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Centers for Disease Control and Prevention

Jeffrey P. Koplan, MD, MPH, Director

National Center for Chronic Disease Prevention
and Health Promotion

James S. Marks, MD, MPH, Director

Office on Smoking and Health

Rosemarie Henson, MSSW, MPH, Director

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Tobacco Control State Highlights 2002: Impact and Opportunity

The following individuals from the Office on Smoking and Health,
National Center for Chronic Disease Prevention and Health Promotion,
Centers for Disease Control and Prevention prepared this publication:

Melissa Albuquerque, Policy Analyst
Alison Kelly, MPIA, Associate Director for Policy, Planning, and Coordination
Michael Schooley, MPH, Lead Epidemiologist
Jeffrey L. Fellows, PhD, Health Economist
Terry F. Pechacek, PhD, Associate Director for Science

Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Office on Smoking and Health

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Foreword

This report highlights the opportunities and challenges that the tobacco control community is currently facing. It lays out the case for action, which has never been stronger, and presents information about the consequences of inaction, which are grave. We hope that this report will provide guidance to state decision makers as they navigate through these extremely challenging times with competing health and homeland security issues now facing our nation. Among these competing demands, tobacco control remains one of America's most pressing public health issues. Although we have very strong evidence that sustained implementation of effective tobacco control programs is a wise investment, tobacco use continues to be the number one leading cause of preventable death and disease.

While in a time of fiscal uncertainty, investing in tobacco control may seem like a difficult choice, but the payoff is clear. States like California, with one of the longest-standing tobacco control programs, are beginning to witness major returns on their investments, both in terms of lives and dollars saved.

We have proven strategies that have been rigorously evaluated and are known to deliver results. The Centers for Disease Control and Prevention (CDC), along with an impressive coalition of federal and private partners, stands ready to assist states in implementing the effective strategies highlighted in this report and detailed in CDC's *Best Practices for Comprehensive Tobacco Control Programs*, the 2000 Surgeon General's report *Reducing Tobacco Use*, the Task Force on Community Preventive Services' tobacco-related recommendations, and the Public Health Service guidelines on smoking cessation.

CDC also is committed to assisting states in developing programs that are fiscally responsible and accountable, and will work with states to track their progress toward meeting the *Healthy People 2010* objectives through surveillance systems, such as the Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Survey, the Youth Tobacco Survey, and the Adult Tobacco Survey.

By working together at the community, state, and national levels and using approaches based in high-quality science, we can achieve our public health goals.

Rosemarie Henson, MSSW, MPH
Director
Office on Smoking and Health
National Center for Chronic Disease Prevention
and Health Promotion
Centers for Disease Control and Prevention

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Tobacco Control: Impact and Opportunity

Executive Summary

Tobacco use is the single most preventable cause of death and disease, causing 442,398 premature deaths in the United States annually from 1995 to 1999. Data in this report indicate that smoking-attributable annual death rates range from a high in Nevada of 414.3 per 100,000 to a low in Utah of 159.8 per 100,000. Smoking is a major risk factor for lung and other cancers, heart disease, and chronic respiratory diseases. One in every five deaths in this country is attributable to smoking.

Smoking among adults has slowly, but steadily, declined since 1993, causing smoking-attributable death rates to decline. However, 46.5 million American adults still currently smoke. Although the increases in youth smoking that persisted throughout the 1990s have leveled off, every day more than 5,000 young people try cigarettes for the first time. If current tobacco use patterns persist in the United States, an estimated 6.4 million children will die prematurely from a smoking-related disease.

The consequences of tobacco use impact the lives of citizens and the economies of industries and states. Direct medical expenditures attributed to smoking have risen since the early 1990s and now total more than \$75 billion per year. In addition to direct medical expenditures, smoking results in losses to productivity. Those losses now total more than \$80 billion per year. As states struggle to curb Medicaid costs, it is important to note that about 14% of all Medicaid expenditures are related to smoking. Within any one state, future changes in the direction of smoking-attributable costs will be related to the direction that a state takes with efforts to prevent and control tobacco use. Without comprehensive, sustained efforts to reduce rates of tobacco use, health care costs related to tobacco will continue to increase.

However, we have the ability to dramatically reduce the health and economic burden of tobacco use by employing proven tobacco control and prevention strategies. Achieving this goal will require collaboration among state decision makers, public health officials, business leaders, and community members.

The purpose of this report by the Centers for Disease Control and Prevention (CDC) is to assist those individuals and organizations committed to achieving a tobacco-free future by providing relevant and timely tobacco control information to guide decision making. Specifically, the report will

- summarize information regarding the health impact and economic burden of tobacco for each state,
- report state-specific data related to key tobacco control objectives,
- highlight evidence-based strategies that when implemented effectively will lead to achieving the highlighted *Healthy People 2010* objectives, and
- compare the current investment in tobacco control at the state level with the specific funding ranges recommended in CDC's *Best Practices for Comprehensive Tobacco Control Programs*.

The tobacco-related objectives of *Healthy People 2010* form the basis for assessing the nation's progress in achieving our tobacco control goals. This report highlights data that relate to four important *Healthy People 2010* objectives: reducing adult cigarette use, reducing tobacco use by adolescents, reducing exposure to environmental tobacco smoke, and eliminating disparities among population groups.

Data presented in this report indicate that the ambitious goals for 2010 are achievable and have already been met in a limited number of states. In most cases, however, there remains a great deal more to be done. Given the wide variation across states in these key indicators, it is clear that the approaches employed to achieve these objectives will need to be tailored to fit each state's unique situation. Fortunately, the foundation for action has already been laid. The proven strategies highlighted in this report are discussed in more detail in CDC's *Best Practices for Comprehensive Tobacco Control Programs*, the 2000 Surgeon General's report *Reducing Tobacco Use*, the Task Force on Community Preventive Services' tobacco-related recommendations, and the Public Health Service guidelines on smoking cessation. When employed as part of a comprehensive program, these strategies have demonstrated reductions in consumption, decreases in smoking prevalence among both youth and adults and, when sustained over time, more rapid declines in lung cancer and heart disease rates.

The state settlement agreements with the tobacco industry and gross cigarette tax revenue account for more than \$16 billion in state revenue each year and provide a major opportunity for tobacco control funding. Of the 48 states and the District of Columbia for which data were available,* 42 have invested a total of \$637.2 million in fiscal year 2002 from settlement revenues and 3 states have invested an additional \$123.9 million* from cigarette excise tax revenue. Another \$13.6 million in general revenues was invested by nine states. State investment in tobacco control totals \$774.7 million* in fiscal year 2002. National funders of state tobacco control programs include federal agencies and private foundations. National funders continue to play an important role in state-level tobacco control efforts, with investments totaling \$89.8 million in fiscal year 2002. In Tennessee and the District of Columbia, funds from national sources are the only funds being invested in tobacco control. In 12 states, funding from national sources accounted for 50% or more of the funds being invested in that state.

For the nation as a whole, combined resources from state and national sources for state-level tobacco control efforts in fiscal year 2002 total \$861.9 million, representing \$3.16 per capita. In fiscal year 2002, at least six states (Hawaii, Maine, Maryland, Minnesota, Mississippi, and Ohio) are meeting or exceeding the *Best Practices* lower estimated funding recommendation. Vermont is at 98% of the lower estimated funding recommendation. Two states (Arizona and Massachusetts) were not analyzed, because their state budgets had not been finalized at the time this publication went to press. Last fiscal year, both states met the *Best Practices* lower estimated funding recommendation.

Although these investments represent a significant commitment to the nation's tobacco control goals, the level of investment still falls short of what is needed to ensure success. And although the level of investment in comprehensive tobacco control programs has been shown to make an

*The investment analysis does not include Arizona and Massachusetts state funding, because fiscal year 2002 budget amounts were undetermined at the time this publication went to press.

independent and significant contribution to reducing consumption of tobacco products, true success will only be achieved by implementing proven strategies, monitoring progress, and sustaining effective programs over time. This report begins to assess the capacity of states to monitor and report on their progress in achieving short-, intermediate- and long-term objectives that can be directly linked to reducing the health and economic burden of tobacco use. States are in varying development stages in evaluating their progress in meeting short- and long-term objectives to reduce the health and economic burden of tobacco.

For more information on data sources, CDC has published *Surveillance and Evaluation Data Resources for Comprehensive Tobacco Control Programs*. The accompanying guide, *Introduction to Program Evaluation for Comprehensive Tobacco Control Programs*, will assist state tobacco control program managers and staff in planning, designing, implementing, and evaluating comprehensive tobacco control efforts.

In conclusion, although it is apparent that there is more to do before we achieve our goals of reducing tobacco-related disease, disability, and death in all states and among all populations, it is also apparent that significant efforts are being made. Sharing information regarding the current tobacco disease burden as well as the initiatives being undertaken to address this burden will allow states to learn from each other and bring the nation closer to meeting its *Healthy People 2010* goals.

Impact and Opportunity

Introduction

Tobacco use is the single most preventable cause of death and disease in the United States. Smoking alone was responsible for 442,398 premature deaths in the United States annually from 1995 to 1999.¹ These include deaths from lung and other cancers, cardiovascular diseases, infant deaths attributed to maternal smoking, and burn deaths. These premature deaths also include deaths from lung cancer and heart disease attributable to exposure to secondhand smoke. Smoking among adults has slowly, but steadily, declined since 1993, causing smoking-attributable death rates to decline. Declines in smoking-attributable death rates are mainly the results of declines in lung cancer death rates among men and declines in cardiovascular death rates among both men and women. Smoking-attributable lung cancer death rates among men have decreased, because of declines in smoking prevalence during the past several decades. Cardiovascular death rates are decreasing due to changes in lifestyles, including declines in smoking prevalence. Data in this report indicate that smoking-attributable annual death rates range from a high in Nevada of 414.3 per 100,000 people to a low in Utah of 159.8 per 100,000 people. Despite these declines, one in every five deaths still is attributable to smoking. Smoking remains a major risk factor for lung cancer, heart disease, and chronic respiratory diseases.² If current tobacco use patterns persist in the United States, an estimated 6.4 million persons currently aged 18 years or younger will die prematurely from a smoking-related disease.³

In addition to the enormous personal, social, and emotional toll of tobacco-related diseases, tobacco use has significant economic and societal impact. In 1998, smoking-attributable direct medical expenditures totaled \$75.5 billion.¹ These expenditures include annual individual expenditures for four types of medical services, including ambulatory care, hospital care, prescription drugs, and other care (including home health care, nonprescription drugs, and other nondurable medical products). Expenditures for vision products and dental care were excluded. Smoking-attributable direct medical expenditures are rising, largely because of medical care inflation and inflation-adjusted, real increases in health care expenditures in the United States. The real growth in health care expenditures may be the result of population aging, increased access to health care, increased demand for health care services independent of access issues, and past smoking behavior. As states struggle to curb Medicaid costs, it is important to note that about 14% of all Medicaid expenditures are related to smoking.⁴ Annually, between 1995 and 1999, smoking-attributable productivity losses from premature deaths totaled \$81.9 billion.¹ Within any one state, future changes in the direction of smoking-attributable costs will be related to the direction that state takes with efforts to prevent and control tobacco use. Without comprehensive, sustained efforts to reduce rates of tobacco use, health care costs related to tobacco use will continue to increase.

Fortunately, a great deal is known about how to prevent and control tobacco use. The science base has been established over several decades of clinical, behavioral, and epidemiologic research and has been proven through rigorous evaluation of comprehensive programs at the national, state, and local levels. The specific strategies that are recommended are contained in the Centers for Disease Control and Prevention's (CDC's) *Best Practices for Comprehensive Tobacco Control Programs*,⁵ the 2000 Surgeon General's report *Reducing Tobacco Use*,⁶ the Task Force on Community

Preventive Services' tobacco-related recommendations,⁷ and the Public Health Service guidelines on smoking cessation.⁸ If these strategies were fully implemented, the rates of tobacco use among young people and adults could be cut in half, thus reducing the number of smoking-attributable deaths and expenditures in the United States.⁹

Furthermore, the Surgeon General and the Institute of Medicine have both concluded that implementing these strategies through a comprehensive state-based program can be an effective means of curtailing the tobacco epidemic.^{6,10} For example, after implementing a comprehensive tobacco control program based on evidence-based strategies in 1993, the state of Massachusetts experienced significant declines in per capita cigarette consumption rates as well as in adult- and youth-smoking prevalence rates.⁶

Currently, all 50 states and the District of Columbia have tobacco control programs in place that have the potential to achieve similar results. If adequately funded, tobacco control programs that draw on strong scientifically-based interventions can reduce the number of adults who smoke by promoting quitting, prevent young people from ever starting, reduce exposure to secondhand smoke, and identify and eliminate disparities in tobacco use among population groups.

To assist states in developing such programs, CDC has established guidelines for effective, comprehensive tobacco control programs, including recommended funding levels for achieving optimal results. These guidelines are contained in the document *Best Practices for Comprehensive Tobacco Control Programs*,⁵ which provides detailed programmatic and funding information regarding the nine program elements of a comprehensive program:

- community programs to reduce tobacco use,
- chronic disease programs to reduce the burden of tobacco-related diseases,
- school programs,
- enforcement,
- statewide programs,
- counter-marketing,
- cessation programs,
- surveillance and evaluation, and
- administration and management.

Based on the experience of California, Massachusetts, and other states with comprehensive programs, CDC's *Best Practices* includes state-specific funding recommendations. In summary, the approximate annual costs to implement all the recommended program components have been estimated to range from \$7 to \$20 per capita in smaller states (population less than 3 million), \$6–\$17 per capita in medium-sized states (population 3–7 million), and \$5–\$16 per capita in larger states (population more than 7 million).

As *Best Practices* provides guidance to states as they undertake efforts to reduce illness, disability, and death related to tobacco use, *Healthy People 2010*¹¹ provides a blueprint for the nation for achieving tobacco control goals. *Healthy People 2010* is a set of health objectives for the nation, established with the input of hundreds of interested individuals and organizations, designed to

shape the public health initiatives of the first decade of the 21st century. Within *Healthy People 2010*, tobacco use is one of 28 focus areas and has also been included in a smaller set of health priorities known as leading health indicators. Reducing cigarette smoking by adults and adolescents are the two *Healthy People 2010* objectives associated with the leading health indicator in tobacco use. In addition, reducing the proportion of nonsmokers exposed to environmental tobacco smoke is the objective associated with the leading health indicator of environmental health. Finally, one of the overarching goals of *Healthy People 2010* is to eliminate health disparities among population groups. This goal will be met only if health disparities associated with tobacco use are eliminated.

These objectives are consistent with the goals of CDC's National Tobacco Control Program, a major source of federal funding for state-based comprehensive tobacco control programs. As a result, this report highlights state-specific data that relate to progress in these four areas. In order to ensure optimal results and efficient allocation of tobacco control resources, state tobacco control programs should monitor and report their progress toward meeting the goal of reducing death and disease caused by tobacco use. Meeting this overall goal should be measured through achievements in short-, intermediate-, and long-term objectives directly linked to reducing the health and economic burden of tobacco use. CDC's *Introduction to Program Evaluation for Comprehensive Tobacco Control Programs*¹² describes strategies to measure program outcomes. This report also highlights state efforts to establish systems by which critical tobacco use indicators can be monitored.

Finally, many new and emerging opportunities exist for states to identify and invest additional resources in tobacco control. From tobacco settlement dollars to excise tax revenues to federal and private funding streams, resources have increased significantly during the past 3–5 years. However, as demands on states are becoming increasingly complex because of rising health care costs, economic uncertainty, and homeland security measures, it becomes more of a challenge for states to determine how to allocate resources appropriately and effectively. CDC recognizes that funding decisions must be determined based on a state's individual needs and priorities, but it is also important to note that the level of investment in comprehensive tobacco control programs has been shown to have a direct and independent effect on tobacco consumption.¹³ Given the enormous economic burden resulting from tobacco use, comprehensive and sustained tobacco control programs are likely to produce significant economic benefits. The California Department of Health Services has estimated that for every \$1 spent on its comprehensive tobacco control program between 1990 and 1998, an estimated \$3.62 in direct medical costs was avoided.¹⁴

The purpose of this *State Highlights* report is to

- summarize information regarding the health impact and economic burden of tobacco for each state,
- report state-specific data related to key tobacco control objectives,
- highlight evidence-based strategies that when implemented effectively will lead to achieving the highlighted objectives, and
- compare the current investment in tobacco control at the state level with the specific funding ranges recommended in CDC's *Best Practices for Comprehensive Tobacco Control Programs*.

Reduce Cigarette Use Among Adults

It has long been recognized that preventing young people from using tobacco is essential to achieving a tobacco-free future. Even if we are completely successful in achieving our youth prevention goals, the enormous economic burden of tobacco use will continue for several more decades to come if the current rate of smoking among adults remains unchanged. To achieve the full social and economic benefit of tobacco control efforts, current smokers must also be assisted in ending their addiction. More than 46.5 million adults in the United States smoke cigarettes,¹⁵ and nearly 70% of them want to quit,¹⁶ but only a small percentage are able to quit permanently each year. Furthermore, because of the impact of social role models and social norms, adult tobacco use is likely to contribute to smoking initiation rates among youth.

For these important reasons, *Healthy People* objectives include an overall objective to cut the prevalence of tobacco use among adults in half by 2010 as well as accomplish a number of specific objectives, such as increasing the number of smoking cessation attempts by adults to 75%.¹¹ Obviously, smoking cessation is key to reducing the number of adults who smoke. The 2000 Surgeon General's report *Reducing Tobacco Use* concludes that pharmacologic treatment of nicotine addiction, combined with behavioral support, will enable 20–25% of users to remain abstinent at 1 year post treatment. Even less intensive measures, such as physicians advising their patients to quit smoking, can produce an increase in cessation of 5–10%.⁶ In its recommendations on reducing tobacco use, the independent Task Force on Community Preventive Services strongly recommends implementing health care provider reminder systems alone or in conjunction with provider education as effective methods to increase cessation attempts. The Task Force also strongly recommends reducing patient out-of-pocket costs for effective cessation treatment in order to increase the number of patients who quit.⁷ According to a recent *MMWR*, however, only one state, Oregon, has a Medicaid program that covers comprehensive tobacco cessation programs outlined in the Agency for Health Care Research's *Public Health Service Clinical Practice Guidelines*.¹⁷ These guidelines make seven recommendations related to behavioral and pharmacologic treatments.⁸ Finally, the Task Force strongly recommends tobacco use cessation telephone counseling in both clinical and community settings, and notes that media campaigns increase the use of these quitlines.⁷

In addition to addressing issues regarding treatment for tobacco dependency and cessation services, reducing the prevalence of adult tobacco use also requires efforts to change social norms regarding the acceptance of tobacco use. The Task Force also strongly recommends mass media campaigns featuring long-term, high-intensity counteradvertising as an effective strategy to reduce adult prevalence by increasing cessation.

In *Reducing Tobacco Use*, the Surgeon General also addressed the impact of changing social norms on the prevalence of tobacco use and concluded that clean indoor air regulations and restrictions on minors' access to tobacco products contribute to a changing social norm with regard to smoking and may influence prevalence directly. In addition, the Surgeon General concluded that increases in the excise tax on tobacco products will reduce the prevalence of smoking among youth and adults, the consumption of tobacco, and the long-term health consequences of tobacco use. The Task Force also strongly recommends increasing the unit price of tobacco products as effective in both increasing cessation and preventing youth initiation.

By incorporating all of these strategies into a comprehensive, sustained, and accountable tobacco control program, some states have seen dramatic results. For example, following the implementation of a tax increase that funded, in part, the establishment of the Arizona Tobacco Education and Prevention Program, adult prevalence rates in the state of Arizona decreased substantially. Declines in prevalence were seen among women, men, whites, and Hispanics throughout the state. Two of the sharpest decreases in prevalence occurred in those with incomes less than \$10,000 and those with less than an eighth-grade education, an encouraging finding that offers promise in eliminating tobacco-related disparities. During the same period, a substantial increase was shown in the proportion of smokers who reported that either a health care provider or a dentist asked about their tobacco use and advised them to quit.¹⁸ As a result, Arizona achieved one of the lowest prevalence rates for cigarette use in the country, with 18.6% of adults indicating that they were current smokers in 2000.¹⁹

Across the country, adult smoking prevalence in 2000 varied more than twofold, ranging from 12.9% in Utah to 30.5% in Kentucky.¹⁸ In addition to Kentucky, the states with the highest current smoking prevalence among adults were Nevada (29.1%), Missouri (27.2%), and Indiana (27.0%). Along with Utah, the states with the lowest prevalence rates were California (17.2%), Arizona (18.6%), and Montana (18.9%). The median smoking prevalence among adults was 23.3%. Based on these data, no state has yet achieved the *Healthy People 2010* objective of reducing tobacco use in adults aged 18 years and older to 12%.

Because of the importance that cigarette price plays in achieving tobacco control goals, and because excise taxes are a significant contributor to the overall price of tobacco products, this report also provides information regarding cigarette excise tax rates among states. These tax rates also vary dramatically, ranging from \$0.025 in Virginia to \$1.50 in New York, which became effective in April 2002. When combined with the federal excise tax on tobacco products of \$0.39,²⁰ it is clear that the *Healthy People 2010* objective of increasing the average federal and state tax on cigarettes to \$2.00 is still far from being achieved.

Reduce Tobacco Use by Adolescents

Data from the National Youth Tobacco Survey indicate that in 2000, 28% of high school students and 11% of middle school students were current smokers, and 34.5% of high school students and 15.1% of middle school students had used some form of tobacco (e.g., cigarettes, smokeless tobacco, cigars, pipes, bidis, or kreteks) during the past month.²¹ These figures underscore the fact that preventing young people from using tobacco products remains a critical element of a comprehensive tobacco control program. As evidence of the importance of this goal, 10 specific *Healthy People 2010* objectives address youth. Although the increases in tobacco use among youth that occurred through the 1990s appear to have leveled off, every day almost 5,000 young people try cigarettes for the first time.²² If current tobacco use patterns persist in the United States, an estimated 6.4 million people who are currently younger than age 18 will die prematurely from a smoking-related disease.³

Fortunately, we know how to prevent tobacco use among young people, and we are beginning to see results from our efforts. Smoking among youth increased during the 1990s, but these troubling trends may be reversing. In addition, the dramatic results achieved in a few states with

comprehensive tobacco control programs in place suggest that even more significant declines can be achieved. In *Reducing Tobacco Use*, the Surgeon General concluded that educational strategies, such as those outlined in CDC's *Guidelines for School Health Programs to Prevent Tobacco Use*,²³ conducted in conjunction with community and media-based activities can postpone or prevent smoking onset in 20–40% of adolescents.⁶

The importance of school programs as part of a comprehensive program was recently demonstrated in the state of Oregon, where the Tobacco Prevention and Education Program was created in 1997 with excise tax revenues generated by a voter-initiated ballot measure. A portion of the approximately \$8.5 million of the new tax revenues appropriated annually for tobacco control was used to implement school-based tobacco control programs consistent with CDC's *Guidelines for School Health Programs*. Because funding for the program is still quite limited, grants were awarded to only about one-third of the schools in the state. Results from this project were carefully analyzed, and the results were clear. From 1999 to 2000, 30-day smoking prevalence among eighth-grade students declined more in schools funded to implement these guidelines than in a comparison group of nonfunded schools.²⁴ These data suggest that comprehensive, school-based tobacco prevention programs that include tobacco-free school policies and community involvement as one component of a statewide program may contribute to reductions in current smoking among eighth graders. Of importance, how the guidelines were implemented was also influential. In schools where the CDC recommendations were implemented more fully, rates of cigarette smoking declined more rapidly.

Counter-marketing, enforcement of regulations such as minors' access restrictions, and clean indoor air regulations are three other components of a comprehensive tobacco control program that are particularly relevant to reducing youth tobacco use. In its independent review of the literature to determine the effectiveness of various strategies to reduce youth tobacco use, the Task Force on Community Preventive Services strongly recommended mass media education campaigns featuring long-term, high-intensity counter-advertising, particularly when these efforts are combined with other interventions, including tobacco price increases and community- or school-based education programs.⁷ This recommendation fully supports the *Best Practices* guidance for counter-marketing funding levels.

According to *Best Practices*, active enforcement of tobacco control policies enhances the efficacy of existing regulations by deterring violators and establishing community norms, and is an important and essential element of a comprehensive effort to reduce young people's use of tobacco. Other types of tobacco control policies and regulations can also contribute to the prevention of youth smoking. As outlined in *Reducing Tobacco Use*, regulation of tobacco products sale and promotion are effective in preventing young people from initiating smoking. The regulation of advertising and promotion, particularly those directed at young people, is likely to reduce both prevalence and commencement of smoking. Finally, raising the price of tobacco products has a rapid and reactive effect on the prevalence of youth tobacco use.

The implementation of strategies designed to address the problem of youth tobacco use varies dramatically across states, and as the data presented in this report demonstrate, so do the rates of tobacco use among youth. State-specific data were collected by states using the Youth Tobacco Survey (YTS)²¹ and the Youth Risk Behavior Survey (YRBS).²⁵ Among the 38 states with data

available for youth in grades 6–8, current smoking rates varied from 6.7% in California to 21.5% in Kentucky. The rates for any current use of tobacco among this age group were also low in California (10%) and highest in Kentucky (28.3%). Forty-seven states collected data on current cigarette smoking in grades 9–12. Current cigarette smoking in this age group ranged from a high of 40.6% in North Dakota to a low of 11.9% in Utah, more than a threefold difference. Only Utah and the District of Columbia (14.7%) have met the *Healthy People 2010* objective of reducing current cigarette use by students in grades 9–12 to 16% or less. Among the 34 states with data available for current use of tobacco among youth in grades 9–12, the rates ranged from 14.5% in Utah to 47.9% in West Virginia. As was the case with cigarette use, only Utah and the District of Columbia (21%) have met the *Healthy People 2010* objective of reducing use of any tobacco product by students in grades 9–12 to 21% or less.

Reduce the Proportion of Nonsmokers Exposed to Environmental Tobacco Smoke

Environmental tobacco smoke (ETS) is a known human carcinogen, responsible for at least 3,000 lung cancer deaths each year,²⁶ as well as more than 35,000 cardiovascular deaths and the exacerbation of hundreds of thousands of asthma cases and lower respiratory tract infections.²⁷ Since the late 1980s, CDC has tracked exposure to ETS by measuring the level of cotinine (a metabolite of nicotine) in representative samples of the U.S. population, including both smokers and nonsmokers, through NHANES. In its report on data from 1999, CDC revealed that the median cotinine level among nonsmokers aged 3 years and older has decreased by more than 75%. This reduction in cotinine levels objectively documents a dramatic reduction in exposure of the general U.S. population to environmental tobacco smoke since the period 1988–1991.²⁸ The public health community, state and local decision makers, and business leaders can take great pride in their accomplishments in reducing exposure to ETS. Because more than one-half of American youth are still exposed to this known human carcinogen, ETS remains a critical public health concern.

The Task Force on Community Preventive Services has strongly recommended smoking bans and restrictions (through policies, regulations, and laws) to effectively reduce exposure to ETS.⁷ The 2000 Surgeon General's report *Reducing Tobacco Use* goes one step further by concluding that although most state and local laws for clean indoor air reduce but do not eliminate nonsmokers' exposure to ETS, smoking bans are the most effective method for reducing ETS exposure.⁶

Although the Surgeon General's report concluded that smoking bans are the most effective means of reducing exposure, the *Healthy People 2010* objectives only include a total ban in school environments. In public and private worksites and in other environments, the *Healthy People 2010*¹¹ objective is to increase the proportion of such environments with formal smoking policies that prohibit smoking or limit it to separately ventilated areas to 100%. In 1998–1999, 79% of worksites with 50 or more employees had formal smoking policies that prohibited or limited smoking to separately ventilated areas.¹¹ Data collected in 1998 and 1999 by the Current Population Survey Tobacco Use Supplement from individuals aged 15 years or older indicate that 69% of people were protected from exposure to tobacco smoke in their worksite. Data presented in this report document state-specific ranges from a high of 84.4% in Utah and 81.7% in Maryland to a low of 48.9% in Nevada and 57.1% in Kentucky.²⁹

Because children continue to be exposed to ETS at a higher rate and this exposure most often occurs at home, *Healthy People 2010* also includes the objective of reducing the proportion of children who are regularly exposed to tobacco smoke at home. An intermediate step toward this goal is to establish a policy within the home that bans smoking. Data collected in 1998 and 1999 through the Current Population Survey Tobacco Use Supplement from individuals aged 15 years or older indicated that 61.1% of people were protected by a ban on tobacco smoke in their homes. State-specific data presented in this report indicate that the percentage of people protected by a ban on tobacco smoke in their homes varies from a high of 81.7% in Utah to a low of 39.9% in Kentucky. In addition to Utah, California had a large number of people (74.3%) who were protected by a ban on tobacco smoke in their homes. In addition to Kentucky, only 42.5% of people in West Virginia were protected by a smoking ban in their homes.³⁰

Eliminate Health Disparities Among Population Groups

Reducing the burden of disease among all population groups is a *Healthy People 2010* goal. The *Healthy People 2010* objectives strive to eliminate health disparities among all population groups. Health disparities exist within a specific segment of the population and are associated with gender, race or ethnicity, education or income, age, geographic location, or sexual orientation. As the data presented in this report indicate, disparities clearly exist among population groups related to tobacco use; however, approaches to eliminate those disparities are still being developed. The first step in eliminating these disparities is to identify which groups are experiencing a higher burden of disease, an increase in tobacco use, or difficulty in accessing tobacco control programs. Data presented in this report can assist states in identifying disparities among different population groups with regard to current cigarette smoking. This report documents current cigarette smoking rates by racial and ethnic group, gender, education, and age.³¹ Education level was very closely correlated with income level; therefore, only education levels are displayed.

The prevalence of current smoking varies significantly among the five racial and ethnic groups for which data are presented. Overall, American Indians (AI) and Alaska Natives (AN) are more likely to smoke than other racial and ethnic groups, with considerable variation in prevalence by tribe. Hispanics, African Americans, and Asian Americans/Pacific Islanders are less likely to smoke than other groups.¹¹ Among the 26 states where data were available from the 1999 and 2000 Behavioral Risk Factor Surveillance System (BRFSS) within the AI/AN populations, current cigarette smoking prevalence ranged from 10.9% in Arizona to 60.8% in Minnesota, with a median prevalence of 34.5%. State-specific data from the 1999 and 2000 BRFSS reveal that among the 49 states and the District of Columbia where data were available, within the Hispanic population, current smoking rates ranged from 12.7% in Arizona to 38.3% in Iowa, with a median of 23.0%. Among the 28 states where data were available, within the Asian American/Pacific Islander population, current cigarette smoking prevalence ranged from 24.9% in Nevada to 5.6% in Connecticut, with the median smoking prevalence of 13.4%. Among the 41 states and the District of Columbia, where data were available for the African American population, current smoking rates ranged from 7.9% in Hawaii to 39% in Oregon, with the median prevalence being 23.3%. All states and the District of Columbia had data for whites, and the current smoking rates ranged from 13.0% in Utah to 30.4% in Kentucky.

Overall, men are more likely to smoke than women.¹¹ State-specific data reveal that current smoking rates among women varied from 11.4% in Utah to 29.5% in Nevada. Current smoking rates among men varied from 14.5% in Utah to 33.4% in Kentucky.

Persons with less than 12 years of education have higher levels of smoking prevalence than persons with 12 or more years of education.¹¹ Persons with more than 12 years of education have much lower smoking rates. State-specific data on persons with less than 12 years of education reveal that current smoking rates range from 15.9% in Minnesota to 49.5% in Alaska. Current smoking rates among persons with 12 years of education range from 19.4% in Utah to 32.4% in Kentucky. Among persons with more than 12 years of education, current smoking rates range from 7.7% in Utah to 24% in Kentucky.

Data reveal high smoking rates among college-age youth (aged 18–24). Among 18- to 24-year-olds, state-specific data on current smoking rates range from 39.7% in Wisconsin to 16.9% in Utah. Current cigarette smoking rates among 25- to 44-year-olds range from 13.9% in Utah to 36.6% in Kentucky. Among 45- to 64-year-olds, current smoking rates range from 13.4% in Utah to 32.4% in Nevada. The population with the lowest smoking rates comprises individuals aged 65 years and older. Current smoking rates among this population range from 4.2% in Utah to 15.7% in Nevada.

When comprehensive programs that are appropriate and effective for each population group are implemented and sustained, our goal of eliminating disparities related to tobacco use will be achieved. A number of states have undertaken new initiatives to address such disparities, and CDC is supporting 13 states in developing strategic plans for their disparities initiatives. In addition, CDC has dedicated approximately \$4 million to establish a network of national organizations that work with eight identified priority populations that can plan, initiate, coordinate, and evaluate tobacco use prevention and control activities to reduce tobacco use in their respective priority population. Finally, CDC is funding AI/AN tribes and tribal organizations to develop or improve tobacco-related resource networks and outreach to AI/AN tribes. In 2001, the American Legacy Foundation announced that it had distributed \$8,500,000 in grants to 32 organizations in 18 states to help reduce tobacco use among priority populations. This is the first of two rounds of funding that will provide a total of \$21 million to a broad range of groups that employ effective and innovative approaches to achieve this goal. These activities are important steps toward establishing a science base in this area that will be essential to our ultimate success in reaching priority populations.

Measuring Progress

In order to continue to document our successes and to learn from our failures, it is imperative to implement and maintain surveillance and evaluation systems. In addition to providing critical programmatic information to guide future activities, such systems provide program accountability for state decision makers and others responsible for fiscal oversight. CDC's *Best Practices* recommends that 10% of total annual program funds be allocated for surveillance and evaluation.⁵

States have varying capacity to evaluate their progress in meeting short- and long-term objectives to reduce the health and economic burden of tobacco. Currently, all 50 states and the District of Columbia track progress toward the goal of reducing smoking among adults through CDC's BRFSS. The BRFSS also tracks smoking prevalence among different population groups based on

demographics, including race/ethnicity, gender, education, income, disability, and age. This surveillance system will assist states in identifying disparities among these groups. The BRFSS now has sufficiently large samples to permit analysis of risk factor data for many metropolitan statistical areas. In some states, the BRFSS can provide baseline data for monitoring local programs as well as a benchmark for comparing data from local surveys.³²

Data presented in this report include the percentage of people protected from ETS in their worksites and homes that comes from the Current Population Survey Tobacco Use Supplement. This national survey also provides state-specific data. States may also track their progress toward eliminating exposure to environmental smoke through the BRFSS tobacco module and through a new survey entitled the Adult Tobacco Survey. The Adult Tobacco Survey is intended to produce data on prevalence, cessation, ETS, and risk perception and social influences.¹²

The two systems that provided data on reducing and preventing tobacco use among young people for this report were the Youth Risk Behavioral Surveillance System (YRBSS) and the YTS. The YRBSS monitors six categories of priority health-risk behaviors among youth and young adults, including tobacco use. The YRBSS includes a national school-based survey conducted by CDC as well as state, territorial, and local school-based surveys conducted by education and health agencies. Thirty-seven states and the District of Columbia collected weighted data between 1991 and spring 1999 on tobacco use.²⁵ The YTS is intended to collect data on prevalence, knowledge and attitudes, indicators of the impact of media and advertising, information on the enforcement of minors' access regulations and laws, knowledge of tobacco in school curriculum, cessation attempts and successes, and exposure to ETS. Thirty-eight states and the District of Columbia collected weighted data from the YTS between 1998 and spring 2001.²¹

Two other important surveillance systems exist to monitor state progress in meeting *Healthy People 2010* tobacco objectives. The Pregnancy Risk Assessment Monitoring System collects population-based surveillance data on selected maternal behaviors, including tobacco use. Seventeen states collected weighted data from this survey in 1999.

The School Health Education Profiles Survey (SHEPS) collects data on health education policies and programs through a survey for lead health educators and a separate survey for school principals at the state level. Twenty-six states collected weighted data from the SHEPS during 1999–2001, and 12 states collected weighted data from the tobacco module.

For more information on data sources, CDC has published *Surveillance and Evaluation Data Resources for Comprehensive Tobacco Control Programs*.³³ The accompanying guide, *Introduction to Program Evaluation for Comprehensive Tobacco Control Programs*,¹² will assist state tobacco control program managers and staff in the planning, design, implementation, and use of practical evaluations of comprehensive tobacco control efforts.

Investment in Tobacco Control

States have many new and emerging opportunities to identify and invest additional resources in tobacco control, including the availability of funds from the settlement of the states' lawsuits against the tobacco industry, state excise tax revenues, and general funds as well as national

funding sources. Evidence indicates that the rate of progress toward meeting these objectives for reducing tobacco use will be related to the level of investment in evidence-based strategies implemented within comprehensive tobacco control programs.¹³

State investment in tobacco control

In 2001, the 50 states received more than \$8 billion in tobacco settlement revenue.³⁴ These funds were available for appropriation in fiscal year 2002, and in 42 states, \$637.2 million in settlement revenue were appropriated for tobacco control programs. All four states that settled independently with the tobacco industry invested in tobacco control, ranging from \$29.8 million in Florida to \$12.5 million in Texas. The highest per capita allocation among these states was in Mississippi, with \$7.59 per capita invested in tobacco control programs. Mississippi and Minnesota receive settlement funds independently from the state through a partnership and a foundation, respectively. Among the remaining 38 states, state investments ranged from \$119.6 million in Ohio to \$500,000 in Kansas and Louisiana. Ohio's funding is directed into a trust fund and does not reflect an actual expenditure.

In fiscal year 2000, more than \$8 billion was collected in gross cigarette tax revenue within the 50 states and the District of Columbia.³⁵ In fiscal year 2002, excise tax revenues have served as an important source of revenue for tobacco control efforts in California, Oregon, and Utah.*

Finally, 12 states have appropriated approximately \$13.6 million from their general revenue to support tobacco use prevention and control programs in fiscal year 2002.

To summarize the analysis of state investment in tobacco control for fiscal year 2002, every state with the exception of Tennessee and the District of Columbia has invested state funds totaling \$774.7 million[†] to support tobacco use prevention and control programs from settlement funds, state excise tax revenues, or general revenues.

National funding for state-based tobacco control activities

National funders of state tobacco control programs include federal agencies and private foundations. Two federal agencies, CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA), provide funds that can support state tobacco control efforts. CDC's Office on Smoking and Health manages the National Tobacco Control Program, which funds state health departments to build and maintain comprehensive tobacco control programs. Between June 1, 2001, and May 30, 2002, CDC has provided \$59.3 million to the 50 states and the District of Columbia. SAMHSA's substance abuse block grant supports state efforts for a variety of substance abuse treatment, prevention, and control efforts. By law, states must report to SAMHSA how much of their substance abuse block grant money will be spent to support administrative functions to carry out the Synar Amendment, which requires states to monitor minors' access to tobacco. A total of 27 states reported to SAMHSA that between October 1, 2001, and September 30, 2002, they will spend \$7.5 million of their block grant monies to monitor youth access to tobacco products.

*In fiscal year 2001, Arizona and Massachusetts also appropriated excise tax revenues for tobacco control. This is expected to continue in fiscal year 2002, although exact funding amounts were unavailable at the time this publication went to press.

[†]Arizona's and Massachusetts' investments in tobacco control are not included, because their state budgets were not finalized at the time this publication went to press.

Private funders also play an important role in supporting state tobacco control programs. The Robert Wood Johnson/American Medical Association SmokeLess States Initiative began a new round of funding in 2001 that supports activities of statewide coalitions working to improve the tobacco policy environment within three policy areas: (1) increasing state tobacco excise taxes in order to reduce the demand for tobacco products, (2) reducing exposure of the population to secondhand smoke, and (3) fostering changes in Medicaid and private insurance to cover tobacco dependence treatment. Within their most recent funding cycle, the SmokeLess States Initiative invested \$12.7 million to support statewide tobacco control programs in 40 states. The American Legacy Foundation, an independent foundation created by the Master Settlement Agreement, has awarded 36 grants totaling \$10.4 million between October 1, 2000, and September 30, 2001, to fund statewide and local programs that create youth empowerment programs, support priority population groups, and enhance applied research for tobacco control. The American Legacy Foundation funds additional grants that are national or multistate in focus. These grants also support activities in the three areas indicated above.‡

In Tennessee and the District of Columbia, funds from national sources are the only investment in tobacco control. In 12 states, funding from national sources accounted for 50% or more of the funds being invested in that state. During fiscal year 2001, in 20 states, funding from national sources accounted for 50% or more of the funds being invested in that state.

Total investment in state tobacco control

In fiscal year 2002, combining resources available from state, federal, and private sources, at least six states (Hawaii, Maine, Maryland, Minnesota, Mississippi, and Ohio) are meeting or exceeding the *Best Practices* lower estimated funding recommendation. Vermont is at 98% of the *Best Practices* lower estimated funding recommendation. Two states (Arizona and Massachusetts) were not analyzed, because their state budgets had not been finalized at the time this publication went to press. Last fiscal year, both states met the *Best Practices* lower bound funding recommendations. Expenditures may differ from appropriated or awarded amounts, because of delays in implementation, program cuts, or the establishments of trusts and endowments, as is the case with Hawaii and Ohio.

The total investments in states from state, federal, and national sources average about 56% of the lower bound funding estimate recommended in *Best Practices*. In 18 states, combined funding from state and national sources provide less than 33% of the lower bound funding estimate.

For the nation as a whole, the combined resources available for tobacco control in fiscal year 2002 totals \$861.9 million.§

Limitations

The funding data report is subject to several limitations. Current events have had a negative impact on the budgets of many states. As the year 2001 drew to a close, several states were in special session reviewing their budgets for possible cuts in order to account for rising Medicaid costs,

‡For more information on American Legacy Foundation programs, visit www.americanlegacy.org.

§Arizona's and Massachusetts' investments in tobacco control are not included, because their state budgets were not finalized at the time this publication went to press.

declines in the stock market, and to cover additional costs for homeland security measures. It is also important to note that this report only includes funds appropriated specifically for tobacco prevention and control. Therefore, the reported amounts exclude appropriations for multiple purposes that included an unspecified amount of funding for tobacco control. However, if such information was available through legislative analysis or a state budget office, this information was included in a footnote. See State Data Sources and Definitions, beginning on page 149 of this report, for further information regarding the rules for inclusion of funds.

State investments are based on appropriations, rather than expenditure, and the funding from national funding sources is based on award amounts. Expenditures may differ from appropriated or awarded amounts, because of delays in implementation, program cuts, or the establishment of trusts or endowments.

Some data on excise taxes and appropriations from state general revenues were collected directly from state budget officers or health department contacts and were not independently verified by legislative analysis. In Mississippi and Minnesota, funding from a state nongovernmental source was collected from the agency. In California and New York, settlement resources are shared with local governments. The local governments' share is not reported. In addition, other private and federal entities do provide funds for state-based tobacco control efforts, including the Public Health and Preventive Services Block Grant, the SAMHSA block grants (for activities other than Synar), the American Cancer Society, the American Lung Association, and the Campaign for Tobacco Free Kids. Funding from these sources was not included in this analysis. Finally, this report does not attempt to evaluate whether the tobacco control funding is being used to support evidence-based components contained in CDC's *Best Practices for Comprehensive Tobacco Control Programs*.

Conclusion

This report documents the continuing importance of our tobacco control efforts and highlights the progress being made in states across the nation. The investment of nearly \$1 billion in tobacco control efforts in fiscal year 2002 is a significant achievement, and because of the importance of sustaining our efforts over time, it is gratifying to note that the data compare very favorably with the investments reported last year. By investing in proven strategies, rigorously monitoring our progress, and continuing to support effective programs, we have the ability to both achieve our tobacco control goals and see an impressive return on our investment.

We can significantly reduce or eliminate the social and economic burden of tobacco use and return to more productive uses. The \$75.5 billion that is currently being used to pay for smoking-attributable direct medical expenditures and the \$81.9 billion of productivity losses related to smoking can be ill-afforded as we work to stimulate our nation's economy.

Working together, local, state, and federal partners can achieve a great deal by supporting scientifically-based, fiscally responsible, and accountable tobacco control programs. A future free from the harm caused by tobacco is no longer a dream. Together, we can make it a reality.

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