Data Sources and Definitions

Future Deaths

The *number of youth projected to die prematurely from their smoking* is based on estimates of young adult smokers who continue to smoke throughout their lifetimes as well as estimates of premature deaths attributable to smoking among continuing smokers and among those who quit after age 35 years.[1]

Adult Tobacco Use

Data for *Current Cigarette Smoking Among Adults Aged 18 and Older* are from the Behavioral Risk Factor Surveillance System (BRFSS).[2] Prevalence data are shown for each state overall and are broken out by demographic groups, including sex, age, and education level. Prevalence estimates for racial/ethnic subgroups are reported for combined years (1998–1999) because of small sample sizes. Data are shown only for demographic groups with at least 50 respondents. Readers should interpret demographic group estimates with caution, because the number of respondents, particularly among racial/ethnic subgroups, may be small. Data on education are presented for persons aged 25 years or older. Estimates are for the civilian noninstitutionalized population. For comparison purposes, each state highlight includes the BRFSS median for all states. The following table of BRFSS estimates can also be used for comparison:

Summary Prevalence Estimates of Adult Cigarette Smoking by Demographic Characteristics
BRFSS 1999

	Participating States*	Median	Minimum	Maximum
Overall	51	22.8	13.9	31.5
Men	51	24.6	16.6	33.9
Women	51	21.0	11.4	30.3
<12 years Education	51	30.8	12.9	51.0
12 years Education	51	26.8	19.8	37.3
>12 years Education	51	17.1	8.8	23.2
White†	51	23.0	13.5	31.1
African American†	40	23.1	14.1	36.7
Hispanic†	51	23.9	15.2	47.9
Asian/Pacific Islander†	27	14.0	7.3	24.2
American Indian/Alaska Native†	22	37.9	14.1	58.1
18–24 years old	51	29.6	17.4	40.8
25–44 years old	51	26.4	15.9	35.8
45–64 years old	51	21.9	13.3	32.5
65+ years old	51	10.4	5.4	22.8

*Includes the District of Columbia.

†Racial/ethnic estimates used BRFSS data for 1998–1999.

Current smokers are defined as persons who reported ever smoking at least 100 cigarettes and who currently smoked every day or some days. Persons for whom smoking status was unknown are excluded from the analysis.

Youth Tobacco Use

National data for *Current Cigarette Smoking Among Youth, Grades 6–8*; *Current Tobacco Use Among Youth, Grades 6–8*; *Current Cigarette Smoking Among Youth, Grades 9–12*; and *Current Tobacco Use Among Youth, Grades 9–12* are from the National Youth Tobacco Survey.

The National Youth Tobacco Survey is representative of students in grades 6–12 in public and private schools in the 50 states and the District of Columbia. Current smokers are defined as those students who reported smoking cigarettes on one or more of the past 30 days preceding the survey. Current tobacco users are defined as those students who reported using cigarettes or cigars or smokeless tobacco or pipes or bidis or kreteks on one or more of the 30 days preceding the survey.

State-specific data for *Current Cigarette Smoking Among Youth, Grades 6–8*; *Current Tobacco Use Among Youth, Grades 6–8*; *Current Cigarette Smoking Among Youth, Grades 9–12*; and *Current Tobacco Use Among Youth, Grades 9–12* are from the state school-based Youth Tobacco Survey,[3] or the state school-based Youth Risk Behavior Survey.[4]

The Youth Tobacco Survey was conducted in a total of 33 states and the District of Columbia from 1998–2000. The Youth Tobacco Survey was designed to produce representative samples of middle school students (grades 6–8) and high school students (grades 9–12) in each state. Data from surveys included in this report had an overall response rate of at least 60%. Thus, the data were weighted and can be generalized to all middle and high school students in the state. Current smokers are defined as those students who reported smoking cigarettes on one or more of the past 30 days preceding the survey. Current tobacco users are defined as those students who reported using cigarettes or cigars or smokeless tobacco or pipes or bidis or kreteks on one or more of the 30 days preceding the survey.

The Youth Risk Behavior Survey was conducted in a total of 36 states and the District of Columbia from 1990–1999. The Youth Risk Behavior Survey was designed to produce representative samples of high school students (grades 9–12) in each state. Data from surveys included in this report had an overall response rate of at least 60%. Thus, the data could be weighted in order to be generalized to all high school students in the state. Current smokers are defined as those students who reported smoking cigarettes on one or more of the past 30 days preceding the survey. Current tobacco users are defined as those students who reported using cigarettes or cigars or using chewing tobacco or snuff on one or more of the 30 days preceding the survey.

Health Impact and Costs

Average Annual Deaths Related to Smoking, 1990–1994 and *Average Annual Years of Potential Life Lost, 1990–1994* were estimated using the Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC) software package (version 3.0).[5] SAMMEC estimates the number of smoking-related deaths from neoplastic, cardiovascular, and respiratory conditions and from diseases among infants by using attributable risk formulas based on smoking prevalence and relative risks for certain conditions among current and former smokers (compared with never smokers). Data from the National Fire Protection Association were used to estimate deaths from fires associated with cigarette smoking. Mortality rates from smoking were calculated for persons aged 35 years and older and were age-adjusted to the 1990 U.S. population to provide comparable estimates across states (these rates exclude deaths among infants and fire deaths among person aged 1–34 years).

Medical Costs Related to Smoking, 1993 was obtained from an article in *Social Science and Medicine*, 1999.[6] Medical care costs attributable to cigarette smoking were estimated using an econometric model of annual individual expenditures for four types of medical services: ambulatory, hospital, prescription drug, and other (includes home health and durable medical equipment and excludes dental and mental health). The econometric models calculate the fraction of medical costs in each state that is attributable to smoking using data from the 1987 National Medical Expenditure Survey, the NCI-sponsored Tobacco Use Supplement to the CPS and 1996 Basic CPS, and the 1993 BRFSS. Nursing home smoking-attributable fractions are based on a preliminary nursing home model which indicates the probability of admission. To calculate medical costs, smoking-attributable fractions were applied to total health care expenditures by state for 1993 as obtained from the Health Care Finance Administration. Totals may not add up due to rounding. Costs do not take into account differences in life expectancy between smokers and nonsmokers and therefore do not reflect total lifetime medical care costs.[7]

Smoking-Attributable Medicaid Expenditures, Fiscal Year 1993 is based on a report published in *Public Health Reports*, March/April 1998, Volume 113.[8]

Lung Cancer Death Rate

Lung Cancer Death Rates, 1997 were obtained from the National Vital Statistics System, Centers for Disease Control and Prevention.[9]

Settlement Payments

The *scheduled settlement payment* was obtained at the National Association of Attorneys General website at http://www.naag.org and represents the scheduled annual 2001 payment to the state from the state's settlement with the tobacco industry.[10]

Tobacco Control Funding, 2001

The *State Appropriation—Settlement (Tobacco Only)* amount was gathered through an analysis of state appropriations legislation enacted as of November 30, 2000. These appropriations used funds generated by settlements with the tobacco industry to resolve lawsuits by states to recover Medicaid expenditures incurred as a result of tobacco use. The figure reflects funding specifically appropriated to any governmental agency, foundation, trust fund, board, or university for tobacco control programs for state fiscal year 2001. The footnotes indicate appropriations where tobacco was mentioned, but the amount for tobacco could not be determined. For example, tobacco may be a component of a program that includes alcohol and other drugs. The analysis does not include funds dedicated toward tobacco research activities, health services, or tobacco farmers or tobacco dependant communities.

The *State Appropriation—Excise Tax Revenue* amount represents state appropriations for fiscal year 2001 resulting from an increase in the states' excise tax on tobacco to support statewide tobacco use prevention and control programs. In some cases, states have dedicated a portion of this excise tax revenue to serve as a stable funding stream for state tobacco control programs.

State Appropriation—Other includes any funds appropriated for fiscal year 2001 from state resources outside of the settlement or tobacco excise tax with the specific purpose of supporting tobacco use prevention and control activities and programs.

State Funding—Other includes funding from non-appropriated state sources. The states of Minnesota and Mississippi established a foundation and a partnership respectively to support tobacco prevention and control activities through consent decrees signed as part of individual settlements with the tobacco industry to resolve lawsuits to recover Medicaid expenditures incurred as a result of tobacco use. The budgets of these entities represent a large share of the states' funding for tobacco control programs.

Federal—CDC Office on Smoking and Health includes funding to state health departments from the Centers for Disease Control and Prevention's Office on Smoking and Health, as part of the National Tobacco Control Program. The purpose of the National Tobacco Control Program is to build and maintain tobacco control programs within state and territorial health departments for a coordinated national program to reduce the health and economic burden of tobacco use. The focus of the program is based on the recently published *Best Practices for Comprehensive Tobacco Control Programs*, which places emphasis on population-based community interventions, counter-marketing, program policy, and surveillance and evaluation. These efforts are directed at social and environmental changes to reduce the prevalence and consumption of tobacco by adults and young people among all populations, eliminate exposure to secondhand smoke, and identify and eliminate disparities experienced by population groups relative to tobacco use and its effects.

The footnotes provide additional information for the State Appropriation—Settlement category regarding related appropriations, appropriations where the tobacco control amount can not be determined and additional explanatory information.

Federal—SAMHSA is not available. The Substance Abuse Prevention and Treatment (SAPT) Block Grant makes available to the States and U.S. jurisdictions through formula grants $1.6 billion annually to support the development and delivery of substance abuse prevention and treatment services nationwide. State substance abuse agencies utilize the prevention portion of the SAPT Block Grant funding to implement programs that have as their focus preventing the use of alcohol, tobacco, and other drugs. States are not required to report how much of their block grant funding is spent on tobacco use prevention, and therefore specific amounts for tobacco control are not available.

States and U.S. jurisdictions that received SAPT Block Grant funds are required, as a pre-condition of award, to enact and enforce laws making illegal the sale and distribution of tobacco products to individuals under the age of 18 (Synar Amendment). The Synar Amendment and its implementing regulation also require each State to conduct annual, random unannounced surveys of tobacco retailers to measure their compliance with state laws and meet negotiated retailer violation targets and a final goal of 20 percent less retailer noncompliance. Failure to meet the requirements of the Synar Amendment and its implementing regulations subjects a state to a penalty of up to 40 percent of its SAPT Block Grant award, depending on the year of noncompliance. Currently, states and U.S. jurisdictions are subject to a 40 percent penalty. SAMHSA has provided and continues to provide extensive technical assistance and guidance to assist the states and jurisdictions in the development of comprehensive programs that include strong tobacco control policies, ongoing law enforcement, community awareness and media advocacy strategies, and merchant education and training.

Non-Government Source—American Legacy Foundation includes funding from the American Legacy Foundation, an independent, national, public health foundation located in Washington, DC, created by the November 1998 Master Settlement Agreement. The organization's goals are to reduce youth tobacco use, decrease exposure to secondhand smoke, reduce disparities in access to prevention and cessation services, and increase successful quit rates. This line item represents the particular state's fiscal year 2001 portion of a three-year, $35 million, matching grant program to establish and support statewide youth movements against tobacco use. Some of the state amounts are projected. The funding cycles vary with most projects having started in the Fall of 2000.

Non-Government Source—RWJF/AMA is not applicable at this time. The Robert Wood Johnson Foundation/American Medical Association SmokeLess States National Program Office is currently reviewing proposals from each State and the District of Columbia to allocate up to $52 million over three years. Approximately $44 million will be allocated directly to private, non-profit organizations for policy-focused interventions and approaches as part of the SmokeLess States program. All final awards will be announced in May for a June 2001 start date. Funding for Fiscal Year 2001 from the previous SmokeLess States Projects were not included since the projects are coming to completion.

Per Capita Funding was calculated by dividing the state population according to the results of the 2000 Census with the total funding for tobacco control in fiscal year 2001.

Funding as a Percentage of CDC *Best Practices* Recommendations

The *Recommended for Total Program Annual Cost and Recommended Per Capita Funding Level Lower and Upper Estimates* are based upon an evidence-based analysis of comprehensive State tobacco control programs published in CDC's *Best Practices for Comprehensive Tobacco Control Programs*, August 1999.[11]

The *Percentage of CDC Best Practices Recommendations* was calculated by dividing the total funding amount for the state tobacco control program by the CDC *Best Practices* lower and upper estimate recommendations for total program annual cost.

Excise Tax

Data for *Cigarette tax per pack* and *Smokeless tobacco tax* were obtained from the State Tobacco Activities Tracking and Evaluation System (STATE), Office on Smoking and Health, Centers for Disease Control and Prevention.[12]

Data for *Number of packages of cigarettes sold and taxed*, *per capita* and *Federal and state taxes as a percentage of retail price* were obtained from Orzechowski and Walker.[13]

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