State Data Sources and Definitions

Health Impacts

Smoking-Attributable Deaths, 1999 and *Smoking-Attributable Deaths, 1999—Disease Specific* were estimated using the Internet-based Adult Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC) software program.[1] Adult SAMMEC estimates the number of smoking-attributable cancer, cardiovascular, and respiratory disease deaths among adults. Smoking-attributable deaths (SAM) are calculated using an attributable-fraction formula that combines smoking prevalence and relative risk data for current and former smokers (compared with never smokers). Age-adjusted SAM rates were calculated for persons aged 35 years and older and were age-adjusted to the 2000 U.S. population to provide comparable estimates across states (these rates exclude burn deaths).

The *number of youth (0–17 years of age) projected to die prematurely from their smoking* is based on 1999 and 2000 Behavioral Risk Factor Surveillance System (BRFSS) 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.[2]

Adult Cigarette Use, 2000

Data for *Adult Cigarette Use, 2000* are from the 2000 BRFSS.[3] Prevalence data for cigarette smoking among adults aged 18 years and older are shown for each state overall. For comparison purposes, each state highlight includes the BRFSS median for all states. 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.

Environmental Tobacco Smoke, 1998–99

National and state data for people protected by smoking policies in their worksite were calculated using the methodology published in "State-Specific Trends in Smoke-Free Workplace Policy Coverage: The Current Population Survey Tobacco Use Supplement 1993–1999."[4] Worksite and home data were calculated using Current Population Survey data from 1998–1999. For worksites, the data were collected from self-respondents 15 years and older who reported having a worksite policy stating that smoking was not allowed in indoor public or common areas and work areas. For homes, data were collected from self-respondents 15 years and older who reported having a rule that smoking was not allowed anywhere in their home.[5]

Youth Tobacco Use[6,7]

National data for *Current Cigarette Smoking Among Youth, Grades 6–8*; *Current Any Tobacco Use Among Youth, Grades 6–8*; *Current Cigarette Smoking Among Youth, Grades 9–12*; and *Current Any Tobacco Use Among Youth, Grades 9–12* are from the 2000 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 1 or more of the past 30 days preceding the survey. Current any tobacco users are defined as those students who reported using cigarettes or cigars or smokeless tobacco or pipes or bidis or kreteks on 1 or more of the 30 days preceding the survey.

State-specific data for *Current Cigarette Smoking Among Youth, Grades 6–8*; *Current Any Tobacco Use Among Youth, Grades 6–8*; *Current Cigarette Smoking Among Youth, Grades 9–12*; and *Current Any Tobacco Use Among Youth, Grades 9–12* are from the state school-based Youth Tobacco Survey (YTS) or the state school-based Youth Risk Behavior Survey (YRBS).

Thirty-eight states and the District of Columbia collected weighted data from the YTS between 1998 and spring 2001. The YTS is representative 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 school students and high school students in the state. Current smokers are defined as those students who reported smoking cigarettes on 1 or more of the past 30 days preceding the survey. Current any tobacco users are defined as those students who reported using cigarettes or cigars or smokeless tobacco or pipes or bidis or kreteks on 1 or more of the 30 days preceding the survey.

Thirty-seven states and the District of Columbia have collected weighted data from the YRBS between 1991 and spring 1999. The YRBS is representative 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 were weighted and can be generalized to all high school students in the state. Current smokers are defined as those students who reported smoking cigarettes on 1 or more of the past 30 days preceding the survey. Current any tobacco users are defined as those students who reported using cigarettes or cigars or chewing tobacco or snuff on 1 or more of the 30 days preceding the survey.

Disparities Among Adult Population Groups, 2000 [8]

Prevalence data for cigarette smoking among adults aged 18 and older are collected from the 2000 BRFSS and are presented by demographic groups, including racial/ethnic, sex, education level, and age. Prevalence estimates for racial/ethnic subgroups are reported for combined years (1999–2000) 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, non-institutionalized population. The table of BRFSS estimates (see table) can also be used for comparison.

Economic Impacts and Investments

The *Percentage of the Center for Disease Control and Prevention's (CDC's) Best Practices Recommendations* was calculated by dividing the total funding amount for the state tobacco control program by CDC's *Best Practices* lower and upper estimate recommendations for total program annual cost.[9]

Smoking-Attributable Medicaid Expenditures were estimated using published data on the smoking-attributable fraction (SAF) of total Medicaid expenditures in each state as of 1993[10] and personal health care expenditures paid by Medicaid in fiscal year 1998 obtained from the Centers for Medicare and Medicaid Services (CMS) available at http://www.hcfa.gov. Medicaid expenditures on personal health care include both state and federal funds. The federal government's share of Medicaid spending in each state varies from 50% to 76%.

Summary Prevalence Estimates of Adult Cigarette Smoking by Demographic Characteristics, BRFSS 2000*

	Number of States†	Median	Minimum	Maximum
Overall	51	23.3	12.9	30.5
Men	51	24.5	14.5	33.4
Women	51	21.2	11.4	29.5
<12 years education	51	30.1	15.9	49.5
12 years education	51	26.6	19.4	32.4
>12 years education	51	17.5	7.7	24.0
White	51	23.2	13.0	30.4
African American	42	23.3	7.9	39.0
Hispanic	50	23.0	12.7	38.3
Asian/Pacific Islander	28	13.4	5.6	24.9
American Indian/AN‡	26	34.5	10.9	60.8
18–24 years old	51	31.1	16.9	39.7
25–44 years old	51	27.1	13.9	36.6
45–64 years old	51	22.4	13.4	32.4
65+ years old	51	9.8	4.2	15.7

*BRFSS = Behavioral Risk Factor Surveillance System.
†The term "States" includes all 50 states and the District of Columbia.
‡AN = Alaska Native.

Smoking-Attributable Direct Medical Expenditures, 1998 were derived from published estimates of the SAF of personal health care expenditures in 1993[11] and 1998 personal health care expenditure data obtained from CMS. Annual state medical expenditures attributable to cigarette smoking were estimated using an econometric model of annual individual expenditures for four types of medical services: 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. The econometric models calculate the fractions of medical costs in each state in 1993 that are attributable to smoking using the 1987 National Medical Expenditure Survey, 1993 data from the Tobacco Use Supplement to the Current Population Survey (CPS) sponsored by the National Cancer Institute, the March CPS, and the BRFSS. Nursing home SAFs are based on a nursing home model that indicates the probability of admission. Costs do not take into account differences in life expectancy between smokers and nonsmokers and therefore do not reflect total lifetime medical care costs.

Smoking-Attributable Productivity Costs, 1999 reflects the productivity costs from smoking-attributable premature deaths. These data were calculated using estimates of the present value of future earnings (PVFE) from paid market and unpaid household work. Age-specific data for 1990 were obtained from Haddix and colleagues (1996).[12]

State Revenue from Tobacco Sales and Settlement

The *tobacco settlement revenue received in 2001* was published by the National Conference of State Legislatures in the report *State Management and Allocation of Tobacco Settlement Revenue 1999–2001*.[13]

The *gross cigarette tax revenue collected in 2000* was published in *The Tax Burden on Tobacco: Historical Compilation 2000*[14] and reflects gross state cigarette taxes collected during fiscal year 2000 ending June 30.

The *cigarette tax per pack* was analyzed from state legislation as of the end of the third quarter in 2001.

The *cigarette sales data* were published in *The Tax Burden on Tobacco: Historical Compilation 2000*[14] and reflect tax paid per capita sales during fiscal year 2000 ending June 30.

Investment in Tobacco Control

The *State Appropriation—Settlement (Tobacco Only)* amount was gathered through an analysis of state appropriations legislation. 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 government agency, foundation, trust fund, board, or university for tobacco control programs for state fiscal year 2002. 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 state's 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 2002 from state resources outside of the settlement or the tobacco excise tax with the specific purpose of supporting tobacco use prevention and control activities and programs.

To verify state appropriations, letters and forms were mailed to state budget offices and addressed to the prime contacts provided by the National Association of State Budget Officers. Forty state budget offices and the District of Columbia communicated budget information to CDC's Office on Smoking and Health, accounting for an approximately 80% response rate. In some cases, the budget amounts provided by the state budget offices were not reported, because they may have been over-ruled by a decision rule from the Office on Smoking and Health regarding the categorization of funding.

Non-Government 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 in order 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 CDC's Office on Smoking and Health as part of the National Tobacco Control Program. This amount represents funds awarded between June 2001 and May 2002. The funding amount may consist of unobligated funds, base award amounts, and supplemental programs. Some awards include supplemental funds for one or more of the following purposes: (1) identify and eliminate disparities among population groups, (2) conduct the Adult Tobacco Survey, and (3) implement asthma and sports programs. 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 emphasizes 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.

Federal—SAMHSA (Substance Abuse and Mental Health Services Administration) includes the Substance Abuse Prevention and Treatment (SAPT) Block Grant, which makes available through formula grants to the states and U.S. jurisdictions $1.6 billion annually to support the development and delivery of substance abuse prevention and treatment services nationwide. State substance abuse agencies use the prevention portion of the SAPT Block Grant funding to implement programs that focus on 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.

States and U.S. jurisdictions that receive SAPT Block Grant funds are required, as a precondition 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 in order to measure their compliance with state laws and to meet negotiated retailer violation targets and a final goal of 20% 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% of its SAPT Block Grant award, depending on the year of noncompliance. 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. The amount represented under SAMHSA is the funding amount of SAPT Block Grant funds that the state reported having committed toward implementing the requirements under the Synar Amendment.

Non-Government Source—American Legacy Foundation includes funding from the American Legacy Foundation, an independent, national public health foundation 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 program funding made to the

state or its local entities between October 1, 2000, and September 30, 2001. These grants support youth movements against tobacco use, programs to enhance applied research for tobacco control, and work with priority population groups.

Non-Government Source—RWJF/AMA (Robert Wood Johnson Foundation/American Medical Association) via the SmokeLess States National Program Office awarded $35 million in 40 new grants to statewide coalitions as part of the $52 million SmokeLess States National Tobacco Policy Initiative. Funding cycles for these awards vary between a March and June 2001 start date. Additional states may receive awards with the next funding cycle. SmokeLess States is a private-sector effort, established in 1993, that supports activities of statewide coalitions working to improve the tobacco policy environment. Grant recipient efforts are complemented with matching funds and aimed at any or all of 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. The policy areas were chosen to significantly diminish the burden of tobacco use. In addition to the 40 grants awarded, statewide coalitions will be able to compete for an additional $8 million in Special Opportunities Grant (SOG) funds. The SOG program was established as part of SmokeLess States several years ago to provide grantees with supplemental funding for unforeseen special initiatives arising from shifts in the local or state tobacco policy environment that provide unique opportunities for action.

Fiscal year 2002 Total Investment in Tobacco Control includes the total investment in state tobacco control programs from state sources, including settlement, excise tax, and other, as well as federal (CDC and SAMHSA) and non-government (American Legacy Foundation and RWJF/AMA) sources.

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 2002.

CDC's Best Practices Recommended Annual Total Costs and Recommended Annual Per Capita Lower and Upper Estimates are based on an evidence-based analysis of comprehensive state tobacco control programs published in CDC's *Best Practices for Comprehensive Tobacco Control Programs—August 1999*.[9]

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