that had children under 17 years of age living in them.

Source:

- Data are from the 2009–2010 National Adult Tobacco Survey (NATS), which is a stratified, national, landline and cell-phone survey of noninstitutionalized adults aged 18 years and older. It was designed to yield representative data on key outcome indicators¹⁹ at both state and national levels for monitoring and evaluating progress toward the goals of the National Tobacco Control Program: preventing initiation of tobacco use among young people, eliminating nonsmokers' exposure to secondhand smoke, promoting quitting among adults and young people, and identifying and eliminating tobacco-related disparities. The NATS estimates in this report are from landline respondents only. All state-level data are weighted to the respective state populations, and national data are weighted to the U.S. population. NATS suppression criteria are the same as for BRFSS, for which results are not shown when the sample included fewer than 50 respondents.

Opinions About Smoking in the Workplace

Smoke-free workplace policies have multiple benefits. In addition to eliminating secondhand smoke exposure among nonsmokers at work, these policies also reduce tobacco consumption among workers who smoke and help to reduce the social acceptability of tobacco use.²¹ Because there is no safe level of secondhand smoke exposure, 100% smoke-free indoor areas is the only way to fully protect from exposure to secondhand smoke.²¹ Public opinion indicating positive attitudes toward smoke-free workplace policies demonstrates recognition of the dangers of secondhand smoke. This recognition is critical to reach the *Healthy People 2020* objective (TU-12) to increase to 100% the proportion of persons covered by indoor worksite policies that prohibit smoking.²⁰

Nationally, 80.5% of adults in 2009–2010 think smoking should never be allowed in indoor workplaces. Across the states, this ranged from 89.1% in California to 67.0% in Kentucky.

Definition:

- The proportion of adults who think smoking should never be allowed in indoor workplaces was determined by adults (aged 18 years and older) who responded “Never allowed” to the question, “At workplaces, do you think smoking indoors should be...?”.

Source:

- Data are from the 2009–2010 National Adult Tobacco Survey (NATS), which is a stratified, national, landline and cell-phone survey of noninstitutionalized adults aged 18 years and older. It was designed to yield representative data on key outcome indicators¹⁹ at both state and national levels for monitoring and evaluating progress toward the goals of the National Tobacco Control Program: preventing initiation of tobacco use among young people, eliminating nonsmokers’ exposure to secondhand smoke, promoting quitting among adults and young people, and identifying and eliminating tobacco-related disparities. The NATS estimates in this report are from landline respondents only. All state-level data are weighted to the respective state populations, and national data are weighted to the U.S. population. NATS suppression criteria are the same as for BRFSS, for which results are not shown when the sample included fewer than 50 respondents.

State Smoke-Free Policy

Prohibiting smoking in all indoor areas of workplaces and public places, including restaurants and bars, is the only way to fully protect employees and the public from indoor exposure to secondhand smoke. The *Healthy People 2020* objective (TU-13) is for all states to establish laws that prohibit smoking in public places and worksites.²⁰ The Surgeon General has concluded that separating smokers from nonsmokers, “cleaning” the air, and ventilating buildings do not eliminate secondhand smoke exposure.²¹

As of June 30, 2012, 26 states had comprehensive smoke-free laws for workplaces, restaurants, and bars; 10 states had partial smoke-free coverage (i.e., smoke-free in one or two but not all three venues); 8 states had less stringent smoking restrictions that do not eliminate exposure (e.g., designated areas, ventilated areas); and 7 states did not have a statewide law of any strength in worksites, restaurants, or bars. Additionally, 12 states had laws that preempt local smoke-free policies in at least one venue. The *Healthy People 2020* objective (TU-16.1) is to eliminate all state laws that preempt local tobacco control laws on smoke-free indoor air.²⁰

Definitions:

- State smoke-free policy is defined as a statute that prohibits smoking in workplaces, restaurants, and/or bars. (If a state statute allows exemptions for designated or ventilated smoking areas in workplaces, restaurants, or bars, the state is not considered smoke-free.) A comprehensive smoke-free policy is defined as a state with smoke-free workplaces, restaurants, and bars.
- Preemption is defined as a state having a statute or judicial opinion that prevents local jurisdictions from enacting smoking restrictions that would be more stringent than state law.

Source:

- Data are from the State Tobacco Activities Tracking and Evaluation System (STATE System), an electronic data warehouse that contains tobacco-related epidemiologic and economic data and information on state legislation. The STATE System is available at <http://www.cdc.gov/tobacco/statesystem>.
- See Appendix B for updates to legislative indicators since June 30, 2012.

Offer

Adults Who Made a Quit Attempt in the Last Year

For tobacco users, attempting to quit is an essential step in the process of becoming tobacco-free. Stopping tobacco use entirely is often preceded by several quit attempts.²⁷ Increasing the proportion of adult tobacco users who have made quit attempts (KOI 3.11.1)¹⁹ may lead to increased cessation rates and a lower prevalence of tobacco use.²⁷ A *Healthy People 2020* objective (TU-4.1) is to increase smoking cessation attempts by adult smokers to 80%.²⁰

Nationally, 55.7% of adult smokers made a quit attempt in the past year in 2009–2010, ranging from 66.0% in Maryland to 42.6% in Idaho.

Definitions:

- Adult smokers are defined as the percent of adult current smokers who quit smoking for 1 day or longer during the past 12 months and former smokers who quit in the past year.
- Current smokers are defined as those who reported they had smoked 100 or more cigarettes in their life and now smoke every day or some days.
- Former smokers are defined as those who reported they had smoked 100 or more cigarettes in their life and now do not smoke at all.

Source:

- Data are from the 2009–2010 National Adult Tobacco Survey (NATS), which is a stratified, national, landline and cell-phone survey of noninstitutionalized adults aged 18 years and older. It was designed to yield representative data on key outcome indicators¹⁹ at both state and national levels for monitoring and evaluating progress toward the goals of the National Tobacco Control Program: preventing initiation of tobacco use among young people, eliminating nonsmokers' exposure to secondhand smoke, promoting quitting among adults and young people, and identifying and eliminating tobacco-related disparities. The NATS estimates in this report are from landline respondents only. All state-level data are weighted to the respective state populations, and national data are weighted to the U.S. population. NATS suppression criteria are the same as for BRFSS, for which results are not shown when the sample included fewer than 50 respondents.

Quitline Utilization

Quitting tobacco use decreases premature mortality as well as tobacco-related costs to society. Although close to 70% of smokers want to quit⁴¹ and more than 50% of smokers try to quit each year, most of their efforts are unaided and unsuccessful.²⁷ Quitlines have been shown to be effective in helping smokers quit.^{27,42,43} State quitlines fully funded at levels recommended by CDC could serve 8% of the state's tobacco users.¹¹

The total number of calls received by quitlines across all states was 1,086,296 in 2010. The total number of tobacco users who received telephone counseling, cessation medications, or both from quitlines was 463,737, representing an estimated median of 1.0% of tobacco users across the states.

Definitions:

- The number of quitline calls is defined as the total number of direct calls that came into the state quitline. It is a sum of calls answered live, calls that went to voicemail, calls hung up or abandoned, and other calls to the quitline that are not accounted for in these categories. Direct calls are the total incoming calls to the quitline, not including referrals that generate an out-bound call from the quitline.
- The estimated percent of tobacco users in the state who received telephone counseling, cessation medications, or both from the quitline was obtained by dividing the total number of tobacco users who received telephone counseling (i.e., began at least one session), cessation medication, or both from the quitline (i.e., the numerator) by the estimated number of adult tobacco users in the state (i.e., the denominator). It is important to note that quitlines vary in terms of what services they provide (e.g., free medication) and also who is eligible for these services (e.g., Medicaid enrollees only). Also, it is important to note that the total number of tobacco users who received telephone counseling may include individuals younger than 18 years of age.
- The estimated number of tobacco users in the state was obtained by multiplying the total number of adults in the state by the percentage of adults who either currently used cigarettes, smokeless tobacco, or both products. Current cigarette smokers are defined as those who reported they had smoked 100 or more cigarettes in their life and now smoke every day or some days. Current smokeless tobacco users are defined as those who reported they currently use chewing tobacco, snuff, or snus every day or some days.

Sources:

- Quitline data are from the online Quitline Services Questionnaire from the National Quitline Data Warehouse (NQDW), a data repository of quitline information for all 50 states, the District of Columbia, Puerto Rico, and Guam, collected and housed by the Centers for Disease Control and Prevention (CDC), Office on Smoking and Health (OSH).
- Adult tobacco use data were from the Behavioral Risk Factor Surveillance System (BRFSS), a population-based survey that provides descriptive data on health risk behaviors for each state and the District of Columbia. Information on BRFSS can be found at <http://www.cdc.gov/brfss/>.
- U.S. Census data on the total number of adults in the state were obtained from <http://2010.census.gov/2010census/popmap/>.

Medicaid Coverage for Counseling and Medications

Despite the progress in reducing tobacco use in the general population, Medicaid enrollees continue to have a higher prevalence of smoking, in part because of limited access to medications and counseling for cessation. The 2008 Update to the Public Health Service Clinical Practice Guideline *Treating Tobacco Use and Dependence: 2008 Update* recommends that private and public health insurance, including Medicaid, cover all effective treatments without deductibles or other barriers.²⁷

A *Healthy People 2020* objective (TU-8) is to increase comprehensive Medicaid insurance coverage of evidence-based treatment for nicotine dependency in states and the District of Columbia.²⁰ Coverage should include all FDA-approved pharmacotherapies as well as behavioral therapies.²⁷ In 2010, only five states (Hawaii, Indiana, Massachusetts, Minnesota, and Pennsylvania) had comprehensive coverage through both managed care and fee-for-service Medicaid contracts for tobacco-dependence treatment, including all nicotine replacement therapies (NRTs), bupropion, varenicline, and counseling (individual and group). All states and the District of Columbia have some Medicaid coverage for medications or counseling.

All states are in the process of transforming tobacco dependence treatment coverage. For example, the Patient Protection and Affordable Care Act (Affordable Care Act) currently provides that all adults should be screened for tobacco use and comprehensive tobacco cessation services 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. Beginning in 2014, states are precluded from excluding tobacco cessation drugs from coverage for Medicaid enrollees.¹⁸ As these and other cessation services become available and expand, in addition to focusing on what services are covered, it is also critical for states to plan to adequately and appropriately promote their availability and encourage access to evidence-based cessation services to increase awareness and utilization.¹⁸

Definitions:

- Medicaid coverage is defined as coverage within the state Medicaid plan for both managed care and fee-for-service contracts during 2010 for nicotine replacement therapies (NRTs), varenicline (Chantix[™]),[†] bupropion (Zyban[™] or its generic equivalent),[†] and counseling. NRTs include nicotine gum, patch, nasal spray, inhaler, and lozenge. Counseling includes group and/or individual counseling. Counseling is currently available to all Medicaid-enrolled smokers through the state quitline.
- A state is considered to have comprehensive Medicaid coverage for tobacco dependence treatment if all seven FDA-approved cessation medications and counseling (i.e., individual and group) are available to all Medicaid enrollees within the state Medicaid plan for both managed care and fee-for-service contracts.
- A state is considered to have Medicaid coverage for NRT if at least one form of NRT is available to all Medicaid enrollees within the state Medicaid plan for both managed care and fee-for-service contracts. Medicaid coverage for NRT is designated as partial (a) if it is available to pregnant women only; as partial (b) if it is only available through fee-for-service contracts; and as partial (c) if at least one form of NRT is available to all Medicaid enrollees through state quitlines only.
- A state is considered to have Medicaid coverage for varenicline if varenicline is available to all Medicaid enrollees within the state Medicaid plan for both managed care and fee-for-service contracts. Medicaid coverage for varenicline is defined as partial (a) if it is available to pregnant women only, and as partial (b) if it is only available through fee-for-service contracts.

[†] Use of trade names is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

- A state is considered to have Medicaid coverage for bupropion if bupropion is available to all Medicaid enrollees within the state Medicaid plan for both managed care and fee-for-service contracts. Medicaid coverage for bupropion is defined as partial (a) if it is available to pregnant women only, and as partial (b) if it is only available through fee-for-service contracts.
- A state is considered to have Medicaid coverage for counseling if either group or individual counseling is available to all Medicaid enrollees within the state Medicaid plan for both managed care and fee-for-service contracts. Medicaid coverage for counseling is defined as partial (a) if it is available to pregnant women only, and as partial (b) if it is only available through fee-for-service contracts.

Source:

- State Medicaid Coverage for Tobacco Dependence Treatments, United States 2010.⁴⁴ (See Appendix A for detailed Medicaid data for each state.)

Warn

Tobacco Countermarketing Media Intensity

Well-designed, hard-hitting countermarketing of sufficient reach, duration, and frequency can increase awareness, promote favorable attitudes toward tobacco control, and influence behavior.^{11,45} Gross rating points (GRPs) are a measure of the total intensity of a general audience media campaign and represent total reach (the percentage of households exposed to an ad campaign) multiplied by frequency of exposure to the ads. Targeted campaigns can be assessed by tracking targeted rating points (TRPs), which measure the percent of the targeted population that is exposed to a media campaign. CDC’s *Best Practices* media funding recommendations translate into approximately 800 youth TRPs (80% of the audience reached with 10 exposures each) and 1,200 general audience GRPs (80% of the audience reached with 15 exposures each) per quarter.

Quarterly GRPs in 2010 ranged from 3,049.5 in Hawaii to 0 in Delaware, Illinois, Massachusetts, and Wyoming. Across the states, the median quarterly GRP was 242.7.

Quarterly TRPs in 2010 ranged from 556.8 in Hawaii to 0 in Delaware, Illinois, Massachusetts, New Jersey, Pennsylvania, Tennessee, and Wyoming. Across the states, the median quarterly TRP for youth was 39.7.

Definitions:

- Media campaign intensity is defined by rating points, a composite metric combining reach and frequency of campaign exposure. *Reach* measures the total number of people (or households) who could potentially be exposed to an ad in a given media market. *Frequency* is the average number of times homes or people in a given media market are exposed to a particular ad in a given time frame. In this document, gross rating points (GRPs) are defined as reach multiplied by frequency for households in the general population. Targeted rating points (TRPs) are defined as reach multiplied by frequency for youths 12–17 years of age. In this document, GRPs and TRPs were averaged across media markets in each state, per quarter, for calendar year 2010. The four quarters were then averaged to produce an average quarterly estimate for 2010.
- Measurements of TRPs and GRPs reflect only state-sponsored media campaigns, not media campaigns run by pharmaceutical companies; nonpaid public service announcements; tobacco industry-funded antitobacco campaigns; federal or national campaigns; or any other not-for-profit advertisements such as those developed by partner organizations (e.g., American Lung Association, Legacy).

- Data for both full disclosure markets and automated discovery markets for each state were used in the analyses.
- GRPs reflect the average viewing patterns of households monitored by Nielsen Media Research in a given media market. TRPs reflect the average viewing patterns for youth (12–17 years of age) within the television households monitored by Nielsen Media Research. Youth could potentially watch any program broadcast in their media market. Even if a state did not run a youth-focused media campaign, a high number of TRPs may be reported due to youths' exposure to advertisements run during general audience programming.
- TRPs and GRPs do not reflect advertisements run on spot cable (i.e., advertisements purchased only for local cable TV in a specific media market), radio, billboards, Internet, transit, or other public places. Additionally, Nielsen Media Research does not provide ratings for digital subchannels that are shared, multicast channels on digital television. As a result, TRPs and GRPs do not reflect ratings from subchannels. States may have other data available on these channels.
- If multiple partners purchased an advertisement and state sponsorship was identified, the advertisement was attributed to the state. If it was determined that an advertisement by a state tobacco prevention foundation was paid for with any state funds, including Master Settlement Agreement funds or state tobacco excise taxes, it also was attributed to the state.
- Data and rankings include “added value spots” and the resulting TRPs and GRPs provided by television outlets if a particular state negotiated a match on advertising buys (e.g., bonus weight such as a 2:1 match on advertising buys).
- Data and rankings reflect exposure to state-sponsored television campaigns to that particular state only and may not reflect the total countermarketing media exposure of residents in the state. Therefore, advertisements that spill over to another state and the resulting TRPs and GRPs are not credited to the state where spillover occurs. Also, states that mainly use nontelevision channels for campaigns may receive low ranks because these media channels are not taken into account.

Source:

- Data analyses were developed by the Institute for Health Research and Policy, University of Illinois at Chicago School of Public Health, based on rating information from Nielsen Media Research, as described elsewhere,⁴⁶ and advertising data from Kantar Media.

Knowledge of the Dangers of Tobacco

Secondhand Smoke

There is no risk-free level of exposure to tobacco smoke.²² Secondhand smoke causes premature death and disease in children and adults who do not smoke.²¹ Increased knowledge of the adverse health effects of breathing smoke from other people's tobacco products is associated with reduced exposure to secondhand smoke (KOI 2.3.5)¹⁹ as well as helping smokers who want to quit.²³ A belief that secondhand smoke is very harmful indicates knowledge and awareness of the health consequences of breathing smoke from other people's tobacco products.

Nationally, 65.6% of adults report that breathing smoke from other people's cigarettes or other tobacco products is very harmful, ranging from 72.1% in California to 55.9% in Kentucky.

Definition:

- The percentage of adults who think secondhand smoke is very harmful was determined by adult (aged 18 years and older) survey respondents' reporting that they think breathing smoke from other people's cigarettes or from other tobacco products is “very harmful” to one's health rather than “somewhat harmful” or “not at all harmful.”

Source:

- Data are from the 2009–2010 National Adult Tobacco Survey (NATS), which is a stratified, national, landline and cell-phone survey of noninstitutionalized adults aged 18 years and older. It was designed to yield representative data on key outcome indicators¹⁹ at both state and national levels for monitoring and evaluating progress toward the goals of the National Tobacco Control Program: preventing initiation of tobacco use among young people, eliminating nonsmokers' exposure to secondhand smoke, promoting quitting among adults and young people, and identifying and eliminating tobacco-related disparities. The NATS estimates in this report are from landline respondents only. All state-level data are weighted to the respective state populations, and national data are weighted to the U.S. population. NATS suppression criteria are the same as for BRFSS, for which results are not shown when the sample included fewer than 50 respondents.

Addictiveness of Smoking

Smoking harms nearly every organ of the body.⁴⁷ The adverse health effects from cigarette smoking account for an estimated 443,000 deaths, or nearly one of every five deaths, each year in the United States.¹ Nicotine addiction is the fundamental reason why individuals who start using tobacco continue to use tobacco products.⁴⁷ Most people do not understand the extreme addictiveness of tobacco, and most believe they can stop tobacco use before health problems occur.²³ Thus, achieving a high percentage of individuals who believe that smoking is very addictive indicates that efforts to warn the public about one of the dangers of cigarettes have been effective.

Nationally, 85.4% of adults reported that cigarette smoking is very addictive, ranging from 90.5% in Vermont to 80.6% in North Carolina in 2009–2010.

Definition:

- The percentage of adults who think that smoking is very addictive was determined by adult (aged 18 years and older) survey respondents' reporting that they think cigarette smoking is "very addictive" rather than "somewhat addictive" or "not at all addictive."

Source:

- Data are from the 2009–2010 National Adult Tobacco Survey (NATS), which is a stratified, national, landline and cell-phone survey of noninstitutionalized adults aged 18 years and older. It was designed to yield representative data on key outcome indicators¹⁹ at both state and national levels for monitoring and evaluating progress toward the goals of the National Tobacco Control Program: preventing initiation of tobacco use among young people, eliminating nonsmokers' exposure to secondhand smoke, promoting quitting among adults and young people, and identifying and eliminating tobacco-related disparities. The NATS estimates in this report are from landline respondents only. All state-level data are weighted to the respective state populations, and national data are weighted to the U.S. population. NATS suppression criteria are the same as for BRFSS, for which results are not shown when the sample included fewer than 50 respondents.

Enforce

State Allows Local Advertising and Promotion Laws

States may preempt the ability of local communities to enact certain local laws, including those that restrict tobacco advertising and promotion. Preemption has a negative effect on tobacco control efforts because communities are restricted from enacting stronger policies. A *Healthy People 2020* objective (TU-16.2) is to eliminate all state laws that preempt local tobacco control laws in advertising.²⁰

As of June 30, 2012, there were several states that preempted local communities from enacting more restrictive advertising and promotion laws than those of the state: 12 preempted retail display laws, 13 preempted promotion laws, and 14 preempted sampling laws. Nine states preempted local communities from enacting more restrictive laws in all three of these areas, three states preempted in two of these areas, and six states preempted in one of these areas.

Definitions:

- A state is defined as allowing local advertising and promotion if the state did not have a statute that preempted local policies regarding the sampling, promotion, or display of tobacco products.
- Preemption is defined as a state having a statute that prevents local jurisdictions from enacting advertising restrictions that would be more stringent than state law.

Source:

- Data were drawn from the State Tobacco Activities Tracking and Evaluation System (STATE System), an electronic data warehouse that contains tobacco-related epidemiologic and economic data and information on state legislation. The STATE System is available at <http://www.cdc.gov/tobacco/statesystem>.
- See Appendix B for updates to legislative indicators since June 30, 2012.

Over-the-Counter Retail Licensure

Laws that require businesses to obtain a license to sell tobacco products over the counter can help to reduce illegal sales to youth and can increase compliance with local, state, and federal tobacco laws (see KOI 1.8.2).¹⁹ Licensing can also serve as an effective mechanism to reduce the concentration, location, and type of tobacco retailers as well as impose restrictions on the sale and promotion of tobacco products at the point of sale, including indoor and outdoor advertising and the display of tobacco products.⁴⁸ Because tobacco sales often represent a significant proportion of a business's revenue, there is a strong incentive to comply with licensure laws. Licensure can also include, among other things, a requirement to obtain a license and renew it annually; a license fee set high enough to cover state costs associated with administration, implementation, and enforcement of the license; and provisions authorizing a penalty to the business, including suspension or revocation of the license for any violation of local, state, or federal tobacco laws.⁴⁹ Beyond having cigarette licensure laws, ensuring licensure for smokeless and other tobacco products extends the reach of the law.

As of June 30, 2012, the number of states that required licensure for over-the-counter cigarette sales was 37, while 14 states did not require licensure. Additionally, of the states that required cigarette licensure, 29 included a provision requiring licensure of smokeless tobacco products. Of the 37 states that required a fee, the fee ranged from \$200 in Indiana to \$0 in Massachusetts and Nevada. Additionally, 33 states required a license renewal, ranging in frequency from annually in 26 states, every

2 years in 3 states, every 3 years in 3 states. Thirty-seven states required penalties for businesses that were not in compliance, including fines of varying rates, civil infractions, criminal infractions (misdemeanor or felony), imprisonment, or some combination of these.

Definitions:

- An over-the-counter retail license is defined as a state statute that requires retailers to obtain a license to sell cigarettes directly to consumers. If the statute includes a provision that the required license for vendors includes the sale of chewing tobacco or snuff, it is noted that the licensure includes smokeless tobacco.
- A minimum license fee is defined as the least amount any retailer must pay to receive a license for over-the-counter sales.
- Renewal requirement is defined as a provision in the statute clearly stating that any person engaged in selling tobacco products over the counter must periodically renew their license or permit. Renewal frequency is a provision in the statute specifying how frequently the retail license must be renewed or when a license expires.
- A penalty to business is defined as a punishment to be incurred by the business for the first violation of the provision of the law. Types of penalties include misdemeanors, fines, imprisonment, felonies, etc. noted in the table as a footnote. If the law does not specify a penalty type, no footnote is included.

Source:

- Data were drawn from the State Tobacco Activities Tracking and Evaluation System (STATE System), an electronic data warehouse that contains tobacco-related epidemiologic and economic data and information on state legislation. The STATE System is available at <http://www.cdc.gov/tobacco/statesystem>.
- See Appendix B for updates to legislative indicators since June 30, 2012.

Raise

Amount of Tobacco Product Excise Tax

The Surgeon General, Institute of Medicine, and World Health Organization have concluded that increasing excise taxes is one of the most effective tobacco control policies because it increases product prices. Increasing the price of tobacco discourages initiation among youth and young adults, prompts quit attempts, and reduces average consumption among those who continue to smoke or use tobacco products (KOI 1.12.1 and 3.12.1).¹⁹ However, in response to tax increases, tobacco manufacturers can utilize price discounts to counteract the impact that excise tax increases have on tobacco prices and to appeal to price-sensitive smokers.^{50,51} While cigarette taxes are often tracked and compared across states, it is also important to monitor taxes on other tobacco products, because differential tax rates may affect accessibility of products, especially for youth. Two *Healthy People 2020* objectives are to increase the federal and state tax on cigarettes (TU-17.1) and smokeless tobacco products (TU-17.2).²⁰

As of June 30, 2012, the median state cigarette excise tax across the states was \$1.339. Across the states, the excise tax per pack of cigarettes ranged from \$4.35 in New York to \$0.17 in Missouri. Nearly all states also impose an excise tax on cigars, little cigars, and smokeless tobacco. Comparisons for these other tobacco products are not done here because states tax them in a variety of ways, including, but not limited to, per-unit tax; weight-based tax; or a percentage of the retail, wholesale, or manufacturer's price.

Definition:

- State tobacco excise tax is defined as the amount of tax levied on each of the following tobacco products: cigarettes, cigars, little cigars, and/or smokeless tobacco. Local and federal taxes are not included.

Source:

- Data were drawn from the State Tobacco Activities Tracking and Evaluation System (STATE System), an electronic data warehouse that contains tobacco-related epidemiologic and economic data and information on state legislation. The STATE System is available at <http://www.cdc.gov/tobacco/statesystem>.
- See Appendix B for updates to legislative indicators since June 30, 2012.

Price Paid for Last Cigarettes Purchased

There is a strong, inverse relationship between cigarette price and smoking prevalence.^{14,19} Many factors influence the purchase price for cigarettes. Tobacco companies use price-discounting strategies and price-reducing marketing activities to lower prices^{52,53} while excise taxes increase prices.^{14,15,23} Pricing data can come from the tobacco industry, cash register scanner studies, researchers obtaining used packs and receipts directly from smokers, or from self-reports about the last cigarettes purchased in population-based surveys.

Nationally, 74.5% of smokers reported buying their last cigarettes by the pack and 23.8% reported buying by the carton in 2009–2010. The average price for the last pack of cigarettes purchased by adult smokers was \$5.29, ranging from \$7.98 in Alaska to \$4.04 in South Carolina. Among 45 states with valid data for carton price, the average price for the last carton of cigarettes purchased was \$40.35, ranging from \$64.45 in Alaska to \$30.46 in Missouri.

Definitions:

- The proportion of smokers who reported purchasing their last cigarettes by the pack or carton is defined as the proportion of adult smokers who reported that they last purchased cigarettes for themselves by the pack or by the carton and not by some other method.
- Price paid for last pack of cigarettes is defined as the self-reported price paid for the last pack of cigarettes bought among adult smokers who reported that they last bought cigarettes for themselves by the pack. Price paid for last carton of cigarettes is defined as the self-reported price paid for the last carton of cigarettes bought among adult smokers who reported that they last bought cigarettes for themselves by the carton. If respondents inquired about discounts or coupons, they were asked to report the prices after discounts or coupons. Only respondents who provided a price were included.
- Smokers included (a) current smokers, (b) those who have smoked less than 100 cigarettes in their lifetime but have at least puffed on a cigarette in the last 30 days, and (c) former smokers who have puffed on a cigarette in the last 30 days.
 - ▶ Current smokers are defined as those who said they had smoked 100 or more cigarettes in their life and now smoke every day or some days.
 - ▶ Former smokers are defined as those who reported they had smoked 100 or more cigarettes in their life and now smoke on no days.
- The average price was calculated as a simple average of the price adult smokers reported paying for the last pack or carton of cigarettes.

Source:

- Data are from the 2009–2010 National Adult Tobacco Survey (NATS), which is a stratified, national, landline and cell-phone survey of noninstitutionalized adults aged 18 years and older. It was designed to yield representative data on key outcome indicators¹⁹ at both state and national levels for monitoring and evaluating progress toward the goals of the National Tobacco Control Program: preventing initiation of tobacco use among young people, eliminating nonsmokers' exposure to secondhand smoke, promoting quitting among adults and young people, and identifying and eliminating tobacco-related disparities. The NATS estimates in this report are from landline respondents only. All state-level data are weighted to the respective state populations, and national data are weighted to the U.S. population. NATS suppression criteria are the same as for BRFSS, for which results are not shown when the sample included fewer than 50 respondents.