AMERICAN LUNG ASSOCIATION®

# STATE OF TOBACCO CONTROL 2019

# Preface

## "State of Tobacco Control" 2019

### By American Lung Association National President and CEO Harold P. Wimmer

Tobacco use is the leading cause of preventable disease and death in the United States, killing more than 480,000 Americans a year. Through our annual "State of Tobacco Control" report we have been tracking efforts to reduce tobacco use by state and federal governments for 17 years. Over this time, the tobacco prevention and quit smoking policies called for in "State of Tobacco Control" have been a remarkable public health success story, resulting in record lows for both adult and youth cigarette smoking rates.

However, new factors, especially the dramatic rise of e-cigarette use among youth and the popularity of flavored cigars among high school boys, warn us that this success could be fleeting. New data show that youth use of highly addictive e-cigarettes has sky-rocketed to what the U.S. Surgeon General calls "epidemic" proportions. E-cigarette use increased by a staggering 78 percent among high school students from 2017 to 2018, and more than 1 million additional kids began to use e-cigarettes in the past year. It could set the stage for another generation of Americans addicted to tobacco products and ultimately more tobacco-caused death and disease.

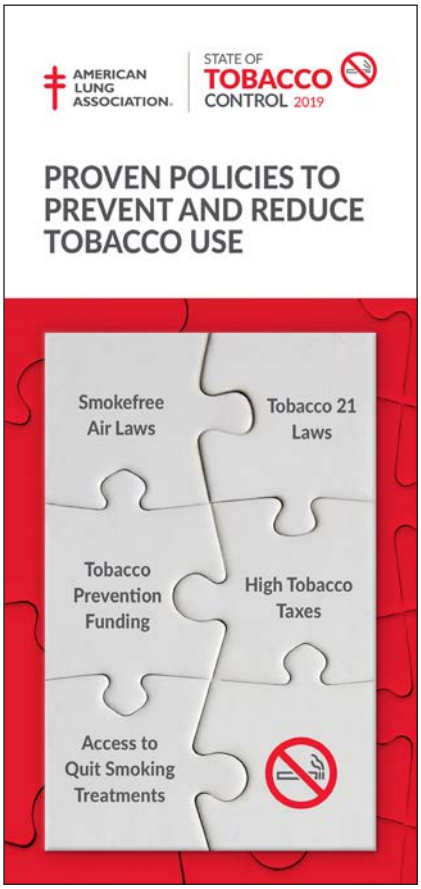
More aggressive action by our country's federal and state policymakers is urgently required. However, "State of Tobacco Control" 2019 has found a disturbing failure by federal and state governments to take action to put in place meaningful and proven-effective policies that would have prevented, and reduced tobacco use during 2018. This failure to act places the lung health and lives of Americans at risk. We have also found that this lack of action has emboldened tobacco companies to be even more brazen in producing and marketing products squarely aimed at kids, such as the JUUL e-cigarettes that look like an easily concealed USB drive, which now dominate the market driven by youth use.

A strategic imperative of the American Lung Association is to eliminate tobacco use and tobacco-related diseases. Our 17th annual "State of Tobacco Control" highlights our progress toward this goal and provides an urgent call to action for state and federal governments. We know how and are ready to save more lives, but we need our elected officials to do much more.

To many, solving America's tobacco crisis might seem like a complex puzzle with no solution. And yet we have known for years what pieces are needed to reduce the disease and death caused by tobacco use.

**Smokefree Air:**
According to the U.S. Surgeon General, there is no safe level of exposure to secondhand smoke, which is attributed to more than 41,000 deaths in the U.S. per year. For the sixth year straight, none of the 22 remaining states passed smokefree workplace laws. It is absolutely critical that the remaining states move to protect their citizens from exposure to secondhand smoke in all public places and workplaces. Exposure to secondhand e-cigarette emissions is also harmful and so new to this year's report is the inclusion of e-cigarettes into the smokefree air grade.

**Tobacco Prevention Funding:**
Nicotine in tobacco is highly addictive, and once addicted, it's hard to quit. The




best way to stop that addiction is to prevent tobacco use, including e-cigarette use before it starts. The Centers for Disease Control and Prevention (CDC) has recommended funding levels that each state should be spending on tobacco prevention programs. However, no states are currently funding tobacco prevention programs at or above the level recommended by CDC.

In addition, 2018 marked the 20th anniversary of the tobacco Master Settlement Agreement where 46 states and the District of Columbia settled with the tobacco industry and received ongoing annual payments, which many state Attorneys General at the time promised to use to fund programs to prevent and reduce tobacco use. However, the anniversary is a vivid reminder of the failure of states to dedicate a portion of the money from these tobacco settlement payments or tobacco taxes to fund tobacco prevention programs. We urge all states to fund their tobacco preventions at or above CDC-recommended levels.

**Tobacco Taxes:**

Tobacco taxes also are highly effective at preventing youth tobacco use, but only the District of Columbia and Oklahoma passed significant tax increases this past year. Tobacco tax ballot measures were attempted in Montana and South Dakota in November 2018 but those efforts were stymied by over $22 million in tobacco industry spending against them.

**Tobacco 21:**

Increasing the legal age of sale for tobacco products to 21 would decrease tobacco use by 12 percent and could prevent 223,000 deaths among those born between 2000 and 2019, according to a 2015 report by the National Academy of Medicine. In 2018, Massachusetts became the sixth state, along with the District of Columbia, to pass a statewide Tobacco 21 law. More than 350 cities and municipalities have passed their own Tobacco 21 laws, showing that often, true leadership comes at the community level.

**Helping Smokers Quit:**

It is difficult to quit smoking—a person often tries between seven and ten times to quit before they are successful. But, it's never too late to quit smoking, and no matter when you quit, your health is improved. To help more smokers quit, all state Medicaid programs must cover a comprehensive tobacco cessation benefit, with no barriers to access the care. Coverage must include the seven FDA-approved medications and three forms of counseling for all Medicaid enrollees. In 2018, only Kentucky, Missouri and South Carolina provided this coverage. Additionally, states must invest in their state quitline, often the only resource for the uninsured to access tobacco cessation services.

**FDA Regulation of Tobacco Products:**

The U.S. Food and Drug Administration (FDA) has comprehensive authority over the manufacturing, marketing and sale of tobacco products, but needs to use that authority much more aggressively to curb the tobacco epidemic. FDA made a number of announcements about potential future actions in 2018, including reducing nicotine in cigarettes and restricting flavored tobacco products. However, in some cases the proposals do not go far enough, and none of these announcements have yet resulted in formal proposed rules. Given the staggering rise in youth e-cigarette use from 2017 to 2018, the health and futures of our children are on the line, and we cannot afford any further delays.

When we look at these and other pieces of the puzzle, we get a clear picture of what is proven-effective and urgently needed to end America's tobacco epidemic. The only piece that's missing is the political will to do it. "State of Tobacco Control" provides a clear picture of what state and federal policymakers must do to create a healthier, tobacco-free future for all Americans. We call on lawmakers, both state and federal, to take action, do their part and consider the lives that could be saved if they put in place the proven tobacco control policies called for in "State of Tobacco Control" 2019.

Harold P. Wimmer

National President & CEO
American Lung Association

# "State of Tobacco Control" 2019: The Failure by Government Officials to Act Jeopardizes Lives and Lung Health

The 17th annual American Lung Association "State of Tobacco Control" report evaluates states and the federal government on actions taken to halt the nation's leading cause of preventable death—tobacco-caused disease—and save lives with proven-effective and urgently needed tobacco control laws and policies.

As a result of implementing the policies called for in "State of Tobacco Control," adult and youth cigarette smoking rates are at an all-time low, with 7.6 percent of high school students[1] and 14.0 percent of adults smoking cigarettes.[2] In particularly positive news, there was a significant drop in adult smoking rates from 15.5 percent in 2016 to 14.0 percent in 2017.[3] However, this positive news was tempered by a dramatic and extremely troubling 78 percent rise in youth e-cigarette use from 2017 to 2018.[4]

Continued progress on reducing both cigarette smoking, and other tobacco product use requires more aggressive action on the part of our federal, state and local governments. On that front, the American Lung Association's 2019 "State of Tobacco Control" report showed a disturbing failure of our policymakers to put in place meaningful policies to prevent and reduce tobacco use in 2018 at both the state and federal level. This failure places the lung health and lives of Americans at risk.

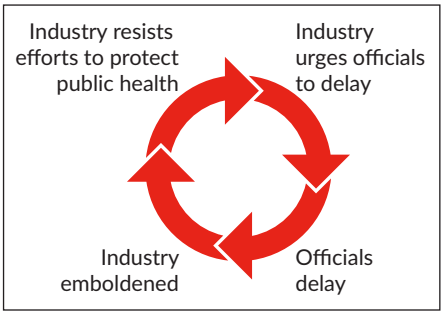
Tobacco remains the leading cause of preventable death and disease in America, killing more than 480,000 Americans each year. In addition, 16 million Americans are living with a tobacco-related disease.[5]

The failure to act to apply proven-effective policies to other tobacco products including cigars and e-cigarettes is directly responsible for the dramatic rise in youth e-cigarette use, and 27 percent of youth now use at least one tobacco product.[6] This could set the stage for not only another generation of Americans addicted to tobacco products but ultimately more tobacco-caused death and disease. Nicotine is not only addictive but also harms adolescent brain development and places youth at risk for a host of other lung diseases related to this relatively new tobacco product.

The rise of JUUL, an e-cigarette product that looks like a USB flash drive, and its popularity with youth is one consequence of inaction by federal and state governments. As noted in last year's "State of Tobacco Control" 2018 report, tobacco use places a greater burden on certain populations and those living in certain parts of the country, and these areas and populations consequently pay a higher price when elected officials fail to act to prevent and reduce tobacco use.

**The Failure to Act Emboldens the Tobacco Industry**

For decades, the tobacco industry has urged federal, state and local officials to delay meaningful action or not take any action at all to prevent and reduce tobacco use, especially among youth. This has resulted in a vicious circle, with tobacco companies becoming even more emboldened to devise new and egregious ways to addict youth and sustain addiction among current users. This delay, allows tobacco companies to resist



meaningful action to protect public health as it would potentially cut into company profits.

This has been especially true of the policies called for in "State of Tobacco Control" 2019. The tobacco industry and its allies routinely oppose efforts at the state level to increase tobacco taxes, pass comprehensive smokefree laws, and in recent years, oppose efforts to increase the tobacco sales age to 21 and restrict access to flavored tobacco products to protect youth. In 2018, they spent over $18 million opposing a ballot measure in Montana that would have both increased the cigarette tax by $2.00 per pack and provided continued funding to the state's expansion of Medicaid. At the federal level, the tobacco industry has made repeated efforts in Congress to weaken the U.S. Food and Drug Administration's (FDA) authority over tobacco products, including trying to exclude "premium" cigars from basic FDA oversight and exempt all cigars, including cigarillos and flavored cigars popular among youth, from FDA review.

**FDA's Failure to Act in Time**

FDA has full authority over the manufacture, marketing and sale of tobacco products in the U.S. under a law passed by Congress in 2009 and through the 2016 "deeming" rule. However, in many cases over the past two Administrations, the agency has failed to implement the law and use this comprehensive authority to put meaningful restrictions on tobacco products in place. This lack of action continued to earn the federal government an "F" grade for FDA Regulation of Tobacco Products in the 2019 "State of Tobacco Control" report.

One clear consequence of FDA's inaction has been a steep rise in e-cigarette use among youth to "epidemic" levels, with 20.8 percent of high school students using e-cigarettes in 2018—a stunning increase from 11.7 percent in 2017.[7] It has also led to the rise of JUUL, an e-cigarette that looks like a USB flash drive, which contains high amounts of nicotine, comes in several kid-friendly flavors and is particularly popular with youth. JUUL has claimed the largest share of the overall e-cigarette market in a very short time period and has inspired a number of other companies to create similar types of e-cigarettes.

In early November, American Lung Association National President and CEO Harold P. Wimmer and his counterparts at several other major national organizations committed to ending tobacco-caused disease sent a letter to FDA Commissioner Scott Gottlieb. The letter included three core principles essential to reducing tobacco use, including:

1. Voluntary action by the industry—including the e-cigarette industry—is insufficient. Industry-wide regulatory action is essential.
2. FDA's approach must be comprehensive and not limited to sales restrictions to prevent illegal sales to youth.
3. It is essential to address the problem of youth use of other tobacco products as well as e-cigarettes.

Since 2009, the American Lung Association has urged aggressive action by FDA to curb these types of products. On November 15, 2018—the same day the study showing a 78 percent spike in high school e-cigarette use in one year was released[8]—the FDA announced several actions it intends to take that it says would help address youth e-cigarette use. Unfortunately, FDA's plans around e-cigarettes rely primarily on sales restrictions of some flavored products in stores that allow customers under the age of 18 to enter, as well as voluntary

actions announced by both Altria (the tobacco company formerly known as Philip Morris) and JUUL regarding their sales of flavored e-cigarettes.

However, these sales restrictions will not apply to mint and menthol flavors of e-cigarettes. An article released by the Centers for Disease and Control and Prevention (CDC) at the same time as FDA's announcement showed that over 50 percent of high school students that use e-cigarettes use mint or menthol flavors of e-cigarettes.[9] This finding severely undercuts any potential impact these sales restrictions might have. In addition, FDA contributed to this problem with its July 2017 decision to delay the review of all e-cigarettes until 2022—the subject of a lawsuit brought against the agency by the American Lung Association and its partners. Given the "epidemic" levels of e-cigarette use revealed by the 2018 National Youth Tobacco Survey, the partial measures announced by FDA are insufficient, as are the voluntary measures from these two major tobacco companies. Ultimately, FDA must take meaningful action and prohibit all flavored tobacco products, including all e-cigarettes.

In its November 2018 announcement, FDA did announce its intention to issue a proposed rule that would prohibit the sale of menthol cigarettes and all flavored cigars. The American Lung Association strongly supports this FDA action, which would be an historic achievement if it comes to pass. Menthol in cigarettes plays a significant role in youth becoming addicted to cigarettes, masking the harsh taste of tobacco smoke and making the poison go down easier. Menthol cigarettes are also disproportionately used by African-Americans and make it more difficult to quit smoking. Earlier in 2018, FDA also launched a new nationwide media campaign focused on reducing e-cigarette use among youth ages 12-17 as part of its "Real Cost" campaign, which is also to be commended.

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**MSA 20th Anniversary and the Failure of States to Act**

November 23, 2018, marked the 20th anniversary of the 1998 tobacco Master Settlement Agreement (MSA), where 46 states*, the District of Columbia and several U.S. territories reached a legal settlement with the tobacco industry requiring the industry to make annual payments to the states in perpetuity to reimburse states for tobacco-caused healthcare costs. The settlement also imposed some advertising and marketing restrictions on tobacco companies, including ending the use of cartoon characters in advertisements, such as Joe Camel.

Around the time the MSA was announced, many state Attorneys General and other state leaders made public promises about the annual payments from the MSA being used to fund programs to prevent and reduce tobacco use. However, there was no provision in the actual MSA that required states to spend money on tobacco prevention and quit smoking programs, and in the 20 years since, virtually all the states have used most or all of the annual MSA payments for different and in some cases questionable purposes.

This broken promise in relation to the MSA represents a tremendous failure on the part of states to fund comprehensive programs proven to drive down smoking rates even faster and prevent more of the previous generation of youth from ever starting. In states where comprehensive tobacco control programs have been in place, states have seen accelerated declines in smoking rates especially among youth, and later saw declines in tobacco-

* Four states—Florida, Minnesota, Mississippi and Texas—reached legal settlements with the tobacco industry along similar lines to the MSA prior to the actual MSA in 1998.

caused diseases. In California, which has routinely invested in its prevention and cessation programs since 1989, deaths from lung cancer have declined rapidly and as of 2013, were 28 percent lower than the rest of the U.S.[10] Overall, states are spending only three cents of every dollar from tobacco settlement payments and tobacco taxes on tobacco control programs in fiscal year 2019.[11] In addition, 43 states and the District of Columbia received "F" grades in "State of Tobacco Control" for failing to spend even 50 percent of CDC-recommended levels on tobacco prevention and quit smoking programs.

**Some Positive News**

The news in 2018 was not all bad. The year saw several important actions taken by states and the federal government to curb tobacco use and exposure to secondhand smoke:

- Massachusetts became the sixth state to pass a law increasing the tobacco sales age to 21, and the District of Columbia implemented its Tobacco 21 law, originally approved in 2016.
- Oklahoma and the District of Columbia approved significant increases in state tobacco taxes of a $1.00 per pack or more.
- San Francisco and a number of other communities in California and in Minnesota passed laws that prohibit the sale of all flavored tobacco products, including menthol, despite intense and well-funded tobacco industry opposition.
- Kansas and New Jersey expanded coverage for quit smoking treatments under their state Medicaid programs, and several states expanded Medicaid under the Affordable Care Act giving more of the state's lower-income population access to low-cost quit smoking treatments.
- The U.S. Department of Housing and Urban Development successfully implemented its rule prohibiting smoking in federally-owned public housing, protecting close to 2 million children and adults living in public housing from exposure to secondhand smoke.

**More About "State of Tobacco Control"**

"State of Tobacco Control" 2019 is focused on proven policies that federal and state governments can enact to prevent and reduce tobacco use rates. These include:

- Tobacco prevention and quit smoking funding, programs and robust insurance coverage;
- Comprehensive smokefree laws that eliminate smoking in all public places and workplaces;
- Increased tobacco taxes;
- Raising the minimum age of sale for tobacco products to 21; and
- Aggressive implementation of the U.S. Food and Drug Administration's (FDA) Family Smoking Prevention and Tobacco Control Act.

The report assigns grades based on laws and regulations designed to prevent and reduce tobacco use in effect as of January 2019. The federal government, all 50 state governments and the District of Columbia (D.C.) are graded to determine if their laws and policies are adequately protecting citizens from the enormous toll tobacco use takes on lives, health and the economy.]

## Successes and Challenges in 2018

### States

Overall, states continued their unfortunate record of failing to put in place the proven policies called for in "State of Tobacco Control" that would help significantly reduce the 480,000 lives lost to tobacco each year. A few states did make notable progress:

- The District of Columbia increased its cigarette tax by $2.00 per pack, and Oklahoma increased its cigarette taxes by $1.00 per pack. Montana and South Dakota had ballot measures to increase cigarette taxes by $2.00 and $1.00 per pack respectively, ultimately not approved by voters, with the tobacco industry spending enormous amounts of money to defeat these measures. Kentucky also increased its cigarette tax in 2018, but only by 50 cents per pack, missing a golden opportunity to take meaningful action to address its nearly highest in the country smoking rates for adults and youth. The average state cigarette tax is now $1.78 per pack – with the District of Columbia now having the highest cigarette tax ($4.50 per pack) and Missouri having the lowest (17 cents per pack).
- Only one state—Massachusetts—passed a law raising the minimum age of sale for all tobacco products to 21 in 2018. Due to revenue from the

increase in the District of Columbia's cigarette tax, the Tobacco 21 law previously approved in 2016 was also finally implemented, as the inclusion in the city's budget was required for the law to take effect. Sadly, Illinois was blocked just short of becoming the seventh state to pass a Tobacco 21 law, when then-Governor Bruce Rauner vetoed a bill passed by the legislature and the legislature failed to override the veto. This brings the national total to six states and the District of Columbia that have acted to reduce youth tobacco initiation and save lives. Many cities and counties in New York have also passed Tobacco 21 laws bringing the population covered by such laws in New York to close to 76 percent.

- Kansas led the way in improving access to cessation treatments for low-income residents in 2018. The state passed a bill providing a comprehensive quit smoking benefit for all Medicaid enrollees. Currently, 12 states have a comprehensive tobacco cessation benefit for all standard Medicaid enrollees, covering all seven tobacco cessation medications and all three forms of counseling to help smokers quit. However, 49 states still have barriers for Medicaid enrollees to access this treatment.
- New Jersey saw a $6.7 million increase in funding for its state tobacco prevention program in fiscal year 2019 as the result of a law approved in 2017 allocating one percent of tobacco tax revenues to tobacco prevention programs. In addition, Florida, Kentucky and the District of Columbia all saw a $1 million or more increase in funding to tobacco prevention programs in fiscal year 2019. However, several states also had setbacks on funding for their tobacco prevention and quit smoking programs, including Idaho, Minnesota and Wyoming. Three states—Connecticut, Tennessee and West Virginia—provided no state funding at all for tobacco prevention and quit smoking programs, severely hampering their ability to respond to large increases in youth tobacco use. The total amount spent by states on tobacco prevention and cessation is over $652 million, less than three cents of every dollar of the close to $27.3 billion states collect from tobacco settlement payments and tobacco taxes.
- Alaska approved a statewide law that prohibits smoking in public places and workplaces in 2018 but included a provision in the law that allows local communities to opt out of the law by ballot measure. Unfortunately, this means the law cannot be considered comprehensive because protections from exposure to secondhand smoke can be taken away by communities at any time. Indeed, in the fall, some Sitka residents attempted to opt out of the law, but the effort was rejected by voters in October 2018. Massachusetts and Rhode Island also added e-cigarettes to their comprehensive smokefree laws, and Florida added e-cigarettes to its current secondhand smoke protections by constitutional amendment in November 2018.
- In June 2018, voters in San Francisco overwhelmingly upheld the city's ordinance to prohibit the sale of flavored tobacco products, including menthol tobacco products, in retail stores. The tobacco industry had referred the law to the ballot and spent over $12 million trying to get it overturned. Additional communities in California and Minnesota also passed similar flavored tobacco product ordinances, in some cases with exemptions for over age 18 or 21 retail tobacco stores. Massachusetts also became the first state to completely prohibit tobacco sales in pharmacies.

## Federal Government:

FDA announced that it intends, in the future, to propose a rule to remove all menthol cigarettes and flavored cigars from the marketplace. However, FDA continued to avoid meaningful action to protect the public's health from the newest tobacco product: e-cigarettes. Other federal government agencies, including the Department of Housing and Urban Development (HUD), made progress on reducing tobacco use and exposure to secondhand smoke.

- In December, Surgeon General Jerome Adams issued a rare public health advisory, warning the public about the e-cigarette epidemic among youth. The advisory was issued the day after 2018 Monitoring the Future data was released that showed a 90 percent increase of e-cigarette use among high school students.[12]
- Despite the skyrocketing of youth e-cigarette use and the declared epidemic, the FDA did not reverse its 2017 delay for newly regulated tobacco products to be reviewed by the FDA before being placed on the market. This action weakened FDA's "deeming" rule that granted FDA's Center for Tobacco Products authority over e-cigarettes, cigars, hookah and other previously unregulated tobacco products in 2016. FDA's delay by more than four years of the deadline looks even more shortsighted with the dramatic increase in rates of youth e-cigarette use from 2017 to 2018, with 1 million more kids using e-cigarettes over the course of one year alone. In response to FDA's failure to implement the law, the American Lung Association and other public health groups filed a lawsuit in 2018 seeking to reverse these damaging changes to FDA's "deeming" rule.
- FDA signaled its intent to propose a rule in the future to remove menthol cigarettes and flavored cigars from the market. However, FDA's plan to restrict the display of flavored e-cigarettes—with the notable exceptions of menthol and mint flavors—in retail stores amounts to a half measure that fails to adequately respond to the youth e-cigarette use crisis. In response to requests for comment by the FDA, the American Lung Association submitted three sets of comments with FDA in 2018 on nicotine reduction, "premium cigars" and flavored tobacco products, where the Lung Association called on FDA to remove flavored tobacco products from the market.
- The tobacco industry—Altria and the cigar industry—combined forces with its Fiscal Year 2019 rider in an attempt to weaken FDA authority over tobacco products. After two years of strong pushback against opening loopholes to allow candy-flavored e-cigarettes to remain on the marketplace indefinitely, the FY19 rider included in the House funding bill for FDA would exclude so-called "premium" cigars and grandfather in flavored and little cigars. The Senate did not include this rider.
- The U.S. Department of Housing and Urban Development's rule requiring all federally-owned public housing to implement smokefree policies took effect on July 30, 2018. The rule will protect close to 2 million people, including 690,000 children living in public housing, from secondhand smoke exposure,[13] as well as prompt many smokers living in public housing to make a quit attempt. The American Lung Association marked the implementation of this historic rule with a celebration at a public housing complex in Milwaukee, Wisconsin, and has a number of state-based projects still in progress to help adult residents of public housing quit smoking.

A 2017 study found that states which expanded Medicaid had a 36 percent increase in the number of tobacco cessation medication prescriptions relative to the states that did not expand Medicaid. This means more quit attempts with proven cessation treatments are being made.[14]

- Despite a federal court judge declaring the entire Affordable Care Act unconstitutional in December, key quit smoking policies required in the Affordable Care Act remain in effect. However, the Administration put forward new rules that expand plans that are not required to cover quit smoking treatments. The U.S. Department of Health and Human Services has also approved a tobacco surcharge for Medicaid enrollees who smoke in Indiana and Wisconsin. The American Lung Association opposes tobacco surcharges as there is no evidence that they help smokers quit.
- Both the House of Representatives and Senate supported maintaining funding in their fiscal year 2019 spending bill for CDC's Office on Smoking and Health and its "Tips from Former Smokers" campaign, a highly effective media campaign that features stories of people living with smoking-related diseases. In previous years, the House had attempted to make cuts to this invaluable program.
- In September 2018, FDA launched an extension of its "The Real Cost" media campaign to address the risks of youth use of e-cigarettes, targeting youth ages 12-17 who have used e-cigarettes or are open to trying them. The American Lung Association applauded FDA for this decision. Given e-cigarettes are now at "epidemic" levels among high school youth at 20.8 percent in 2018 and the rise of JUUL, this media campaign came at a critical time.[15]
- During 2018, major tobacco companies were finally required to issue "corrective statements" about the dangers of smoking and secondhand smoke through print newspaper and TV ads, on company websites and on cigarette packs. These corrective statements were one of the remedies from a lawsuit won by the Department of Justice against the tobacco companies in 2006 where the major tobacco companies were found guilty of civil racketeering. However, the industry delay of these "corrective statements" through numerous legal challenges since 2006 potentially keeps them from being viewed by a wider audience due to the inability to be placed in more modern media channels online.
- In August 2018, a U.S. District Court judge ruled FDA unreasonably delayed finalizing a new rule requiring graphic warning labels on cigarettes. In her order, the judge required FDA to submit a plan and timeline to the court. FDA previously met a Tobacco Control Act-mandated timeline of finalizing graphic warning labels on 50 percent of the front and back of cigarette packs. However, after the cigarette companies sued FDA and a judge sided with the industry and tossed out the specific warnings, FDA failed to move forward with proposing new graphic warning labels, despite it being required by law. The lawsuit compelling FDA to act was filed by the American Lung Association and other public health groups, aimed at forcing action by FDA on this important public policy, which could have a substantial impact on smoking rates.

# 2019: Policies that States and the Federal Government Can Put in Place to End their Failure to Act and See Lasting Reductions in Tobacco Use and Exposure to Secondhand Smoke

## States

- **States Must Increase Funding for Tobacco Control Programs and Focus These Programs on At-Risk Populations:** States must fund programs that prevent youth from starting to use tobacco and help smokers quit at levels recommended by the Centers for Disease Control and Prevention (CDC). State tobacco control programs must also prioritize reaching and serving the needs of populations that continue to use tobacco at higher rates, and adequate funding for tobacco prevention and quit smoking programs can be particularly important in accomplishing that. Comprehensive tobacco control prevention programs must also include efforts aimed at reducing youth e-cigarette use.
- **The Remaining 22 States Must Pass Comprehensive Smokefree Laws**: While many workplaces in these 22 states are smokefree, people working in the hospitality (i.e., restaurants, bars and gaming establishments) and manufacturing sectors may be and often are exposed to secondhand smoke at work on a daily basis. Certain racial/ethnic groups are disproportionately represented in the hospitality sector and are therefore more likely to be exposed to secondhand smoke.[16] They will benefit the most if the remaining 22 states pass comprehensive smokefree laws that include all workplaces, including restaurants, bars and gaming establishments. In 2006, the U.S. Surgeon General concluded that there is no safe level of exposure to secondhand smoke.
- **States Must Expand Comprehensive Cessation Coverage in All Medicaid Programs:** It is well-established that helping smokers quit saves lives and money. Smoking is a serious addiction, and while nearly seven out of 10 smokers want to quit, only 10 percent quit successfully.[17] Medicaid covers some of the most vulnerable groups in society including poor families, low-income pregnant women and people with disabilities, as well as a high percentage of smokers (24.5 percent of Medicaid recipients smoke[18]). Additionally, Medicaid is the largest single payer for behavioral health services in the United States.[19] Despite the overwhelming evidence that the number of people quitting smoking increases when coverage provides access to all seven FDA-approved tobacco cessation treatments and all three forms of counseling without barriers, such as copays and prior authorization, only two states require such coverage.

  States must ensure that both standard and expansion Medicaid offer comprehensive quit smoking coverage without barriers such as copays, prior authorization or stepped therapy (where a patient must try and fail with one product before using others). As of December 31, 2018, 43 states limit the duration of cessation treatment and 36 states require prior authorization for at least some plans.
- **States Must Increase Tobacco Taxes and Equalize Taxes Across All Tobacco Products:** Significantly increasing tobacco taxes is one of the most effective ways to reduce tobacco use, especially among youth. Georgia, Missouri, North Carolina, North Dakota and Virginia have the five lowest state cigarette tax rates in the country and are long overdue for significant increases. These states also all have adult cigarette smoking rates higher than the national smoking rate of 14 percent. Bringing parity to (equalizing) tobacco taxes across all products, including cigars, little cigars and roll-your-own, eliminates any financial incentive for people to switch to a different product, thereby encouraging people to quit tobacco entirely.

- **States Must Increase the Minimum Age of Sale to 21.** The National Academy of Medicine (formerly the Institute of Medicine) found increasing the minimum age of sale for all tobacco products to 21 could prevent 223,000 deaths among people born between 2000 and 2019, including 50,000 fewer dying from lung cancer, the nation's leading cancer killer.[20] Six states, the District of Columbia and hundreds of localities have already passed such laws.

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## Federal Government:

- **FDA Must End Its Delay of the Deeming Rule.** FDA Commissioner Scott Gottlieb, M.D., threatened—on a case-by-case basis—to revisit the July 2017 decision to delay pre-market review of all newly deemed tobacco products. However, FDA has taken no action to implement this critical provision of the Tobacco Control Act. Litigation brought by the American Lung Association and our public health partners in response to FDA's 2017 announcement remains ongoing.
- **FDA Must Move Forward with Graphic Warning Labels on Cigarettes.** A federal court judge sided with the American Lung Association and other public health litigants in August and ruled that FDA is still responsible for implementation of graphic warning labels on all cigarette packs. The judge's timeline for FDA to comply with the ruling is still pending.
- **FDA Must Issue a Product Standard Eliminating All Flavored Tobacco Products, Including Menthol.** In July, the American Lung Association submitted comments to FDA, urging them to remove all flavored tobacco products including e-cigarettes, smokeless, cigars, hookah and menthol cigarettes from the marketplace. The evidence is overwhelming that flavored tobacco products are more appealing to youth and are one of the primary reasons that kids use tobacco products. In addition, menthol tobacco products make it both easier for kids to start smoking and harder for adults to quit, in particular African-Americans who have long been targeted by the tobacco industry.[21] A 2011 report from FDA's own Tobacco Products Scientific Advisory Committee concluded that "removal of menthol cigarettes from the marketplace would benefit public health in the United States."[22]
- **Federal Government Must Do More to Help Smokers Quit.** Current law requires that Medicaid expansion and most private insurance plans cover a comprehensive quit smoking benefit with no cost sharing. However, a December 2016 study co-authored by the American Lung Association and the Centers for Disease Control and Prevention found of the 31 states and the District of Columbia that have expanded Medicaid, only nine states require health plans to cover all seven FDA-approved cessation treatments as well as individual and group counseling.[23]

  Similar studies of private insurance plans have also found that plans are not covering this benefit. The Department of Health and Human Services, the Department of Labor, and the Department of Treasury must be proactive in putting health insurance plans on notice that they must cover these critical preventive services.

  CDC has declared 2019 to be the "Year of Cessation," an important first step that underscores the need for comprehensive coverage for cessation services.

- **CDC and FDA Must Continue Their Successful and Cost-Effective Mass Media Campaigns.** FDA's "Real Cost" and CDC's "Tips from Former Smokers" mass media campaigns are succeeding in reducing smoking rates. It is critically important that both campaigns continue and that they retain their emphasis on reaching historically underserved populations including racial/ethnic minorities, LGBTQ people and rural communities.

  In January 2017, CDC published a report that found FDA's "The Real Cost" Campaign prevented almost 350,000 youth from smoking from 2014-2016.[24] A 2018 CDC study also found that the "Tips" campaign led to approximately 522,000 people quitting smoking for at least six months from 2012 to 2015.[25] The campaigns also feature and focus on tobacco use among priority populations. A 2016 study found that priority populations including African-Americans and Hispanics perceive the "Tips" ads to be effective in reaching them.[26]

- **Congress Must Increase Taxes on All Tobacco Products.** The Federal Government has not increased taxes on cigarettes and other tobacco products since 2009 and is long overdue for a significant increase. The $0.62 increase in 2009 had a significant impact on smoking rates and increasing tobacco taxes is one of the most significant actions Congress could take to prevent and reduce tobacco use. Equalizing taxes between cigarettes and other tobacco products is also important to help tobacco users quit for good.

"State of Tobacco Control" 2019 provides a blueprint that states, and the federal government can follow to put in place proven policies that will have the greatest impact on reducing tobacco use and exposure to secondhand smoke in the U.S. **The real question is: Will lawmakers end their failure to act and take this opportunity to achieve lasting reductions in tobacco-related death and disease?**

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# Tobacco Prevention and Cessation Funding Overview

| State Name | Tobacco Settlement Funding | Tobacco Tax Funding | Other State Funding | Total State Funding | Federal Funding to States | Total Funding | CDC-Recommended Spending Level | Percentage of CDC-Recommended Level | State Tobacco-Related Revenue | Grade |
|---|---|---|---|---|---|---|---|---|---|---|
| Alabama | $1,000,000 | $0 | $1,088,137 | $2,088,137 | $2,619,127 | $4,707,264 | $55,900,000 | 8.4% | $300,200,000 | F |
| Alaska | $0 | $0 | $9,122,400 | $9,122,400 | $887,405 | $10,009,805 | $10,200,000 | 98.1% | $83,200,000 | A |
| Arizona | $0 | $17,343,100 | $0 | $17,343,100 | $1,848,394 | $19,191,494 | $64,400,000 | 29.8% | $429,500,000 | F |
| Arkansas | $12,008,972 | $0 | $0 | $12,008,972 | $2,009,944 | $14,018,916 | $36,700,000 | 38.2% | $282,700,000 | F |
| California | $0 | $247,382,000 | $2,999,999 | $250,381,999 | $8,747,467 | $259,129,466 | $347,900,000 | 74.5% | $2,808,300,000 | B |
| Colorado | $0 | $23,616,821 | $520,000 | $24,136,821 | $2,621,889 | $26,758,710 | $52,900,000 | 50.6% | $286,300,000 | D |
| Connecticut | $0 | $0 | $0 | $0 | $2,180,091 | $2,180,091 | $32,000,000 | 6.8% | $500,800,000 | F |
| Delaware | $6,295,100 | $0 | $0 | $6,295,100 | $727,843 | $7,022,943 | $13,000,000 | 54.0% | $154,700,000 | D |
| District of Columbia | $905,000 | $1,000,000 | $0 | $1,905,000 | $722,358 | $2,627,358 | $10,700,000 | 24.6% | $72,900,000 | F |
| Florida | $70,401,719 | $0 | $0 | $70,401,719 | $2,603,379 | $73,005,098 | $194,200,000 | 37.6% | $1,534,700,000 | F |
| Georgia | $750,000 | $0 | $0 | $750,000 | $2,200,138 | $2,950,138 | $106,000,000 | 2.8% | $393,300,000 | F |
| Hawaii | $3,650,126 | $0 | $859,103 | $4,509,229 | $1,435,886 | $5,945,115 | $13,700,000 | 43.4% | $160,300,000 | F |
| Idaho | $3,456,700 | $170,900 | $0 | $3,627,600 | $1,155,048 | $4,782,648 | $15,600,000 | 30.7% | $76,700,000 | F |
| Illinois | $9,100,000 | $0 | $0 | $9,100,000 | $3,091,979 | $12,191,979 | $136,700,000 | 8.9% | $1,068,800,000 | F |
| Indiana | $7,500,000 | $0 | $0 | $7,500,000 | $2,236,579 | $9,736,579 | $73,500,000 | 13.2% | $556,900,000 | F |
| Iowa | $0 | $0 | $4,021,225 | $4,021,225 | $1,588,630 | $5,609,855 | $30,100,000 | 18.6% | $274,200,000 | F |
| Kansas | $847,014 | $0 | $0 | $847,014 | $1,469,625 | $2,316,639 | $27,900,000 | 8.3% | $190,000,000 | F |
| Kentucky | $3,773,000 | $0 | $0 | $3,773,000 | $2,114,376 | $5,887,376 | $56,400,000 | 10.4% | $507,300,000 | F |
| Louisiana | $500,000 | $4,726,830 | $9,619,681 | $14,846,511 | $1,233,018 | $16,079,529 | $59,600,000 | 27.0% | $459,600,000 | F |
| Maine | $4,787,921 | $0 | $62,593 | $4,850,514 | $1,526,813 | $6,377,327 | $15,900,000 | 40.1% | $188,500,000 | F |
| Maryland | $9,705,528 | $0 | $770,053 | $10,475,581 | $2,324,036 | $12,799,617 | $48,000,000 | 26.7% | $525,000,000 | F |
| Massachusetts | $0 | $0 | $4,218,872 | $4,218,872 | $3,148,623 | $7,367,495 | $66,900,000 | 11.0% | $864,500,000 | F |
| Michigan | $0 | $1,631,500 | $0 | $1,631,500 | $3,530,398 | $5,161,898 | $110,600,000 | 4.7% | $1,216,600,000 | F |
| Minnesota | $11,770,426 | $0 | $3,200,000 | $14,970,426 | $2,188,096 | $17,158,522 | $52,900,000 | 32.4% | $703,600,000 | F |
| Mississippi | $8,440,000 | $0 | $0 | $8,440,000 | $1,866,711 | $10,306,711 | $36,500,000 | 28.2% | $248,400,000 | F |
| Missouri | $48,500 | $0 | $0 | $48,500 | $2,164,063 | $2,212,563 | $72,900,000 | 3.0% | $258,900,000 | F |
| Montana | $4,958,279 | $0 | $0 | $4,958,279 | $1,092,860 | $6,051,139 | $14,600,000 | 41.4% | $108,500,000 | F |
| Nebraska | $2,579,000 | $0 | $0 | $2,579,000 | $1,049,133 | $3,628,133 | $20,800,000 | 17.4% | $104,000,000 | F |
| Nevada | $950,000 | $0 | $0 | $950,000 | $927,208 | $1,877,208 | $30,000,000 | 6.3% | $230,400,000 | F |
| New Hampshire | $0 | $0 | $140,000 | $140,000 | $1,113,038 | $1,253,038 | $16,500,000 | 7.6% | $254,900,000 | F |
| New Jersey | $0 | $6,732,000 | $500,000 | $7,232,000 | $3,643,631 | $10,875,631 | $103,300,000 | 10.5% | $919,600,000 | F |
| New Mexico | $5,684,500 | $0 | $0 | $5,684,500 | $947,463 | $6,631,963 | $22,800,000 | 29.1% | $131,500,000 | F |
| New York | $0 | $0 | $39,769,600 | $39,769,600 | $3,155,603 | $42,925,203 | $203,000,000 | 21.1% | $2,037,100,000 | F |
| North Carolina | $0 | $0 | $2,800,000 | $2,800,000 | $3,253,615 | $6,053,615 | $99,300,000 | 6.1% | $450,400,000 | F |
| North Dakota | $5,286,666 | $0 | $0 | $5,286,666 | $928,674 | $6,215,340 | $9,800,000 | 63.4% | $53,600,000 | C |
| Ohio | $12,500,000 | $0 | $500,000 | $13,000,000 | $1,805,544 | $14,805,544 | $132,000,000 | 11.2% | $1,292,500,000 | F |
| Oklahoma | $19,921,127 | $1,266,210 | $101,830 | $21,289,167 | $1,259,463 | $22,548,630 | $42,300,000 | 53.3% | $525,600,000 | D |
| Oregon | $0 | $8,150,000 | $1,895,640 | $10,045,640 | $1,165,203 | $11,210,843 | $39,300,000 | 28.5% | $338,800,000 | F |
| Pennsylvania | $15,539,000 | $0 | $0 | $15,539,000 | $2,992,001 | $18,531,001 | $140,000,000 | 13.2% | $1,688,200,000 | F |
| Rhode Island | $0 | $0 | $390,926 | $390,926 | $2,083,442 | $2,474,368 | $12,800,000 | 19.3% | $195,000,000 | F |
| South Carolina | $0 | $5,000,000 | $0 | $5,000,000 | $1,461,223 | $6,461,223 | $51,000,000 | 12.7% | $238,200,000 | F |
| South Dakota | $0 | $4,500,000 | $0 | $4,500,000 | $880,166 | $5,380,166 | $11,700,000 | 46.0% | $86,900,000 | F |
| Tennessee | $0 | $0 | $0 | $0 | $1,506,829 | $1,506,829 | $75,600,000 | 2.0% | $422,000,000 | F |
| Texas | $0 | $0 | $4,246,909 | $4,246,909 | $4,571,762 | $8,818,671 | $264,100,000 | 3.3% | $1,933,300,000 | F |
| Utah | $3,847,100 | $3,159,700 | $0 | $7,006,800 | $1,074,415 | $8,081,215 | $19,300,000 | 41.9% | $141,900,000 | F |
| Vermont | $1,563,918 | $0 | $1,603,103 | $3,167,021 | $1,097,073 | $4,264,094 | $8,400,000 | 50.8% | $99,800,000 | D |
| Virginia | $10,784,678 | $0 | $0 | $10,784,678 | $1,330,054 | $12,114,732 | $91,600,000 | 13.2% | $304,400,000 | F |
| Washington | $0 | $0 | $1,527,607 | $1,527,607 | $2,740,647 | $4,268,254 | $63,600,000 | 6.7% | $552,600,000 | F |
| West Virginia | $0 | $0 | $0 | $0 | $1,837,400 | $1,837,400 | $27,400,000 | 6.7% | $238,000,000 | F |
| Wisconsin | $5,300,000 | $0 | $0 | $5,300,000 | $2,687,204 | $7,987,204 | $57,500,000 | 13.9% | $757,800,000 | F |
| Wyoming | $3,045,522 | $0 | $0 | $3,045,522 | $835,432 | $3,880,954 | $8,500,000 | 45.7% | $40,200,000 | F |

# Smokefree Air Grading Chart

| State | Government Worksites | Private Worksites | K-12 Schools | Childcare Facilities | Restaurants | Bars | Casinos/ Gaming Establishments | Retail stores | Recreational/ Cultural Facilities | E- Cigarettes Included | Penalties | Enforcement | Total Score | Grade |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alabama | 2 | 0 | 2 | 2 | 0 | 0 | 0 | 2 | 2 | -2 | 4 | 2 | 14 | F |
| Alaska | 5 | 5 | 4 | 4 | 4 | 4 | N/A | 4 | 4 | 0 | 4 | 4 | 42 | B |
| Arizona | 4 | 4 | 5 | 4 | 4 | 4 | 4 | 4 | 4 | -2 | 4 | 4 | 43 | A |
| Arkansas | 4 | 3 | 4 | 4 | 3 | 1 | 1 | 4 | 4 | -2 | 4 | 3 | 33 | C |
| California | 5 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 0 | 4 | 2 | 43 | A |
| Colorado | 5 | 3 | 4 | 4 | 4 | 3 | 4 | 4 | 4 | -2 | 4 | 2 | 39 | B |
| Connecticut | 4 | 2 | 4 | 2 | 4 | 3 | 4 | 4 | 4 | -1 | 3 | 3 | 36 | C |
| Delaware | 4 | 4 | 4 | 4 | 4 | 5 | 4 | 4 | 4 | 0 | 4 | 4 | 45 | A |
| District of Columbia | 4 | 4 | 5 | 4 | 4 | 2 | N/A | 4 | 4 | 0 | 3 | 4 | 38 | A |
| Florida | 4 | 4 | 4 | 4 | 4 | 1 | 4 | 4 | 4 | 0 | 3 | 4 | 40 | B |
| Georgia | 4 | 3 | 4 | 4 | 3 | 1 | N/A | 3 | 4 | -2 | 1 | 2 | 27 | D |
| Hawaii | 5 | 5 | 4 | 4 | 4 | 5 | N/A | 4 | 4 | 0 | 4 | 3 | 42 | A |
| Idaho | 4 | 3 | 4 | 4 | 4 | 0 | 4 | 4 | 4 | -2 | 3 | 2 | 34 | C |
| Illinois | 5 | 5 | 4 | 4 | 4 | 5 | 4 | 4 | 4 | -2 | 4 | 4 | 45 | A |
| Indiana | 4 | 4 | 4 | 4 | 3 | 1 | 0 | 4 | 4 | -2 | 4 | 3 | 33 | C |
| Iowa | 4 | 4 | 5 | 4 | 4 | 4 | 1 | 4 | 4 | -2 | 4 | 4 | 40 | A |
| Kansas | 5 | 5 | 4 | 4 | 4 | 4 | 1 | 4 | 4 | -2 | 3 | 4 | 40 | A |
| Kentucky | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | -2 | 1 | 0 | 2 | F |
| Louisiana | 4 | 4 | 4 | 4 | 4 | 0 | 1 | 4 | 4 | -2 | 3 | 4 | 34 | C |
| Maine | 5 | 5 | 5 | 4 | 5 | 4 | 3 | 4 | 4 | -1 | 4 | 4 | 46 | A |
| Maryland | 4 | 4 | 4 | 4 | 4 | 5 | 4 | 4 | 4 | -2 | 2 | 4 | 41 | A |
| Massachusetts | 4 | 4 | 4 | 4 | 4 | 3 | 4 | 4 | 4 | 0 | 4 | 3 | 42 | A |
| Michigan | 4 | 4 | 4 | 4 | 4 | 4 | 1 | 4 | 4 | -2 | 4 | 4 | 39 | C |
| Minnesota | 3 | 3 | 4 | 4 | 4 | 5 | 4 | 4 | 4 | -2 | 3 | 4 | 40 | A |
| Mississippi | 3 | 0 | 4 | 4 | 0 | 0 | 0 | 0 | 0 | -2 | 1 | 2 | 12 | F |
| Missouri | 2 | 1 | 3 | 4 | 1 | 0 | 0 | 1 | 1 | -2 | 3 | 1 | 15 | F |
| Montana | 4 | 4 | 4 | 4 | 4 | 5 | 4 | 4 | 4 | -2 | 3 | 4 | 42 | A |
| Nebraska | 4 | 4 | 4 | 4 | 4 | 3 | 4 | 4 | 4 | -2 | 4 | 3 | 40 | A |
| Nevada | 4 | 4 | 5 | 4 | 4 | 1 | 1 | 4 | 4 | -2 | 2 | 2 | 33 | C |
| New Hampshire | 2 | 2 | 4 | 4 | 4 | 2 | 2 | 2 | 2 | -2 | 4 | 4 | 30 | F |
| New Jersey | 4 | 4 | 5 | 4 | 4 | 2 | 2 | 4 | 4 | 0 | 3 | 4 | 40 | A |
| New Mexico | 5 | 3 | 4 | 4 | 4 | 3 | 0 | 4 | 4 | -2 | 3 | 4 | 36 | B |
| New York | 4 | 4 | 5 | 4 | 4 | 2 | 4 | 4 | 4 | 0 | 4 | 4 | 43 | A |
| North Carolina | 2 | 0 | 4 | 3 | 4 | 3 | N/A | 0 | 0 | -2 | 2 | 4 | 20 | F |
| North Dakota | 5 | 5 | 4 | 4 | 4 | 5 | 4 | 4 | 4 | 0 | 3 | 3 | 45 | A |
| Ohio | 4 | 4 | 4 | 4 | 4 | 5 | 4 | 4 | 4 | -2 | 3 | 4 | 42 | A |
| Oklahoma | 3 | 3 | 5 | 4 | 3 | 0 | 3 | 4 | 4 | -2 | 3 | 3 | 33 | D |
| Oregon | 5 | 5 | 4 | 4 | 4 | 3 | 4 | 4 | 4 | 0 | 4 | 4 | 45 | A |
| Pennsylvania | 4 | 4 | 4 | 4 | 3 | 0 | 2 | 4 | 4 | -2 | 3 | 4 | 34 | D |
| Rhode Island | 4 | 4 | 4 | 4 | 4 | 3 | 2 | 4 | 4 | 0 | 3 | 4 | 40 | A |
| South Carolina | 1 | 0 | 2 | 4 | 0 | 0 | N/A | 0 | 1 | -2 | 3 | 1 | 10 | F |
| South Dakota | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | -2 | 3 | 2 | 39 | C |
| Tennessee | 4 | 3 | 4 | 4 | 3 | 1 | N/A | 4 | 4 | -2 | 2 | 4 | 31 | D |
| Texas | 0 | 0 | 1 | 4 | 0 | 0 | 0 | 0 | 1 | 0 | 3 | 1 | 10 | F |
| Utah | 4 | 4 | 5 | 4 | 4 | 5 | N/A | 4 | 4 | 0 | 4 | 4 | 42 | A |
| Vermont | 4 | 4 | 4 | 4 | 4 | 4 | N/A | 4 | 4 | 0 | 3 | 3 | 38 | A |
| Virginia | 1 | 0 | 3 | 3 | 2 | 2 | 0 | 1 | 1 | -2 | 2 | 3 | 16 | F |
| Washington | 5 | 5 | 4 | 4 | 4 | 5 | 4 | 4 | 4 | -2 | 3 | 4 | 44 | A |
| West Virginia | 1 | 0 | 4 | 1 | 0 | 0 | 0 | 0 | 0 | -2 | 1 | 0 | 5 | D* |
| Wisconsin | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | -2 | 2 | 4 | 40 | A |
| Wyoming | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | F |

Note: The Casinos/Gaming Establishments category does not include casinos/gaming establishments located on Native American tribal lands.

* This state's grade is based on percentage of population covered by comprehensive local smokefree laws/regulations rather than the statewide law.

# Tobacco Taxes Grading Chart

| State | Cigarette Tax | Tax on Little Cigars | Tax on Large Cigars | Tax on Smokeless Tobacco | Tax on Pipe/RYO Tobacco | Tax on Dissolvable Tobacco | Total Score | Grade |
|---|---|---|---|---|---|---|---|---|
| Alabama | 6 | 1 | 1 | 0 | 0 | 0 | 8 | F |
| Alaska | 18 | 2 | 2 | 2 | 2 | 2 | 28 | C |
| Arizona | 18 | 1 | 1 | 0 | 0 | 0 | 20 | F |
| Arkansas | 12 | 2 | 1 | 2 | 2 | 2 | 21 | F |
| California | 24 | 2 | 2 | 2 | 2 | 2 | 34 | B |
| Colorado | 6 | 2 | 2 | 2 | 2 | 2 | 16 | F |
| Connecticut | 30 | 2 | 1 | 0 | 1 | 0 | 34 | B |
| Delaware | 18 | 1 | 1 | 0 | 1 | 0 | 21 | F |
| District of Columbia | 30 | 2 | 0 | 2 | 2 | 2 | 38 | A |
| Florida | 12 | 0 | 0 | 2 | 2 | 2 | 18 | F |
| Georgia | 6 | 1 | 2 | 2 | 2 | 0 | 13 | F |
| Hawaii | 24 | 2 | 1 | 2 | 2 | 2 | 33 | B |
| Idaho | 6 | 2 | 2 | 2 | 2 | 2 | 16 | F |
| Illinois | 18 | 2 | 1 | 0 | 1 | 0 | 22 | F |
| Indiana | 12 | 2 | 2 | 0 | 2 | 0 | 18 | F |
| Iowa | 12 | 2 | 1 | 1 | 2 | 0 | 18 | F |
| Kansas | 12 | 1 | 1 | 1 | 1 | 1 | 17 | F |
| Kentucky | 12 | 1 | 1 | 0 | 1 | 1 | 16 | F |
| Louisiana | 12 | 1 | 1 | 1 | 2 | 1 | 18 | F |
| Maine | 18 | 1 | 1 | 2 | 1 | 2 | 25 | D |
| Maryland | 18 | 2 | 1 | 1 | 1 | 1 | 24 | D |
| Massachusetts | 24 | 2 | 1 | 2 | 1 | 2 | 32 | B |
| Michigan | 18 | 1 | 1 | 1 | 1 | 1 | 23 | F |
| Minnesota | 24 | 2 | 1 | 2 | 2 | 2 | 33 | B |
| Mississippi | 6 | 2 | 2 | 2 | 2 | 2 | 16 | F |
| Missouri | 6 | 2 | 2 | 2 | 2 | 2 | 16 | F |
| Montana | 12 | 2 | 2 | 0 | 2 | 0 | 18 | F |
| Nebraska | 6 | 2 | 2 | 0 | 2 | 0 | 12 | F |
| Nevada | 18 | 1 | 1 | 1 | 1 | 1 | 23 | F |
| New Hampshire | 18 | 2 | 0 | 2 | 2 | 2 | 26 | D |
| New Jersey | 24 | 1 | 1 | 0 | 1 | 0 | 27 | D |
| New Mexico | 12 | 2 | 1 | 1 | 1 | 1 | 18 | F |
| New York | 30 | 2 | 1 | 0 | 1 | 0 | 34 | B |
| North Carolina | 6 | 2 | 2 | 2 | 2 | 2 | 16 | F |
| North Dakota | 6 | 2 | 2 | 0 | 2 | 0 | 12 | F |
| Ohio | 12 | 2 | 1 | 1 | 1 | 1 | 18 | F |
| Oklahoma | 18 | 2 | 1 | 2 | 2 | 2 | 27 | D |
| Oregon | 12 | 2 | 1 | 2 | 2 | 2 | 21 | F |
| Pennsylvania | 18 | 2 | 0 | 0 | 0 | 0 | 20 | F |
| Rhode Island | 30 | 2 | 1 | 0 | 1 | 0 | 34 | B |
| South Carolina | 6 | 1 | 1 | 1 | 1 | 1 | 11 | F |
| South Dakota | 12 | 2 | 2 | 2 | 2 | 2 | 22 | F |
| Tennessee | 6 | 2 | 1 | 1 | 1 | 1 | 12 | F |
| Texas | 12 | 0 | 0 | 2 | 2 | 2 | 18 | F |
| Utah | 12 | 2 | 2 | 2 | 2 | 0 | 20 | F |
| Vermont | 24 | 2 | 2 | 2 | 2 | 2 | 34 | B |
| Virginia | 6 | 2 | 2 | 0 | 2 | 0 | 12 | F |
| Washington | 24 | 2 | 1 | 0 | 2 | 0 | 29 | C |
| West Virginia | 12 | 1 | 1 | 1 | 1 | 1 | 17 | F |
| Wisconsin | 18 | 2 | 1 | 2 | 2 | 2 | 27 | D |
| Wyoming | 6 | 2 | 2 | 2 | 2 | 2 | 16 | F |

# Access to Cessation Services Grading Chart

| State | Medicaid Medications | Medicaid Counseling | Medicaid Barriers to Coverage | Medicaid Expansion | SEHP Medications | SEHP Counseling | SEHP Barriers to Coverage | Investment Per Smoker | Private Insurance Mandate | Tobacco Surcharge | Total Score | Grade |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alabama | 14 | 7 | 7 | -8 | 4 | 2 | 1 | 5 | 0 | 0 | 32 | F |
| Alaska | 14 | 5 | 10 | 0 | 3 | 3 | 1 | 20 | 0 | 0 | 56 | B |
| Arizona | 14 | 5 | 11 | 0 | 4 | 2 | 2 | 10 | 0 | 0 | 48 | D |
| Arkansas | 10 | 9 | 10 | 0 | 2 | 2 | 1 | 10 | 0 | 1 | 45 | D |
| California | 14 | 13 | 11 | 0 | 3 | 2 | 1 | 10 | 0 | 2 | 56 | B |
| Colorado* | 14 | 13 | 11 | 0 | 0* | 0* | 0* | 20 | 2 | 1 | 61 | B |
| Connecticut | 14 | 13 | 12 | 0 | 2 | 4 | 1 | 0 | 0 | 1 | 47 | D |
| Delaware | 14 | 5 | 9 | 0 | 4 | 3 | 1 | 20 | 1 | 0 | 57 | B |
| District of Columbia | 11 | 5 | 8 | 0 | 4 | 2 | 1 | 15 | 0 | 2 | 48 | D |
| Florida | 10 | 6 | 11 | -8 | 4 | 1 | 1 | 15 | 0 | 0 | 40 | F |
| Georgia | 11 | 11 | 7 | -8 | 4 | 2 | 1 | 0 | 0 | 0 | 28 | F |
| Hawaii | 11 | 9 | 9 | 0 | 3 | 3 | 1 | 20 | 0 | 0 | 56 | B |
| Idaho | 14 | 5 | 9 | 0 | 4 | 0 | 1 | 20 | 0 | 0 | 53 | C |
| Illinois | 11 | 4 | 8 | 0 | 4 | 4 | 1 | 5 | 1 | 0 | 38 | F |
| Indiana | 14 | 13 | 5 | 0 | 4 | 2 | 1 | 5 | 0 | -2 | 42 | D |
| Iowa | 14 | 9 | 8 | 0 | 4 | 4 | 1 | 5 | 0 | 0 | 45 | D |
| Kansas | 14 | 13 | 12 | -8 | 4 | 3 | 1 | 0 | 0 | 0 | 39 | F |
| Kentucky | 14 | 13 | 13 | 0 | 4 | 3 | 1 | 0 | 0 | 1 | 49 | C |
| Louisiana | 11 | 11 | 8 | 0 | 4 | 1 | 1 | 5 | 1 | 0 | 42 | D |
| Maine | 14 | 13 | 11 | 0 | 3 | 3 | 1 | 20 | 0 | 0 | 65 | A |
| Maryland | 14 | 9 | 10 | 0 | 4 | 2 | 2 | 15 | 2 | 0 | 58 | B |
| Massachusetts | 14 | 13 | 10 | 0 | 4 | 4 | 1 | 5 | 0 | 2 | 53 | C |
| Michigan | 14 | 11 | 13 | 0 | 4 | 3 | 1 | 0 | 0 | 0 | 46 | D |
| Minnesota | 14 | 11 | 13 | 0 | 4 | 4 | 1 | 20 | 0 | 0 | 67 | A |
| Mississippi | 14 | 6 | 11 | -8 | 3 | 2 | 1 | 10 | 0 | 0 | 39 | F |
| Missouri | 14 | 13 | 13 | -8 | 4 | 3 | 2 | 0 | 0 | 0 | 41 | F |
| Montana | 14 | 9 | 10 | 0 | 2 | 4 | 1 | 20 | 0 | 0 | 60 | B |
| Nebraska | 14 | 7 | 5 | 0 | 4 | 0 | 1 | 5 | 0 | 0 | 36 | F |
| Nevada | 12 | 4 | 11 | 0 | 4 | 4 | 1 | 0 | 0 | 0 | 36 | F |
| New Hampshire | 14 | 7 | 9 | 0 | 4 | 3 | 1 | 5 | 0 | 0 | 43 | D |
| New Jersey | 12 | 9 | 12 | 0 | 4 | 3 | 1 | 10 | 3 | 2 | 56 | B |
| New Mexico | 12 | 6 | 10 | 0 | 1 | 1 | 1 | 20 | 3 | 0 | 54 | C |
| New York | 13 | 11 | 12 | 0 | 2 | 1 | 1 | 10 | 1 | 2 | 53 | C |
| North Carolina | 14 | 9 | 10 | -8 | 4 | 2 | 1 | 10 | 0 | 1 | 43 | D |
| North Dakota | 14 | 5 | 5 | 0 | 4 | 4 | 1 | 20 | 1 | 0 | 54 | C |
| Ohio | 14 | 13 | 11 | 0 | 2 | 3 | 1 | 5 | 0 | 0 | 49 | C |
| Oklahoma | 14 | 9 | 13 | -8 | 4 | 3 | 1 | 20 | 0 | 0 | 56 | B |
| Oregon | 14 | 13 | 12 | 0 | 2 | 4 | 1 | 0 | 2 | 0 | 48 | D |
| Pennsylvania | 11 | 9 | 9 | 0 | 2 | 3 | 1 | 5 | 0 | 0 | 40 | F |
| Rhode Island | 14 | 9 | 11 | 0 | 4 | 4 | 1 | 0 | 5 | 2 | 50 | C |
| South Carolina | 14 | 13 | 13 | -8 | 2 | 2 | 1 | 20 | 0 | 0 | 57 | B |
| South Dakota | 4 | 2 | 5 | -8 | 2 | 3 | 1 | 20 | 0 | 0 | 29 | F |
| Tennessee | 14 | 5 | 4 | -8 | 4 | 2 | 1 | 0 | 0 | 0 | 22 | F |
| Texas | 14 | 9 | 9 | -8 | 4 | 1 | 1 | 0 | 0 | 0 | 30 | F |
| Utah | 14 | 5 | 4 | 0 | 4 | 2 | 1 | 20 | 1 | 0 | 51 | C |
| Vermont | 14 | 5 | 10 | 0 | 4 | 3 | 1 | 20 | 3 | 2 | 62 | B |
| Virginia | 11 | 4 | 8 | 0 | 2 | 2 | 1 | 0 | 0 | 0 | 28 | F |
| Washington | 11 | 4 | 8 | 0 | 3 | 4 | 1 | 0 | 0 | 0 | 31 | F |
| West Virginia | 14 | 9 | 8 | 0 | 4 | 2 | 1 | 0 | 0 | 0 | 38 | F |
| Wisconsin | 14 | 9 | 11 | -8 | 4 | 2 | 1 | 5 | 0 | -2 | 36 | F |
| Wyoming | 14 | 5 | 8 | -8 | 2 | 0 | 1 | 20 | 0 | 0 | 42 | D |

* This state did not provide data in one of three Access to Cessation Services categories, and received 0 points in those categories as a result.

# Tobacco 21 Laws Overview

| State | Age of Sale | Military Exemption | Products Exemption | Grade |
|---|---|---|---|---|
| Alabama | 19 | No | No | D |
| Alaska | 19 | No | No | D |
| Arizona | 18 | No | No | F |
| Arkansas | 18 | No | No | F |
| California | 21 | Yes | No | B |
| Colorado | 18 | No | No | F |
| Connecticut | 18 | No | No | F |
| Delaware | 18 | No | No | F |
| District of Columbia | 21 | No | No | A |
| Florida | 18 | No | No | F |
| Georgia | 18 | No | No | F |
| Hawaii | 21 | No | No | A |
| Idaho | 18 | No | No | F |
| Illinois | 18 | No | No | F |
| Indiana | 18 | No | No | F |
| Iowa | 18 | No | No | F |
| Kansas | 18 | No | No | F |
| Kentucky | 18 | No | No | F |
| Louisiana | 18 | No | No | F |
| Maine | 21 | No | No | A |
| Maryland | 18 | No | No | F |
| Massachusetts | 21 | No | No | A |
| Michigan | 18 | No | No | F |
| Minnesota | 18 | No | No | F |
| Mississippi | 18 | No | No | F |
| Missouri | 18 | No | No | F |
| Montana | 18 | No | No | F |
| Nebraska | 18 | No | No | F |
| Nevada | 18 | No | No | F |
| New Hampshire | 18 | No | No | F |
| New Jersey | 21 | No | No | A |
| New Mexico | 18 | No | No | F |
| New York | 18 | No | No | C* |
| North Carolina | 18 | No | No | F |
| North Dakota | 18 | No | No | F |
| Ohio | 18 | No | No | F |
| Oklahoma | 18 | No | No | F |
| Oregon | 21 | No | No | A |
| Pennsylvania | 18 | No | No | F |
| Rhode Island | 18 | No | No | F |
| South Carolina | 18 | No | No | F |
| South Dakota | 18 | No | No | F |
| Tennessee | 18 | No | No | F |
| Texas | 18 | No | No | F |
| Utah | 19 | No | No | D |
| Vermont | 18 | No | No | F |
| Virginia | 18 | No | No | F |
| Washington | 18 | No | No | F |
| West Virginia | 18 | No | No | F |
| Wisconsin | 18 | No | No | F |
| Wyoming | 18 | No | No | F |

* This state's grade is based on percentage of population covered by local laws increasing the age of sale to 21 rather than the state age of sale.

# "State of Tobacco Control" 2019 Methodology

The American Lung Association's "State of Tobacco Control" 2019 is a report card that evaluates state and federal tobacco control policies by comparing them against targets based on the most current, recognized criteria for effective tobacco control measures, and translating each state and the federal government's relative progress into a letter grade of "A" through "F." A grade of "A" is assigned for excellent tobacco control policies while an "F" indicates inadequate policies. The principal reference for all state tobacco control laws is the American Lung Association's *State Legislated Actions on Tobacco Issues* online database, available at www.lung.org/slati. The American Lung Association has published this comprehensive summary of state tobacco control laws since 1988. Data for the state cessation section is taken from the American Lung Association's *State Cessation Coverage* database, available at http://www.lungusa2.org/cessation2.

In response to new data and information, the American Lung Association periodically reviews the methodology for the State of Tobacco Control report, and makes revisions to the methodology for state grading categories if necessary to update the report to use the most current evidence and best practices. Because of the revisions to the state grading methodology in "State of Tobacco Control 2015," state grades from "State of Tobacco Control 2018" cannot be directly compared to grades from "State of Tobacco Control 2014" or earlier reports.

## Calculation of Federal Grades

Tobacco control and prevention measures at the federal level are graded in four areas: U.S. Food and Drug Administration (FDA) regulation of tobacco products; federal coverage of tobacco cessation treatments; federal excise taxes on tobacco products; and federal mass media campaigns. The sources for the targets and the basis of the evaluation criteria are described below.

### U.S. Food and Drug Administration Regulation of Tobacco Products

Since the passage of the Family Smoking Prevention and Tobacco Control Act giving FDA the authority to regulate tobacco products in June 2009, the grading system for this category has been based on how FDA is implementing its new authority, and whether Congress is providing full funding to FDA with no policy riders to limit their authority.

The American Lung Association has identified four important items that FDA was required by the Tobacco Control Act to implement or that FDA indicated they would take action on: 1) implementation of a rule asserting authority over all other tobacco products besides cigarettes, smokeless tobacco and roll-your-own tobacco—also known as the "deeming" rule; 2) issuing at least one product standard to reduce the toxicity, addictiveness and/or appeal of cigarettes and other tobacco products; 3) requiring large, graphic cigarette warning labels that cover the top 50 percent of the front and back of cigarette packs; and 4) removal of menthol cigarettes from the marketplace. Points were awarded on how FDA implemented these four items as well as whether Congress funded FDA's Center for Tobacco Products at the levels called for in the Family Smoking Prevention and Tobacco Control Act.

The FDA regulation of tobacco products grade breaks down as follows:

| Grade | Points Earned |
|---|---|
| A | 18 to 20 Total Points |
| B | 16 to 17 Total Points |
| C | 14 to 15 Total Points |
| D | 12 to 13 Total Points |
| F | Under 12 Total Points |

**Implementation of Final "Deeming" Rule Giving FDA Authority over All Tobacco Products (4 points)**

Target is implementation of final rule that gives FDA authority over all tobacco products in addition to cigarettes and smokeless tobacco.

+4 points: Deeming rule fully implemented without additional delay
+2 points: FDA only implementing portions of deeming rule
+0 points: FDA postpones implementation of the entire rule

**Product Standards (4 points)**

Target is FDA issues a product standard to reduce the toxicity, addictiveness and/or appeal of cigarettes and other tobacco products.

+4 points: Strong product standard that will be appropriate for the protection of public health that will reduce the toxicity, addictiveness and/or appeal of cigarettes and other tobacco products is finalized.
+1 points: Strong product standard that will be appropriate for the protection of public health that will reduce the toxicity, addictiveness and/or appeal of cigarettes and other tobacco products is proposed.
+0 points: No strong product standard is issued or proposed.

**Graphic Cigarette Warning Labels (4 points)**

Target is FDA **requires large, graphic cigarette warning labels that cover the** top 50 percent of the front and back of cigarette packs.

+4 points: FDA **requires large, graphic cigarette warning labels that cover the** top 50 percent of the front and back of cigarette packs.
+1 points: FDA proposes **large, graphic cigarette warning labels that cover the** top 50 percent of the front and back of cigarette packs.
+0 points: No graphic warning label requirement is issued.

**Removal of Menthol Cigarettes from the Marketplace (4 points)**

Target is FDA takes action to remove all cigarettes with menthol as a characterizing flavor from the marketplace.

+4 points: Strong product standard is finalized that will be appropriate for the protection of public health by eliminating menthol as a characterizing flavor in cigarettes.
+1 points: Strong product standard is proposed that will be appropriate for the protection of public health by eliminating menthol as a characterizing flavor in cigarettes.
+0 points: No strong product standard is issued.

**Funding for FDA Center for Tobacco Products (4 points)**

Target is Congress provides funding for FDA Center for Tobacco Products at levels called for in Family Smoking Prevention and Tobacco Control Act without attaching limiting policy riders.

+4 points: Congress provides full funding without attaching limiting policy riders.
+2 points: Congress provides full funding but with policy riders.
+1 points: Congress provides funding at a level inconsistent with the Tobacco Control Act
+0 points: No funding at all provided.

## Federal Cessation Treatment Coverage

The cessation treatment coverage criteria used in the American Lung Association's "State of Tobacco Control" 2019 report are based on the coverage of tobacco cessation treatments provided by the federal government through its four main public insurance programs: 1) Medicare (for Americans over age 65), 2) Medicaid (for low-income and/or disabled Americans), 3) TRICARE (for members of the military and their families), and 4) Federal Employee Health Benefits Program (for federal employees and their families). A fifth category covers federal requirements for tobacco cessation treatment coverage in state health insurance marketplaces under the Patient Protection and Affordable Care Act or health care reform law. Providing help to quit through these programs and state health insurance exchanges will reach large numbers of tobacco users, improve health, prevent unnecessary death, save taxpayer money and set an example for other health plans. The federal government must lead by example and cover a comprehensive benefit for everyone to whom it provides health care.

The definition of a comprehensive tobacco cessation benefit used in these criteria follows the recommendations in the Clinical Practice Guideline entitled *Treating Tobacco Use and Dependence*. In this Guideline, published in 2008 the U.S. Public Health Service recommends the use of seven medications and three types of counseling as effective for helping tobacco users quit. This definition has been reaffirmed in the 2015 United States Preventive Services Task Force (USPSTF) recommendation.

The cessation coverage grade breaks down as follows:

| Grade | Points Earned |
|---|---|
| A | 18 to 20 Total Points |
| B | 16 to 17 Total Points |
| C | 14 to 15 Total Points |
| D | 12 to 13 Total Points |
| F | Under 12 Total Points |

**Medicare (4 points)**

Target is all Medicare recipients have easy access to a comprehensive cessation benefit.

+4 points: All Guideline-recommended medications and counseling are covered.
+3 points: At least 4 medications and 1 type of counseling are covered.
+2 points: At least 2 medications and 1 type of counseling are covered.
+1 point: At least 1 treatment is covered.
+0 points: No coverage.

**Medicaid (4 points)**

Target is all Medicaid enrollees have easy access to a comprehensive cessation benefit.

+4 points: All Guideline-recommended medications and counseling are required to be covered.
+3 points: At least 4 medications and 1 type of counseling are required to be covered.
+2 points: At least 2 medications and 1 type of counseling are required to be covered.
+1 point: At least 1 treatment is required to be covered.
+0 points: No required coverage.

**TRICARE (4 points)**

Target is all TRICARE enrollees have easy access to a comprehensive cessation benefit.

+4 points: All Guideline-recommended medications and counseling are covered.
+3 points: At least 4 medications and 1 type of counseling are covered.
+2 points: At least 2 medications and 1 type of counseling are covered.
+1 point: At least 1 treatment is covered.
+0 points: No coverage.

**Federal Employee Health Benefits (FEHB) (4 points)**

Target is all federal employees & dependents have easy access to a comprehensive cessation benefit.

+4 points: All Guideline-recommended medications and counseling are covered.
+3 points: At least 4 medications and 1 type of counseling are covered.
+2 points: At least 2 medications and 1 type of counseling are covered.
+1 point: At least 1 treatment is covered.
+0 points: No coverage.

**Federal Requirements for State Health Insurance Marketplaces**

Target is all plans in marketplaces cover a comprehensive tobacco cessation benefit.

+4 points: All Guideline-recommended medications and counseling are required to be covered.
+3 points: Administration releases guidance outlining coverage of a comprehensive tobacco cessation benefit as a preventive service.
+2 points: Administration requires that all plans sold in the State Health Insurance Marketplaces cover tobacco cessation treatment as part of the preventive services requirement.
+1 points: Administration proposes new regulations that no longer require all plans in the State Health Insurance Marketplaces to provide tobacco cessation.
+0 points: Administration finalizes new regulations or issues guidance that no longer require all plans in the State Health Insurance Marketplaces to provide tobacco cessation.

**Bonus Points:** 1 bonus point in each category is awarded if coverage is provided with minimal barriers to access.

## Federal Tobacco Excise Taxes

Criteria for the federal tobacco excise taxes grade are identical to the state tobacco excise tax grade. For more information, see the State Tobacco Excise Taxes section starting on page 30.

**The Excise Tax grades break down as follows:**

| Grade | Points Earned |
|---|---|
| A | 36 to 40 points |
| B | 32 to 35 points |
| C | 28 to 31 points |
| D | 24 to 27 points |
| F | 23 and below points |

## Federal Mass Media Campaigns

Health communications interventions, including mass media campaigns designed to encourage tobacco users to quit or discourage youth from starting to smoke have been found to be an effective intervention to prevent and reduce tobacco use, according to the U.S. Surgeon General and U.S. Centers for Disease Control and Prevention (CDC). More information on health communications interventions and their effectiveness can be found in CDC's *Best Practices for Comprehensive Tobacco Control Programs—2014*.

Two agencies of the federal government ran mass media campaigns for part or all of 2018 that seek to discourage tobacco use among different populations: 1) CDC's Tips from Former Smokers media campaign, which targets adults who use tobacco and 2) FDA's Real Costs campaign, which targets youth ages 12 to 17 with tobacco prevention messages. Both mass media campaigns will continue to run in 2019.

The federal mass media campaign grade criteria are based off the reach, duration and frequency of these mass media campaigns as well as if the campaign refers people to available services that can help them.

**The mass media campaign grade breaks down as follows:**

| Grade | Points Earned |
|---|---|
| A | 22 to 24 points |
| B | 20 to 21 points |
| C | 17 to 19 points |
| D | 15 to 16 points |
| F | Under 15 points |

**Reach (3 points for each campaign, 6 points total)**

Target: Advertising from each mass media campaign reaches 75 percent or more of its target audience each quarter the campaign is running.

+3 points: Ads reach 75 percent or more of target audience each quarter
+2 points: Ads reach 55-74 percent of target audience each quarter
+1 point: Ads reach 1-54 percent of target audience each quarter
+0 points: No ad campaign

**Duration (3 points for each campaign, 6 points total)**

Target: Each mass media campaign runs for 12 months of the year.

+3 points: Ads run 9-12 months per year
+2 points: Ads run 6-9 months per year
+1 point: Ads run 1-5 months per year
+0 points: No ad campaign

**Frequency (3 points for each campaign, 6 points total)**

Target: Each campaign has an average gross rating point of 1,200 for the 1st quarter the campaign is running and 800 or higher rating points for subsequent quarters.

+3 points: Average targeted rating point of 1,200 or higher for 1st quarter of campaign; average targeted rating point of 800 or higher for subsequent quarters
+2 points: Average targeted rating point of 1,000 or higher for 1st quarter of campaign; average targeted rating point of 600 or higher for subsequent quarters
+1 points: Average targeted rating point of 800 or higher for 1st quarter of campaign; average targeted rating point of 400 or higher for subsequent quarters
+0 points: No ad campaign

**Promotion of Available Services (3 points for each campaign, 6 points total)**

Target: Media campaign refers people to available resources that can help them.

+3 points: Media campaign refers people to available resources directly
+1 points: Media campaign refers people to location where available resources can be accessed
+0 points: Campaign does not refer people to additional resources

## Calculation of State Grades

State level tobacco control policies are graded in five key areas: tobacco prevention and cessation funding, smokefree air laws, state tobacco excise taxes, access to tobacco cessation treatments and services and laws to increase the tobacco sales age to 21. The sources for the targets and the basis of the evaluation criteria are described below.

### Tobacco Prevention and Cessation Funding

In January 2014, the Centers for Disease Control and Prevention (CDC) published an updated version of its *Best Practices for Comprehensive Tobacco Control Programs*, which was first published in 1999, and previously updated in 2007. Based on "Best Practices" as determined by evidence-based analysis of state tobacco control programs, this CDC guidance document recommends that states establish programs that are comprehensive, sustainable and accountable. The CDC lists five components as crucial in a comprehensive tobacco control program: State and Community Interventions, Mass-Reach Health Communication Interventions, Cessation Interventions, Surveillance and Evaluation and Infrastructure, Administration and Management.

The CDC also recommends an overall level of funding for each state's tobacco control program based on a variety of state-specific factors such as prevalence

of tobacco use, the cost and complexity of conducting mass media to reach targeted audiences and the proportion of the population that is below 200 percent of the federal poverty level. For the tobacco prevention and control spending area, the CDC recommendation for state funding of comprehensive programs served as the denominator in the percentage calculation to obtain each state's grade. Each state's total funding for these programs (including federal funding from the CDC and FDA given to states for tobacco prevention and cessation activities) served as the numerator. After calculating the percentage of the CDC recommendation each state had funded, grades were assigned according to the following formula.

| Grade | Percent of CDC Recommended Level |
|---|---|
| A | 80 percent or more |
| B | 70 percent to 79 percent |
| C | 60 percent to 69 percent |
| D | 50 percent to 59 percent |
| F | 50 percent or less |

**Limitation of Grading System on State Tobacco Control Expenditures**

The American Lung Association bases its tobacco prevention and control spending grades on the total amount allocated to tobacco control programs, including applicable federal funding, in each state, but does not evaluate the expenditure in each of the CDC-recommended categories. The Lung Association does not evaluate the efficacy of any element of any state's program. Therefore, a state may receive a high grade but be significantly underfunding a component or components of a comprehensive program. It also may be true that a state with a low grade is adequately funding a specific component or program in one community.

However, the CDC recommends a comprehensive program and explains that simply funding an element of the program will not achieve the needed results. The CDC explicitly calls for programs that are comprehensive, sustained and accountable. The American Lung Association agrees with the CDC and believes that the total funding is a fair basis for grading state programs and a state's tobacco control funding performance.

## Smokefree Air Laws

The smokefree air laws grading system is based on criteria developed by an advisory committee convened by the National Cancer Institute with some modification to reflect the current policy environment. The criteria were presented in the article, "Application of a Rating System to State Clean Indoor Air Laws (USA)" (Chriqui JF, et al. Tobacco Control. 2002;11:26-34). This approach provides scoring in nine categories: Government Workplaces, Private Workplaces, Schools, Child Care Facilities, Restaurants, Retail Stores, Recreational/Cultural Facilities, Penalties and Enforcement. All laws are open to interpretation and our analysis may differ from those of the authors noted in the above study.

To reflect the current policy environment, two additions have been made to the advisory committee's recommended categories of smokefree establishments. An additional category for bars has been added to all states. A second category, Casinos/Gaming Establishments, was added to the states which allow casinos or gaming establishments. Adding these categories became necessary after the committee made its recommendations in 2002, because a number of states

have prohibited smoking in bars and casinos/gaming establishments since then, and states need to be recognized in the grading system for protecting workers in these places from secondhand smoke.

In addition, in "State of Tobacco Control" 2019 a penalty was added to the grade for state's that have not included e-cigarettes in their laws restricting or prohibiting smoking. A state that has not included e-cigarettes in their laws or only has included them in select locations receives a -2 point penalty; a state that has included e-cigarettes in many but not all public places and workplaces covered by state law gets a -1 point penalty; and no penalty is applied for states that have included e-cigarettes in all places where smoking is prohibited by state law.

The smokefree air grade for each state is based on a total of all points received in all categories. The grades are based on a maximum score of 40 if the state has no casinos or gaming establishments, or 44 if the state has casinos or gaming establishments. Both these high scores have been attained by states in this year's report. The maximum score of 40 or 44 becomes the denominator, and the state's total points serve as the numerator. The percentage was calculated and grades were assigned following a standard grade-school system. States receiving scores in the top 10 percent of the range (90 to 100 percent) earned an "A." Those receiving scores falling between 80 and 89 percent got a grade of "B," between 70 and 79 percent a "C" and between 60 and 69 percent a "D." Those that fell below 60 percent received an "F." The points break down as follows:

| Assigned Grade | No State Casino/ Gaming Establishments | State Casino/ Gamin Establishments Present |
|---|---|---|
| A | 36 to 40 | 40 to 44 |
| B | 32 to 35 | 36 to 39 |
| C | 28 to 31 | 31 to 35 |
| D | 24 to 27 | 27 to 30 |
| F | 23 and below | 26 and below |

There are two situations that create exceptions to the grading system:

- Preemption or Local opt-out: State preemption of stricter local ordinances or states that have a provision in its law allowing communities to opt-out of the law is penalized by a reduction of one letter grade. States with preemption that have a score of 40 points or higher (or 44 points or higher dependent on whether the Casinos/Gaming Establishments category is applicable for that state) are not penalized for preemption.
- Local Ordinances: States without strong statewide smokefree laws may be graded on the basis of local ordinances. Strong local smokefree air ordinances that include most workplaces, all restaurants and bars are considered according to the percentage of population covered in the state. States with over 95 percent of their population covered by comprehensive local smokefree ordinances will receive an "A," over 80 percent a "B," over 65 percent a "C" and over 50 percent a "D." Local ordinances that cover less than 50 percent of the population will not be considered for evaluation under this exception.[1]

## Key to Smokefree Laws Ratings by Category

For all categories, laws that require that smoking be permitted or laws without any restrictions for the particular category receive a score of zero (0).

1. **Government Workplaces** (4 points): Target is "state and local government workplaces are 100 percent smokefree, no exemptions." Score is lowered if restriction depends on type of ventilation, location of smoking area and/or number of employees. A bonus point (+1) is available if the laws meet the target criteria and require the grounds or a specified distance from entries or exits to be smokefree.
2. **Private Workplaces** (4 points): Target is "private workplaces are 100 percent smokefree, no exemptions." Score is lowered if restriction depends on type of ventilation, location of smoking area and/or number of employees. A bonus point (+1) is available if the laws meet the target criteria and require the grounds or a specified distance from entries or exits to be smokefree.
3. **Schools** (4 points): Target is "no smoking permitted in public and non-public schools during school hours or while school activities are being conducted." Score is lowered if restriction depends on type of school, school hours, type of ventilation and/or location of smoking area. A bonus point (+1) is available if the laws meet the target criteria and extend the law/policy to any time in school facilities, on school grounds, and at school-sponsored activities.
4. **Child Care Facilities** (4 points): Target is "no smoking permitted during operating hours in childcare facilities (explicitly including licensed, home-based facilities)." Score is lowered if restrictions depend on ventilation standards, location of smoking areas and/or exemptions for certain types of facilities.
5. **Restaurants** (4 points): Target is "restaurants (explicitly including bar areas of restaurants) are 100 percent smokefree." Score is lowered if restriction depends on type of ventilation, location of smoking areas and/or exemptions for some restaurants. A bonus point (+1) is available if the laws meet the target criteria and extend the law/policy to outdoor seating areas of restaurants.
6. **Bars/Taverns** (4 points): Target is "bars/taverns and similar types of establishments are 100 percent smokefree." Score is lowered if restriction depends on ventilation standards, location of smoking area and/or if laws only applied to some but not all bars/taverns. A bonus point (+1) is available if the laws meet the target criteria and extend the law/policy to private clubs or similar establishments at all times.
7. **Casinos/Gaming Establishments** (4 points): Target is "casinos/gaming establishments are 100 percent smokefree." Score is lowered if restriction depends on ventilation standards, location of smoking area and/or if laws only apply to some but not all casinos/gaming establishments. This category does not apply to states that do not have casinos/gaming establishments or only casinos/gaming establishments on Native American lands.
8. **Retail Stores** (4 points): Target is "retail stores or retail businesses open to the public are 100 percent smokefree." Score is lowered if restriction depends on ventilation standards and/or location of smoking area, and if laws only apply to some but not all retail stores or businesses.

9. **Recreational/Cultural Facilities** (4 points): Target is "recreational and cultural facilities are 100 percent smokefree." Score is lowered if restriction depends on ventilation standards, location of smoking area and/or if laws only apply to some but not all recreational/cultural facilities.
10. **Penalties** (4 points): Target is "graduated penalties or fines, applicable to smokers and to proprietors or employers, for any violation of clean indoor air legislation." Score is lowered if penalties included possibilities for delay, exceptions for either smokers or proprietors/employers, or penalties that only apply to some but not all offenses. An intent requirement or affirmative defense against violation reduces the score by one (1) point.
11. **Enforcement** (4 points): Target is "designate an enforcement authority for clean indoor air, require sign posting and have a phone number and/or online location to report violations." Score is lowered if there is no requirement for sign posting, there is no phone number or online location to report violations, enforcement authority only applies to some sites, or an enforcement authority or sign requirement exists, but not both. A bonus point (+1) is available if the laws meet the target criteria and require the enforcement authority to conduct compliance inspections.

## State Tobacco Excise Taxes

The U.S. Surgeon General, in *The Health Consequences of Smoking—50 Years of Progress*, released in January 2014 to commemorate the 50th anniversary of the first Surgeon General's report on smoking in 1964, concluded that "increases in the prices of tobacco products, including those resulting from excise tax increases, prevent initiation of tobacco use, promote cessation and reduce the prevalence and intensity of tobacco use among youth and adults."[2]

Research has clearly demonstrated that as the price of cigarettes increases, consumption decreases. For each 10 percent price increase, it is estimated that consumption drops by about 7 percent for youth and 3 to 5 percent for adults.[3] Increasing taxes on tobacco products other than cigarettes is also important as while rates of cigarette smoking are declining, rates of cigar smoking and smokeless tobacco use are stagnant or increasing. In a number of states, rates of cigar smoking among youth actually exceed rates of cigarette smoking.

Prior to "State of Tobacco Control 2015" report, the American Lung Association assigned grades to states based on the level of a state's cigarette tax only. However, starting with "State of Tobacco Control 2015," taxes on tobacco products other than cigarettes were incorporated into the grading system. The grading system also was switched to a points-based system, with the level of state's cigarette tax worth up to 30 possible points and taxes on other tobacco products worth up to 10 possible points, for a total of 40 points available in the grading category.

The 30 points for the level of a state's cigarette tax will continue to be based on the average (mean) of all state taxes as the midpoint, or the lowest "C." The average cigarette tax was chosen because it is often seen as an indication of where states are in their cigarette taxing policies. The average state excise tax on January 1, 2019 was $1.78 per pack. The range of state excise taxes ($0.17 to $4.50 per pack) is divided into quintiles, and a state is assigned six points for attaining each quintile.

The score earned for the level of a state's cigarette tax is broken down as follows:

| Score | Tax |
|---|---|
| 30 points | $3.56 and over |
| 24 points | $2.67 to $3.559 |
| 18 points | $1.78 to $2.669 |
| 12 points | $0.89 to $1.779 |
| 6 points | Under $0.89 |

For taxes on tobacco products other than cigarettes, a state is evaluated on whether the tax on five specific types of tobacco products is a) equivalent to the state's tax on cigarettes and b) the tax on the specific type of tobacco product is not based on the weight of the product. Taxing tobacco products other than cigarettes by weight is inadequate because it means the tax level does not keep pace with inflation and tobacco industry or other price increases.

The five specific types of tobacco products other than cigarettes which states are evaluated on are: 1) little cigars, 2) large cigars, 3) smokeless tobacco, 4) pipe/roll-your-own tobacco and 5) dissolvable tobacco products. States can earn up to 2 points total for each type of other tobacco product; 1 point if the tax is equivalent to the cigarette tax and 1 point if the tax is not weight-based. States will not be penalized for having a weight-based tax if they also have a minimum tax that is equal to the current cigarette tax or the weight-based tax is equivalent to the cigarette tax.

The overall grade breaks down as follows:

| Grade | Points Earned |
|---|---|
| A | 36 to 40 points |
| B | 32 to 35 points |
| C | 28 to 31 points |
| D | 24 to 27 points |
| F | 23 and below points |

## Access to Cessation Services

The Access to Cessation Services grading system sets targets for states and awards points in three areas – 1) Medicaid coverage of tobacco cessation treatments, 2) State Employee Health Plan coverage of tobacco cessation treatments and 3) the Investment per Smoker each state makes in its quitline, a service available in all states that provides tobacco cessation counseling over the phone. Bonus points are available in two other target areas, Standards for Private Insurance and Tobacco Surcharges.

In 2008, the U.S. Department of Health and Human Services' Public Health Service published an update to its Clinical Practice Guideline on *Treating Tobacco Use and Dependence*. This Guideline, based on a thorough review of scientific evidence on tobacco cessation, recommends several treatment options that have proven effective in helping people quit smoking. These options include the use of five nicotine-replacement therapies (gum, patch, lozenge, nasal spray, inhaler), bupropion (generic) or Zyban (brand name) and varenicline (non-nicotine medications), and three types of counseling (individual, group and phone). It also recommends that all public and private health insurance plans cover the cessation treatments recommended in the

Guideline. Targets established in the Medicaid, State Employee Health Plan and Standards for Private Insurance categories were based on these Public Health Service Guideline recommendations for cessation treatments.

In the 2014 *Best Practices for Comprehensive Tobacco Control Programs* document, discussed previously in the Tobacco Prevention and Control Spending section above, the CDC establishes benchmarks for quitlines that are funded at the recommended levels. Grading in this section is based on the amount of funding provided to the state quitline for services divided by the number of smokers in the state.

In 2015, the Lung Association incorporated information on what tobacco cessation treatments are provided to the Medicaid expansion population into this grade. Points awarded in the Medicaid Coverage section below incorporate this information. Points available in the Medicaid coverage section were 40 to represent new Medicaid expansion enrollees. If a state has not opted to expand Medicaid up to the levels established in the Affordable Care Act (ACA), the state receives an automatic deduction of 8 points to represent the large number of tobacco users that do not have access to cessation treatments because of this decision.

The Lung Association will deduct up to 2 points for any state that implements a policy to charge Medicaid enrollees a tobacco surcharge or that has policies that charge Medicaid enrollees that smoke more for coverage than non-tobacco user Medicaid enrollees. The Lung Association also added 2 bonus points available to states who prohibit or limit tobacco surcharges, or health insurance policies that charge tobacco users more in premiums than non-tobacco users. States have the ability to limit or remove these surcharges.

All data in the Cessation section of "State of Tobacco Control" 2019 was collected and analyzed by the American Lung Association.

The cessation grades are based on the maximum number of total points, a score of 70, assigned according to the categories described in detail below. Over half of the points (40 points total) under the Access to Cessation Services section are awarded for coverage under a state's Medicaid program. This weighting is due to the higher smoking rates among the Medicaid population than among the general population, as well as the need to cover treatments to help low-income smokers quit. Twenty points total are awarded for the investment per smoker in the state's quitline and 10 points total are awarded for State Employee Health Plan coverage.

The score of 70 serves as the denominator, and the state's total points serves as the numerator to calculate a percentage score. Grades were given following a standard grade-school system using that percentage score.

The grades break down as follows:

| Grade | Points Earned |
|---|---|
| A | 63 to 70 |
| B | 56 to 62 |
| C | 49 to 55 |
| D | 42 to 48 |
| F | 41 and under |

## Key to Cessation Coverage Ratings by Category:

**Medicaid Coverage (40 points):**[4] Target is barrier-free coverage of all Guideline-recommended medications and counseling for the state's entire Medicaid population (including the Medicaid expansion population).

1. States receive up to 14 points for coverage of medications: 1 point for coverage of each of the 7 medications, and an additional point per medication if ALL Medicaid enrollees have coverage of that medication;
2. States receive up to 13 points for coverage of counseling: 1 point for covering any counseling for all members, and 2 points for each type of counseling covered (individual, group and phone). Two additional points per type of counseling were given if ALL Medicaid enrollees have coverage of that type of counseling;
3. States receive up to 13 points for providing coverage without barriers: 1 to 3 points are deducted for each barrier to coverage that exists in a state. Deductions vary based on type of barrier and severity.
4. If a state has not expanded Medicaid coverage up to the levels established in the Affordable Care Act (138 percent of the federal poverty level for all eligibility categories), 8 points are automatically deducted from the Medicaid coverage score.
5. State that impose a tobacco surcharge or charge tobacco users higher premiums than non-tobacco users for Medicaid coverage will have two points deducted from the Medicaid coverage score.

**State Employee Health Plan Coverage (10 points):** Target is barrier-free coverage of all Guideline-recommended medications and counseling for all of a state's employees and dependents.

1. 0 to 4 points are given for coverage of medications; deductions were made if only some health plans/managed care organizations provide coverage;
2. 0 to 4 points are given for coverage of counseling; deductions were made if only some health plans/managed care organizations provide coverage;
3. 0 to 2 points are given if coverage is free of barriers.

**Quitlines (20 points):** States are graded based on a curve set by the median investment per smoker, which in 2019 was $2.21 per smoker. Points are awarded based on the scale below:

| | |
|---|---|
| $$/smoker > $4.41 | 20 points |
| $$/smoker $3.32- $4.41 | 15 points |
| $$/smoker $2.21 - $3.31 | 10 points |
| $$/smoker $1.11- $2.20 | 5 points |
| $$/smoker < $1.11 | 0 points |

**Standards for Private Insurance Coverage (up to 5 bonus points):** Target is a legislative or regulatory standard requiring coverage of all PHS-recommended medications and counseling in private insurance plans within the state.

1. 1 point given for the presence of a legislative or regulatory private insurance standard or if a state insurance commissioner issues a bulletin on the enforcement of the tobacco cessation FAQ issued by the federal government;[5]
2. 0 to 2 points given for required coverage of medications;
3. 0 to 2 points given for required coverage of counseling.

**Tobacco Surcharges (up to 2 bonus points):** Target is a state policy prohibiting small group and individual health insurance plans from charging tobacco users higher premiums than non-tobacco users. States are able to prohibit this practice or limit these surcharges to amounts smaller than federal law allows, which is 50 percent.

1. 2 points given if state prohibits tobacco surcharges; OR
2. 1 point given if state limits tobacco surcharges to less than 50 percent of the premium charged to non-tobacco users.

## Tobacco 21 Laws

In March 2015, the National Academy of Medicine (formerly the Institute of Medicine) issued a report looking at the effect increasing the age of sale for tobacco products could have on youth smoking rates. The report concluded that increasing the age of sale for tobacco products to 21 could prevent 223,000 deaths among people born between 2000 and 2019, including 50,000 fewer dying from lung cancer, the nation's leading cancer killer.[6]

Grades were awarded in this category based on whether a state had increased the age of sale for tobacco products to 21. Letter grades were deducted based on if groups, like active duty military, were exempted from the age of sale of 21, some tobacco products, such as e-cigarettes were exempted or the age of sale was 19 or 20 years old.

Grades break down as follows:

A = age of sale for all tobacco products is 21 years of age with no exceptions;
B = age of sale for all tobacco products is 21 years of age, but certain groups, such as active duty military are exempted;
D = age of sale for all tobacco products is 19 or 20 years old and/or one or more types of tobacco products are exempted from a law increasing the age of sale to 21; and
F = age of sale for some or all tobacco products is 18 years of age.

There is one situation that creates an exception to the grading system:

- Local Ordinances: States without a statewide age of sale for tobacco products of 21 years old may be graded based on local ordinances. Local ordinances that increase the age of sale for all tobacco products to 21 are considered according to the percentage of population covered in the state. States with over 95 percent of their population covered by local Tobacco 21 ordinances will receive an "A," over 80 percent a "B," over 65 percent a "C" and over 50 percent a "D." Local ordinances that cover less than 50 percent of the population will not be considered for evaluation under this exception.

## State Statistics Used in the Report

Adult smoking and tobacco use rates are taken from the CDC's 2017 Behavioral Risk Factor Surveillance System. Adult tobacco use includes having used cigarettes, smokeless tobacco, or electronic cigarettes on one or more of the past 30 days.

High school smoking and tobacco use and middle school smoking rates are taken from CDC's 2017 Youth Risk Behavior Survey, state youth tobacco surveys or other state-based surveys that measure youth smoking or tobacco use rates. High school tobacco use includes having used cigarettes, cigars, smokeless tobacco, or electronic vapor products on one or more of the past

30 days for most states. In states where the tobacco products covered by the survey used are different, a sentence has been added to the state-specific footnotes on each state page describing the tobacco products included.

Health impact and economic information is taken from CDC's Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

State-by-state tobacco-related revenue data (revenue from state tobacco settlement payments and tobacco taxes) is obtained from the Campaign for Tobacco-Free Kids.

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1. Data to calculate percent of state populations covered by local ordinances is obtained from the Americans for Nonsmokers' Rights Foundation.
2. U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta, GA: U.S. 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, 2014.
3. There is general consensus among tobacco researchers that every 10 percent increase in the price of cigarettes decreases cigarette consumption by about 4 percent in adults and about 7 percent in children. Tauras J, et al. Effects of Price and Access Laws on Teenage Smoking Initiation: A National Longitudinal Analysis, *Bridging the Gap Research, ImpacTeen*. April 24, 2001.
4. As of January 1, 2014, the Affordable Care Act (ACA) required that state Medicaid programs no longer exclude coverage of tobacco cessation medications. In State of Tobacco Control 2019 a state was only given credit for covering tobacco cessation medications if there is documentable evidence that the Medicaid program is covering that medication, regardless of the federal requirement.
5. On May 2, 2014, the U.S. Departments of Labor, Health and Human Services and Treasury issued an FAQ that clarified what health insurance plans under the Affordable Care Act should cover in terms of tobacco cessation medications and counseling, https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/aca_implementation_faqs19.html (see question 5).
6. Institute of Medicine, *Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products*, Washington, DC: The National Academies Press, 2015, http://www.nationalacademies.org/hmd/Reports/2015/TobaccoMinimumAgeReport.aspx.

# United States Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

UNITED STATES

## Food and Drug Administration Regulation of Tobacco Products — F

Implementation of Rule Asserting Authority over All Tobacco Products: **Rule partially implemented**

Product Standards for Tobacco Products: **Product standard to reduce cancer-causing chemical in smokeless tobacco proposed**

Graphic Cigarette Warning Labels: **No warning labels re-proposed or finalized**

Menthol Cigarette Product Standard: **No product standard on menthol cigarettes proposed or finalized**

Funding for FDA Center for Tobacco Products: **No FY2019 budget in place currently**

## Tobacco Taxes — F

**CIGARETTE TAX:**

Tax rate per pack of 20: **$1.01**

**OTHER TOBACCO PRODUCT TAXES:**

Little Cigars: Equalized: **Yes; Weight-Based: Yes**

Large Cigars: Equalized: **No; Weight-Based: No**

Smokeless Tobacco: Equalized: **No; Weight-Based: Yes**

Pipe/RYO Tobacco: Equalized: **No; Weight-Based: Yes**

Dissolvable Tobacco: Equalized: **No; Weight-Based: Yes**

## Cessation Coverage — D

Medicaid Coverage: **Partially Required**

Medicare Coverage: **Partially Covered**

TRICARE Coverage: **Covered**

Federal Employee Health Benefits Coverage: **Covered**

State Health Insurance Exchanges: **Partially Required**

Thumbs down for the federal government for undermining healthcare access to comprehensive tobacco cessation coverage.

## Mass Media Campaigns — A

**TIPS FROM FORMER SMOKERS MEDIA CAMPAIGN:**

Reach: **Meets Target**

Duration: **Under Target**

Frequency: **Meets Target**

Promotion of Services: **Meets Target**

**FDA "REAL COSTS" MEDIA CAMPAIGN:**

Reach: **Meets Target**

Duration: **Meets Target**

Frequency: **Meets Target**

Promotion of Services: **Under Target**

## Federal Highlights:

The American Lung Association has identified four key actions that federal policymakers must take in 2019 that will ultimately eliminate the death and disease caused by tobacco use:

1. FDA must release both a proposed and final rule, eliminating all flavored tobacco products from the marketplace, including menthol cigarettes, flavored cigars and e-cigarettes;
2. Clarify and ensure that all tobacco users have access to a comprehensive tobacco cessation benefit without barriers and cost-sharing;
3. Ensure the Centers for Disease Control and Prevention's (CDC) Tips from Former Smokers Campaign and the Food and Drug Administration's (FDA) Real Cost Campaign continue; and
4. Pass legislation raising the minimum of age of sale for all tobacco products to 21.

E-cigarette use among youth continued to lead national headlines in 2018. In January 2018, the National Academies of Science, Engineering and Medicine released a major report at the behest of Congress that found using e-cigarettes causes health risks, increases the chance that youth will start to use combustible tobacco products and exposes others to dangerous secondhand e-cigarette emissions.

Throughout 2018, the Lung Association urged FDA to take more meaningful and aggressive action to reduce youth e-cigarette use in response but to no avail. These efforts by the Lung Association and its public health partners included: suing the FDA to compel it to follow the Tobacco Control Act and complete a pre-market review of all e-cigarettes, cigars and other newly regulated tobacco products currently on the market; requesting the agency enforce the law and stop e-cigarettes that look like Juul from coming onto the market without the agency's prior review and authorization; and the Lung Associa-

tion's National President and CEO and his counterparts sending a letter to FDA Commissioner Scott Gottlieb outlining key principles and provisions the agency needs to take in order to reduce youth e-cigarette use.

Results released from the 2018 National Youth Tobacco Survey in November found that high school student use of e-cigarettes had increased by a staggering 78 percent from 2017 to 2018. FDA Commissioner Scott Gottlieb released a statement saying that the agency would move forward with releasing a proposed rule removing all menthol cigarettes and flavored cigars from the marketplace. He also announced additional sales and youth access restrictions around flavored e-cigarette use but failed to heed the advice of these organizations which urged FDA to remove all flavored tobacco products from the market. FDA had yet to take any of these steps formally when this report went to print.

In December, U.S. Surgeon General Jerome Adams declared e-cigarette use among youth to have reached epidemic levels. And Altria announced it purchased a significant stake in Juul, the most popular e-cigarette brand and the biggest driver of youth use.

The strong tobacco mass media campaigns from the federal government continued in 2018. CDC's highly effective and extremely cost-effective "Tips from Former Smokers" campaign began its seventh Survey.year of highlighting the diseases caused by tobacco use. In September, the Lung Association applauded FDA for adding e-cigarettes to its highly successful youth prevention campaign, "The Real Cost."

Other notable 2018 highlights include:

- A federal court found in favor of the Lung Association and against the FDA for its delay in implementing graphic warning labels on cigarette packs. The judge ruled that "FDA has unlawfully withheld and unreasonably delayed action."
- A rule making all public housing smokefree took effect on July 31, 2018. This protected close to two million residents, including hundreds of thousands of children, from secondhand smoke in their homes.
- The House of Representatives again attached a provision to FDA's funding bill that would undermine the Tobacco Control Act and create special protections for candy-flavored cigars. The rider remains unresolved as part of the Fiscal Year 2019 budget, that was unresolved as of the time this report went to print.
- In May 2018, the federal court judge overseeing the decades-old racketeering lawsuit against major tobacco companies ruled that the companies must publish corrective statements on both their websites and on cigarette packs starting in 2018. These statements are aimed at holding these tobacco companies accountable for decades of fraud and deception, and follow earlier statements published in major newspapers and aired on television.

## United States Facts

| | |
|---|---|
| Economic Costs Due to Smoking: | $289,500,000,000 |
| Adult Smoking Rate: | 14.0% |
| Adult Tobacco Use Rate: | 19.2% |
| High School Smoking Rate: | 7.6% |
| High School Tobacco Use Rate: | 27.1% |
| Middle School Smoking Rate: | 2.1% |
| Middle School Tobacco Use Rate: | 7.2% |
| Smoking Attributable Deaths per Year: | 480,320 |
| Smoking Attributable Lung Cancer Deaths per Year: | 163,700 |
| Smoking Attributable Respiratory Disease Deaths per Year: | 113,100 |

Adult smoking and tobacco use rates are taken from the 2017 National Health Interview Survey. High school and middle school smoking rates are taken from the 2017 National Youth Tobacco Survey. High school and middle school tobacco use rates are taken from the 2018 National Youth Tobacco Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

# Alabama Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

ALABAMA

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $2,088,137 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $2,619,127* |
| FY2019 Total Funding for State Tobacco Control Programs: | $4,707,264 |
| CDC Best Practices State Spending Recommendation: | $55,900,000 |
| Percentage of CDC Recommended Level: | 8.4% |
| State Tobacco-Related Revenue: | $300,200,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: F

**OVERVIEW OF STATE SMOKING RESTRICTIONS:**

Government Worksites: **Restricted**

Private Worksites: **No provision**

Schools: **Restricted**

Child Care Facilities: **Restricted**

Restaurants: **No provision**

Bars: **No provision**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **Restricted**

Recreational/Cultural Facilities: **Restricted**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: ALA. CODE §§ 22-15A-1 et seq. (2003).

Note: The Smokefree Air grade only examines state tobacco control law and does not reflect local smokefree ordinances. Alabama has made great strides in protecting people from secondhand smoke by passing comprehensive local smokefree ordinances that cover 13.1% of the state's population.

## Tobacco Taxes: F

**CIGARETTE TAX:**

Tax Rate per pack of 20: **$0.675**

OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: Equalized: **No; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: Yes**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: F

**OVERVIEW OF STATE CESSATION COVERAGE:**

STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access coverage**

Medicaid Expansion: **No**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Limited counseling is covered**

Barriers to Coverage: **Some barriers exist to access coverage**

STATE QUITLINE:

Investment per Smoker: **$1.40; the median investment per smoker is $2.21**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Alabama Tobacco Cessation Coverage page for specific sources.

## Minimum Age: D

Minimum Age of Sale for Tobacco Products: **19**

# **Alabama** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Alabama. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Alabama's elected officials:

1. Pass a comprehensive statewide smokefree law that protects all workers and patrons from secondhand smoke;
2. Increase funding for the Alabama tobacco prevention and control program; and
3. Increase the tax on cigarettes and other tobacco products.

Tobacco prevention and control legislation was once again not a priority for the members of the Alabama Legislature in 2018. The Alabama Legislature continues to have a residual lack of support for tobacco control measures, such as supporting a statewide smokefree air law or increased funding for tobacco control and prevention programs.

Local municipalities continue to take the lead on public health issues by implementing strong smokefree ordinances. The cities of Luverne and Sheffield were public health leaders in passing smokefree air ordinances in 2018 to protect their workers and residents from exposure to secondhand smoke. Tobacco control partners are very engaged with community education on the dangers of secondhand smoke across Alabama. The Lung Association plays a prominent role by offering technical assistance on securing smokefree protections for all workers and residents in local municipalities across the state.

The Alabama Department of Public Health continues to affect social norm change around tobacco use, address the marketing of tobacco products to youth, and promote policies that eliminate exposure to secondhand smoke through the presence of Tobacco Prevention Coordinators in strategic public health areas across Alabama and the funded non-profit organizations of the Youth Tobacco Prevention Program.

In 2019, the American Lung Association in Alabama will educate state legislators about the benefits of a statewide smokefree law and the need for increased funding for the tobacco control program. In order to reduce the death and disease caused by tobacco use in Alabama, state legislators will need to recognize the health and economic burden of tobacco use and secondhand smoke exposure by enacting public health protections and investing in evidence-based tobacco prevention programs. The Lung Association will continue to work with partners in the Coalition for a Tobacco Free Alabama to ensure successful passage and preservation of comprehensive local smokefree ordinances.

## Alabama State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $1,885,747,576 |
| Adult Smoking Rate: | 20.9% |
| Adult Tobacco Use Rate: | 27.2% |
| High School Smoking Rate: | 10.9% |
| High School Tobacco Use Rate: | 35.5% |
| Middle School Smoking Rate: | 3.4% |
| Smoking Attributable Deaths: | 8,650 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school and middle school smoking rates are taken from the 2016 Youth Tobacco Survey. High school tobacco use rate is taken from the 2015 Youth Risk Behavior Surveillance System.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Alabama**
(205) 968-2266
www.lung.org/alabama

# Alaska Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

ALASKA

## Tobacco Prevention and Control Program Funding: A

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $9,122,400 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $887,405* |
| FY2019 Total Funding for State Tobacco Control Programs: | $10,009,805 |
| CDC Best Practices State Spending Recommendation: | $10,200,000 |
| Percentage of CDC Recommended Level: | 98.1% |
| State Tobacco-Related Revenue: | $83,200,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: B*

**OVERVIEW OF STATE SMOKING RESTRICTIONS:**

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

Casinos/Gaming Establishments: **N/A (tribal establishments only)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **Yes**

Penalties: **Yes**

Enforcement: **Yes**

Preemption/Local Opt-Out: **Yes**

Citation: ALASKA STAT. §§ 18.35.301 to 18.35.399 (2018).

*If the local opt-out provision in Alaska's law were removed, Alaska's grade would be an "A."

## Tobacco Taxes: C

**CIGARETTE TAX:**

Tax Rate per pack of 20: **$2.00**

OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: Yes; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: B

**OVERVIEW OF STATE CESSATION COVERAGE:**

STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Most medications are covered**

Counseling: **Most counseling is covered**

Barriers to Coverage: **Minimal barriers exist to access care**

STATE QUITLINE:

Investment per Smoker: **$5.20; the median investment per smoker is $2.21**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Alaska Tobacco Cessation Coverage page for specific sources.

## Minimum Age: D

Minimum Age of Sale for Tobacco Products: **19**

# **Alaska** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in Alaska. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Alaska's elected officials:

1. Protect Medicaid Expansion to preserve access to tobacco cessation treatments for this population; and
2. Protect tobacco prevention and control funding.

Passage of a bill providing protections from secondhand smoke in public places and workplaces by the Alaska Legislature in 2018 came after two decades of work at the local level, and five years in the state legislative process. Bethel was the first community in Alaska to pass a smokefree workplace law back in 1998. Since that time, Anchorage, Juneau and other communities across the state had acted to protect their residents.

For much of the rest of the state, though, a statewide law was the only way to ensure protection due to limited local municipal government powers. Combined with the thousands of Alaskans who live in areas with no local government at all, Alaska's law, implemented on October 1, 2018, protected 350,000 Alaskans who could not be legally protected from secondhand smoke at the local level.

Extending smokefree protections in public places and workplaces to places in Alaska that were unable to pass local ordinances is an important step to help protect communities. Unfortunately, the inclusion of the local opt-out provision means the legislation falls short of the comprehensive protections that all Alaskans deserve. The Lung Association strongly encourages all communities in Alaska to keep smokefree protections in place to protect their residents from secondhand smoke, and was heartened to see Sitka, Alaska voters defeat an attempt to opt-out of the statewide law in October 2018.

Currently 44,767 Alaskans are covered through Medicaid Expansion in our state. By definition, Medicaid covers low-income Alaskans. Retaining coverage is critical for reducing the toll of tobacco in Alaska because Medicaid provides cessation coverage and this population uses tobacco at a much higher rate than other income levels.

Alaska's Tobacco Prevention and Control program follows the Centers for Disease Control & Prevention's Best Practices with the goals of preventing youth from starting tobacco use; protecting non-smokers from secondhand smoke; promoting cessation; and identifying and eliminating tobacco-related disparities. Since 1996, the rate of Alaskan adults who smoke has dropped from 28 percent to 19 percent due in large part to our comprehensive tobacco control program. There remain, however, significant disparities and rates overall exceed national rates. Alaska Native, low socio-economic status, young adult (18-24), Alaskans experiencing mental illness and/or substance abuse disorders, and the LGBT community all have higher tobacco use rates.

Alaska has also made huge progress in reducing youth cigarette smoking rates, by over 60 percent since 1995 to 11 percent overall today. Youth in Alaska are now, however, using electronic smoking devices (18%) more than conventional cigarettes, and continued policy and education strategies are needed to curb this disturbing trend.

## Alaska State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $438,143,263 |
| Adult Smoking Rate: | 21.0% |
| Adult Tobacco Use Rate: | 26.7% |
| High School Smoking Rate: | 10.9% |
| High School Tobacco Use Rate: | 25.9% |
| Middle School Smoking Rate: | N/A |
| Smoking Attributable Deaths: | 610 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data come from the 2017 Youth Risk Behavior Surveillance System. A current middle school smoking rate is not available for this state.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Alaska**
(907) 276-5864
www.lung.org/alaska

# Arizona Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

ARIZONA

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $17,343,100 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $1,848,394* |
| FY2019 Total Funding for State Tobacco Control Programs: | $19,191,494 |
| CDC Best Practices State Spending Recommendation: | $64,400,000 |
| Percentage of CDC Recommended Level: | 29.8% |
| State Tobacco-Related Revenue: | $429,500,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: A

**OVERVIEW OF STATE SMOKING RESTRICTIONS:**

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

Casinos/Gaming Establishments: **Prohibited (tribal establishments exempt)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: ARIZ. REV. STAT. § 36-601.01 & AZ ADMIN RULES §§ R9-2-101 to R9-2-112 (2007).

## Tobacco Taxes: F

**CIGARETTE TAX:**

Tax Rate per pack of 20: **$2.00**

OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: No; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: Yes**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: D

**OVERVIEW OF STATE CESSATION COVERAGE:**

STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Few barriers exist to access care**

Medicaid Expansion: **Yes**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **No barriers exist to access care**

STATE QUITLINE:

Investment per Smoker: **$3.19; the median investment per smoker is $2.21**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Arizona Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Arizona** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in Arizona. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Arizona's elected officials:

1. Raise the minimum sales age for tobacco products to 21;
2. Increase Arizona's tobacco taxes; and
3. Maintain or increase funding for tobacco prevention and cessation programs.

The American Lung Association in Arizona continues to champion tobacco control issues in Arizona by leading legislative efforts and partnering with key organizations, state departments, and legislators to ensure tobacco education and prevention remains among the state's top priorities.

In 2018, funding for Arizona's tobacco control program, Tobacco Free Arizona, went from $17.8 million in fiscal year 2018 to $17.8 million in fiscal year 2019. The program is funded by a percentage of revenue from tobacco taxes, and funding has remained relatively consistent over the years. However, the American Lung Association in Arizona keeps a close eye on funding levels to ensure these vital tobacco prevention and quit smoking programs receive the funding dedicated to them. Even at current funding levels, the state remains well short of Centers for Disease Control and Prevention recommended levels.

During the 2018 legislative session, the Lung Association in Arizona worked on state legislation raising the sales age of tobacco products to 21. The bill passed the House Health Committee 8-1 but failed to be heard in its other assigned committees.

The Arizona Smoke-Free Living Coalition, of which the American Lung Association is a partner, continued efforts toward supporting smokefree policies in apartment communities throughout Arizona. Outreach efforts to educate and support multi-family housing property managers and owners to adopt and implement a smoke-free policy yielded positive results. In 2018, a total of 480 apartment communities across Arizona had fully implemented written smokefree policies, of which 352 do not permit the use of electronic smoking devices. An additional 112 apartment communities are in the process of transitioning to smokefree.

Furthermore, Arizona Smoke-Free Living Coalition was instrumental in an effort, effective in 2018, requiring all Low-Income Housing Tax Credit Program awardees to implement a smokefree policy level that prohibits electronic smoking devices. The Coalition aims to continue to provide education and support to increase the number of smokefree apartment communities statewide in the coming year.

During the 2019 legislative session, the American Lung Association in Arizona will again work diligently to educate our lawmakers on the enormous negative economic impacts that tobacco use has on Arizona. Raising the minimum sales age for tobacco products to 21 will also be a priority.

## Arizona State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $2,383,033,467 |
| Adult Smoking Rate: | 15.6% |
| Adult Tobacco Use Rate: | 20.1% |
| High School Smoking Rate: | 7.1% |
| High School Tobacco Use Rate: | 21.6% |
| Middle School Smoking Rate: | 2.4% |
| Smoking Attributable Deaths: | 8,250 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data come from the 2017 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the 2017 Youth Tobacco Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Arizona**
(602) 258-7505
www.lung.org/arizona

# Arkansas Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

ARKANSAS

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $12,008,972* |
| FY2019 Federal Funding for State Tobacco Control Programs: | $2,009,944** |
| FY2019 Total Funding for State Tobacco Control Programs: | $14,018,916 |
| CDC Best Practices State Spending Recommendation: | $36,700,000 |
| Percentage of CDC Recommended Level: | 38.2% |
| State Tobacco-Related Revenue: | $282,700,000 |

*The Arkansas Legislature appropriated $14,341,229 to the Arkansas Tobacco Prevention and Cessation Program, however, only $12,008,972 is allocated for tobacco prevention and control activities. The Arkansas Tobacco Prevention and Cessation Program is mandated by law to distribute funding to other agencies. The total funding amount above includes the activities of the Arkansas Department of Health's Tobacco Prevention and Cessation Program, tobacco prevention activities of the Minority Health and Health Disparities Program and the Arkansas Tobacco Control Board.

**Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: C

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited (non-public workplaces with three or fewer employees exempt)**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Restricted***

Bars: **Restricted***

Casinos/Gaming Establishments: **Restricted**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: ARK. CODE ANN. §§ 20-27-1801 et seq. (2015).

*Smoking is allowed in restaurants and bars that do not allow persons under 21 to enter at any time.

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$1.15**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: D

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **Some medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access coverage**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Some medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access coverage**

#### STATE QUITLINE:

Investment per Smoker: **$2.85; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **Limits tobacco surcharges**

Citation: See Arkansas Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Arkansas** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Arkansas. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Arkansas' elected officials:

1. Increase taxes on cigarettes and other tobacco products by $1.00 per pack or more;
2. Maintain current level of funding for the state's tobacco prevention and cessation program, including the Arkansas Quitline;
3. Strengthen and remove the current exemptions in the state's clean indoor air act to protect all workers in the state from secondhand smoke.

Although the 2018 Session was focused on state fiscal matters, comprehensive tobacco prevention and control legislation was once again not a priority for the members of the Arkansas Legislature. The Arkansas Legislative Council challenged the contract and funding for the Arkansas Quitline that provides cessation counseling and medications to Arkansas residents. With education and advocacy from partners statewide, the Arkansas Quitline was approved for a short-term extension to evaluate the effectiveness and impact of the cessation program.

The American Lung Association in Arkansas continues to serve as the lead agency for the statewide tobacco control coalition. The coalition provides support for local tobacco control efforts including; smokefree municipal policies, smokefree/tobacco-free workplace polices and smokefree multi-unit housing policies and implementation. In partnership with tobacco prevention partners, the American Lung Association in Arkansas continued to educate about the dangers of secondhand smoke exposure and the need for comprehensive smokefree policies in all public places and workplaces, including bars and gaming facilities, and the use of electronic smoking devices at the local level.

In 2019, the American Lung Association in Arkansas will continue to educate state legislators about the benefits of comprehensive tobacco control policies and programs, including a comprehensive statewide smokefree law and maintained funding for the tobacco control program. In order to reduce the death and disease caused by tobacco use in Arkansas, state legislators will need to recognize the health and economic burden of tobacco use and exposure to secondhand smoke by enacting public health protections and investing in evidence-based tobacco prevention programs.

## Arkansas State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $1,215,082,968 |
| Adult Smoking Rate: | 22.3% |
| Adult Tobacco Use Rate: | 29.3% |
| High School Smoking Rate: | 13.7% |
| High School Tobacco Use Rate: | 26.3% |
| Middle School Smoking Rate: | N/A |
| Smoking Attributable Deaths: | 5,790 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data come from the 2017 Youth Risk Behavior Surveillance System. A current middle school smoking rate is not available for this state.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Arkansas**
(501) 260-1291
www.lung.org/arkansas

# California Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

CALIFORNIA

## Tobacco Prevention and Control Program Funding: B

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $250,381,999 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $8,747,467* |
| FY2019 Total Funding for State Tobacco Control Programs: | $259,129,466 |
| CDC Best Practices State Spending Recommendation: | $347,900,000 |
| Percentage of CDC Recommended Level: | 74.5% |
| State Tobacco-Related Revenue: | $2,808,300,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: A

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited (public schools only)**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

Casinos/Gaming Establishments: **Prohibit (tribal establishments exempt)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **Yes**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: CA LABOR CODE § 6404.5 (2016); CA GOVT. CODE §§ 7596 to 7598 (2007); CA EDUC. CODE §§ 48900 & 48901 (1986); & CA HEALTH & SAFETY CODE § 1596.795 (1993).

## Tobacco Taxes: B

### CIGARETTE TAX:

Tax Rate per pack of 20: **$2.87**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: Yes; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: B

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **All counseling is covered**

Barriers to Coverage: **Some barriers exist to access coverage**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Most medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access coverage**

#### STATE QUITLINE:

Investment per Smoker: **$3.14; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **Prohibits tobacco surcharges**

Citation: See California Tobacco Cessation Coverage page for specific sources.

Thumbs up for California for providing comprehensive coverage for all tobacco cessation medications and types of counseling to Medicaid enrollees with minimal barriers.

## Minimum Age: B

Minimum Age of Sale for Tobacco Products: **21**

# **California** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in California. To address this enormous toll, the American Lung Association calls for the following actions to be taken by California's elected officials:

1. Restrict the sale of flavored tobacco products, including menthol;
2. Address secondhand smoke in multi-unit housing; and
3. Reduce youth access to tobacco products.

This past year proved to be another success for the American Lung Association in California. At the state level, the Lung Association successfully pushed back against attempts to restrict the flow of tobacco tax funding to tobacco prevention programs, ensuring that these world-renowned programs can continue to reduce tobacco use in California.

At the local level, there was a huge uptick in the number of communities pursuing and adopting policies restricting the sale of flavored tobacco products, including menthol. There are currently a total of 29 policies addressing flavored products, 23 of which include menthol. This includes the city of San Francisco, which became the largest city in the country to completely prohibit the sale of all flavored tobacco products, including menthol. The Lung Association was a crucial player in the fight in San Francisco, where the tobacco industry spent over $12 million dollars in an unsuccessful attempt to defeat the ballot initiative on this issue. Ultimately, in June 2018 the voters sided with the Lung Association, and overwhelmingly voted to support the initiative 68 percent to 31 percent.

Many other local communities are also making important strides toward a future free of tobacco-related disease. In 2018, communities such as Beverly Hills, Emeryville, Clayton, Ross, Citrus Heights, Half Moon Bay, and Rohnert Park all adopted strong policies to protect their citizens from harmful secondhand smoke in multi-unit housing.

Recent statewide polling conducted by the Lung Association shows strong support (71%) for local policies to restrict the sale of flavored tobacco products in youth sensitive areas, and strong support (72%) for policies that prohibit exposure to secondhand smoke in areas frequented by the public. These polls clearly indicated the public is ready for action on these important issues.

With the public support behind these issues, in 2019 the American Lung Association in California will continue to fight for policies that protect youth from accessing tobacco products through local and state policies that restrict the sale of flavored tobacco products and new types of tobacco products. Additional efforts will seek to improve the quality of life of individuals with lung disease living in multi-unit housing, by adopting local policies that restrict tobacco use in those properties.

## California State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $13,292,359,950 |
| Adult Smoking Rate: | 11.3% |
| Adult Tobacco Use Rate: | 14.2% |
| High School Smoking Rate: | 5.4% |
| High School Tobacco Use Rate: | 27.4% |
| Middle School Smoking Rate: | 2.8% |
| Smoking Attributable Deaths: | 39,950 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking rate data comes from the 2017 and tobacco use data comes from the 2015 Youth Risk Behavior Surveillance System. Middle school smoking rate (7th grade only) is taken from the 2013-15 California Healthy Kids Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in California**
(916) 554-5864
www.lung.org/california

# Colorado Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

COLORADO

## Tobacco Prevention and Control Program Funding: D

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $24,136,821 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $2,621,889* |
| FY2019 Total Funding for State Tobacco Control Programs: | $26,758,710 |
| CDC Best Practices State Spending Recommendation: | $52,900,000 |
| Percentage of CDC Recommended Level: | 50.6% |
| State Tobacco-Related Revenue: | $286,300,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: B

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited (non-public workplaces with three or fewer employees exempt)**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited (allowed in cigar-tobacco bars)**

Casinos/Gaming Establishments: **Prohibited (tribal establishments exempt)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: COLO. REV. STAT. ANN. §§ 25-14-201 et seq. (2008).

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$0.84**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: Yes; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: B

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **Covers all 7 medications**

Counseling: **Covers all 3 forms of counseling**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Data not provided***

Counseling: **Data not provided***

Barriers to Coverage: **Data not provided***

#### STATE QUITLINE:

Investment per Smoker: **$5.79; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Yes**

Tobacco Surcharge: **Limits tobacco surcharges**

Citation: See Colorado Tobacco Cessation Coverage page for specific sources.

*Current data on tobacco cessation coverage for state employees was not provided this year, therefore zero points were awarded in the State Employee Health Plans subcategory.

Thumbs up for Colorado for providing comprehensive coverage for all tobacco cessation medications and types of counseling to Medicaid enrollees with minimal barriers.

## Minimum Age: F

| | |
|---|---|
| Minimum Age of Sale for Tobacco Products: | 18 |

# **Colorado** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in Colorado. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Colorado's elected officials:

1. Enhance Colorado's smokefree laws to include electronic smoking devices;
2. Strengthen state and local laws around youth access to tobacco products; and
3. Protect and increase funding for tobacco prevention and cessation programs.

The American Lung Association in Colorado is a member of the Colorado Tobacco Free Alliance, which consists of statewide advocate partner groups working together to develop sound tobacco control polices. Joining with grassroots organizations at both the state and local level has strengthened the Lung Association's tobacco education, prevention and advocacy efforts statewide.

During the 2018 legislative session, the Colorado Tobacco Free Alliance successfully defeated two bills that would have undermined tobacco control efforts in the state. The first one would have extended a tax credit for out-of-state tobacco sales with the revenue to pay for it being diverted from tobacco tax revenues used to support Colorado's tobacco control program and other important programs. A second bill would have redefined large and premium cigars which would affect excise taxes collected from the products.

Thanks to a veto from Governor Hickenlooper, the Colorado Tobacco Free Alliance and Lung Association were also able to fight off an attempt to undermine state smokefree laws through the creation of marijuana consumption establishments where marijuana use through e-cigarettes could have occurred. The Alliance hopes to solve this problem permanently in 2019 by getting e-cigarettes added to the state smokefree law.

Local communities continue to lead the way in Colorado. In 2018, Denver International Airport officially became smokefree as its last remaining smoking lounge closed due to a previously passed city ordinance. Additionally, Avon, Basalt, and Carbondale all raised the sale age for tobacco products to 21. In addition to raising the sales age, Avon voters approved a ballot measure establishing a $3.00 per pack local cigarette tax and Basalt voters passed a ballot measure raising the cigarette tax by $2.00 per pack and adding a 40 percent tax on other tobacco products. The additional revenue generated by the new taxes will fund tobacco-related education and tobacco-related health issues.

In 2019, the American Lung Association in Colorado will continue its work with partners to support state and local strengthening of smokefree laws and reduce tobacco use through strategies like raising the sales age for tobacco to 21.

## Colorado State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $1,891,467,308 |
| Adult Smoking Rate: | 14.6% |
| Adult Tobacco Use Rate: | 20.2% |
| High School Smoking Rate: | 7.0% |
| High School Tobacco Use Rate: | 30.3% |
| Middle School Smoking Rate: | 1.9% |
| Smoking Attributable Deaths: | 5,070 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2017 Youth Risk Behavior Surveillance System. High school tobacco use rate is taken from the 2015 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the 2015 Colorado Healthy Kids Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Colorado**
(303) 388-4327
www.lung.org/colorado

# Connecticut Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

CONNECTICUT

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $0 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $2,180,091* |
| FY2019 Total Funding for State Tobacco Control Programs: | $2,180,091 |
| CDC Best Practices State Spending Recommendation: | $32,000,000 |
| Percentage of CDC Recommended Level: | 6.8% |
| State Tobacco-Related Revenue: | $500,800,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

Thumbs down for Connecticut for providing no state funding for tobacco prevention programs despite smoking costing the state over $2 billion in healthcare costs each year.

## Smokefree Air: C

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Restricted**

Schools: **Prohibited**

Child Care Facilities: **Restricted**

Restaurants: **Prohibited**

Bars: **Prohibited (allowed in tobacco bars)**

Casinos/Gaming Establishments: **Prohibited (tribal establishments exempt)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **Partially**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: CONN. GEN. STAT. §§ 19a-342 & 31-40q (2003); 19a-342a (2015) and CT ADMIN CODE §§ 19a-79-7(d)(6) & 19a-87b-9 (1993).

## Tobacco Taxes: B

### CIGARETTE TAX:

Tax Rate per pack of 20: **$4.35**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: D

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **All 3 forms of counseling are covered**

Barriers to Coverage: **Limited barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Some medications are covered**

Counseling: **All 3 forms of counseling are covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$0.15*; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **Limits tobacco surcharges**

Citation: See Connecticut Tobacco Cessation Coverage page for specific sources.

*The state quitline is using additional unspent funds carried over from past years. Those dollars have been excluded from this report as they were counted in a previous year's report.

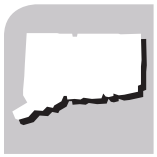
Thumbs up for Connecticut for providing comprehensive coverage for all tobacco cessation medications and types of counseling to Medicaid enrollees with minimal barriers.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Connecticut** State Highlights:





Tobacco use remains the leading cause of preventable death and disease in the United States and in Connecticut. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Connecticut's elected officials:

1. Raise the tobacco sales age to 21;
2. Provide state funding for tobacco prevention and cessation programs; and
3. Close the loopholes in Connecticut's indoor smokefree air laws.

Tobacco prevention and cessation program funding suffered a huge loss in the 2018 Connecticut Legislative Session. The most disappointing and frustrating outcome of the session was the indefinite elimination of the funding for the Tobacco and Health Trust Fund. This last-minute language change in the budget completely eliminated the budget line for tobacco Master Settlement Agreement (MSA) fund deposits to the Tobacco and Health Trust Fund in Connecticut. In October 2018, the Tobacco and Health Trust Fund Board met and confirmed that there is ZERO dollars within the fund and no future planned transfer. This is incomprehensible, especially given Connecticut has one of the highest cigarette taxes in the country, and must be reversed.

As part of the MSA originally negotiated in 1998, Connecticut continues to receive more than $100 million annually. However, Connecticut has not set aside state money for tobacco prevention programs since 2015. The Centers for Disease Control and Prevention recommends Connecticut spend $32 million annually on tobacco prevention and cessation programs, yet in 15 years the state has spent only $29.2 million in total.

The other news is not all so grim. One bill which was the best attempt in years to close significant loopholes within state clean indoor air laws in the state, passed the Public Health and General Law Committees but got bogged down with a detrimental amendment in the final hours of session. Additionally, a key priority of the Lung Association to raise the retail sales age of tobacco products to 21 statewide garnered significant press and political support with 43 co-sponsors on the bill. The Lung Association looks forward to capitalizing on the progress made last session and seizing on the momentum from passage of the local Tobacco 21 ordinance in Hartford to move this issue forward in 2019.

In October 2018, the state Department of Public Health released the annual Youth Tobacco Survey results based on data collected in 2017. Overall high school student use of electronic nicotine delivery systems (ENDS) has doubled since 2015 (from 7.2% to 14.7%). The survey found that 20 percent of high school seniors currently use ENDS.

The American Lung Association in Connecticut and our partners clearly have our work cut out for us in 2019, however there has been positive movement around the state. Cities and towns all over Connecticut are working to make their youth's health a priority by raising the tobacco sale age to 21 on a local level. The evidence is clear that we must act; the Lung Association implores Connecticut lawmakers to do more to prevent and reduce tobacco use.

## Connecticut State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $2,038,803,314 |
| Adult Smoking Rate: | 12.7% |
| Adult Tobacco Use Rate: | 15.7% |
| High School Smoking Rate: | 3.5% |
| High School Tobacco Use Rate: | 17.9% |
| Middle School Smoking Rate: | 0.8% |
| Smoking Attributable Deaths: | 4,900 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data are taken from the 2017 Youth Tobacco Survey. High school tobacco use includes cigarettes, cigars, smokeless tobacco, and electronic vapor products, as well as pipes and hookah, making it incomparable to other states. Middle school smoking rate is taken from the 2015 Youth Tobacco Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Connecticut**
(860) 289-5401
www.lung.org/connecticut

# Delaware Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

DELAWARE

## Tobacco Prevention and Control Program Funding: D

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $6,295,100 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $727,843* |
| FY2019 Total Funding for State Tobacco Control Programs: | $7,022,943 |
| CDC Best Practices State Spending Recommendation: | $13,000,000 |
| Percentage of CDC Recommended Level: | 54.0% |
| State Tobacco-Related Revenue: | $154,700,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: A

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

Casinos/Gaming Establishments: **Prohibited**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **Yes**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: DEL. CODE ANN. tit. 16, §§ 2901 et seq. (2015).

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$2.10**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: No; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: B

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$8.98; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Cessation bulletin issued**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Delaware Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Delaware** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Delaware. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Delaware's elected officials:

1. Increase the minimum sales age for tobacco products to 21 years old;
2. Fund tobacco prevention and cessation programs at the Centers for Disease Control and Prevention (CDC) recommended level; and
3. Increase the cigarette tax by $1.00 per pack or more and equalize taxes on tobacco products to the cigarette tax.

The 2018 legislative session was the second year of the 49th General Assembly of Delaware's two-year session. In 2018, the American Lung Association in Delaware was successful in fighting back an attempt to put a cap on cigar taxes in Delaware. House bill 417 would have set an artificial and unjustified given the public health dangers limit on cigar taxes of 50 cents per cigar. The bill was moved out of the House Committee on Revenue and Finance without recommendation but stalled out after that in the House Committee on Appropriations.

While there was discussion prior to the 2018 legislative session amongst the Lung Association and other public health partners about introducing a bill to increase the tobacco sales age to 21, the decision was made to postpone this effort. The Lung Association and partners are poised to move forward with a Tobacco 21 campaign in 2019.

The Delaware Health Fund is where tobacco Master Settlement Agreement (MSA) dollars received by the state have been directed since within the first few years after the MSA was negotiated 20 years ago in 2018. Delaware has been one of the few states to largely keep promises made at the time and use the money for health-related purposes. Total tobacco prevention and cessation funding, which comes from this Fund, remained about the same as the previous year at close to $6.3 million in fiscal year 2019. However, this amount of funding is lower than historical levels, and the Lung Association believes funding for this vital program needs to be increased.

The American Lung Association in Delaware will continue to educate lawmakers on the ongoing fight against tobacco. Our goal is to build champions within the legislature and a groundswell of advocates to advance our goals, including funding to prevent our youth from starting to smoke as well as helping individuals who want to quit to do so and increasing the minimum age of sale for all tobacco products to 21 years old.

## Delaware State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $532,321,239 |
| Adult Smoking Rate: | 17.0% |
| Adult Tobacco Use Rate: | 20.9% |
| High School Smoking Rate: | 6.2% |
| High School Tobacco Use Rate: | 19.4% |
| Middle School Smoking Rate: | 1.5% |
| Smoking Attributable Deaths: | 1,440 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use rates are taken from the 2017 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the 2015 Youth Tobacco Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Delaware**
(717) 971-1129
www.lung.org/delaware

# District of Columbia Report Card

AMERICAN LUNG ASSOCIATION.

STATE OF TOBACCO CONTROL 2019

DISTRICT OF COLUMBIA

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 City Funding for Tobacco Control Programs: | $1,905,000 |
| FY2019 Federal Funding for City Tobacco Control Programs: | $722,358* |
| FY2019 Total Funding for City Tobacco Control Programs: | $2,627,358 |
| CDC Best Practices City Spending Recommendation: | $10,700,000 |
| Percentage of CDC Recommended Level: | 24.6% |
| State Tobacco-Related Revenue: | $72,900,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

Thumbs up for the District of Columbia for increasing funding for its city tobacco prevention program by $1 million this fiscal year.

## Smokefree Air: A

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited (allowed in cigar bars and allows for an economic hardship waiver)**

Casinos/Gaming Establishments: **N/A**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **Yes**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: D.C. CODE ANN. tit. 7 §§ 7-741.01 to 7-741.07 (2017).

## Tobacco Taxes: A

### CIGARETTE TAX:

Tax Rate per pack of 20: **$4.50***

*On October 1, 2018, the cigarette tax increased from $2.50 to $4.50 per pack.

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: N/A**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

Thumbs up for the District of Columbia for increasing its cigarette tax by $2.00 to $4.50 per pack, which is now the highest cigarette tax in the country.

## Access to Cessation Services: D

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **Most medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$3.80; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **Prohibits tobacco surcharges**

Citation: See District of Columbia Tobacco Cessation Coverage page for specific sources.

## Minimum Age: A

Minimum Age of Sale for Tobacco Products: **21**

Thumbs up for the District of Columbia for including funding in its budget this year to implement Tobacco 21 legislation originally approved in 2016.

# **District of Columbia** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in the District of Columbia. To address this enormous toll, the American Lung Association calls for the following actions to be taken by the District of Columbia's elected officials:

1. Fund tobacco prevention and cessation programs at the level recommended by the Centers for Disease Control and Prevention (CDC);
2. Improve the city's Medicaid coverage for tobacco cessation treatments to be comprehensive and consistent across plans; and
3. Restrict the sale of flavored tobacco products, including menthol in the city.

2018 was an incredibly successful year for tobacco control in the District of Columbia, and a product of hard work by the American Lung Association in the District of Columbia and its public health partners.

During the 2018 session of the District of Columbia City Council, the Department of Health Cessation Fund Amendment Act of 2017 was placed and passed into the District's budget. This legislation was a triple win when it comes to preventing and reducing tobacco use as it increased the District of Columbia's cigarette tax by $2.00 per pack to $4.50 per pack, designated 10 percent of total revenue for tobacco control programs such as the Quitline, and allocated funding to implement legislation increasing the tobacco sales to 21 passed in the city council in 2016.

The implementation of Tobacco 21 legislation and the increased tobacco tax went into effect on October 1, 2018. This means the District's current cigarette tax is the highest in the country among the 50 states and the District of Columbia. Even better, other tobacco product taxes, except for large cigars, automatically adjust to the cigarette tax rate creating parity in taxes between cigarettes and most other tobacco products. Funding for tobacco prevention and cessation programs also increased by about $1 million for fiscal year 2019 as expected.

The American Lung Association in the District of Columbia will continue to educate lawmakers on the ongoing fight against tobacco in 2018. Our goal is to build champions within the DC City Council and a groundswell of advocates to advance our goals: fund tobacco prevention and cessation programs at CDC-recommended levels, improve the city's Medicaid coverage of tobacco cessation treatments and explore the possibility of prohibiting the sale of flavored tobacco products in the city.

## District of Columbia Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $391,048,877 |
| Adult Smoking Rate: | 14.3% |
| Adult Tobacco Use Rate: | 15.6% |
| High School Smoking Rate: | N/A |
| High School Tobacco Use Rate: | N/A |
| Middle School Smoking Rate: | N/A |
| Smoking Attributable Deaths: | 790 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. Current high school smoking, tobacco use and middle school smoking rates are not available for the city.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in District of Columbia**
(202) 785-3355
www.lung.org/districtofcolumbia

# Florida Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

FLORIDA

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $70,401,719 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $2,603,379* |
| FY2019 Total Funding for State Tobacco Control Programs: | $73,005,098 |
| CDC Best Practices State Spending Recommendation: | $194,200,000 |
| Percentage of CDC Recommended Level: | 37.6% |
| State Tobacco-Related Revenue: | $1,534,700,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

Thumbs up for Florida for constitutionally protecting the allocation of tobacco settlement dollars to its tobacco control program, so a consistent investment can be made.

## Smokefree Air: B

**OVERVIEW OF STATE SMOKING RESTRICTIONS:**

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Restricted***

Casinos/Gaming Establishments: **Prohibited (tribal establishments exempt)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **Yes**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: FLA. STAT. ch. 386.201 et seq. (2011).

*Smoking is allowed in bars that make 10% or less of their sales from food.

Thumbs up for Florida voters for approving a constitutional amendment prohibiting e-cigarette use in public places and workplaces where smoking is prohibited.

## Tobacco Taxes: F

**CIGARETTE TAX:**

Tax Rate per pack of 20: **$1.339**

**OTHER TOBACCO PRODUCT TAXES:**

Tax on little cigars: **Equalized: No; Weight-Based: N/A**

Tax on large cigars: **Equalized: No; Weight-Based: N/A**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: F

**OVERVIEW OF STATE CESSATION COVERAGE:**

STATE MEDICAID PROGRAM:

Medications: **Some medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **No**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Limited counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

STATE QUITLINE:

Investment per Smoker: **$4.25; the median investment per smoker is $2.21**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Florida Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Florida** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Florida. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Florida's elected officials:

1. Increase tobacco control funding to CDC-recommended levels;
2. Increase the minimum age of sale for tobacco products to 21 years old; and
3. Strengthen Florida's smokefree air law by removing exemptions.

Florida's Constitution provides for a once every 20-year process of reviewing Florida's Constitution and proposing changes for voter consideration on the election ballot. The thirty-seven-member panel appointed to consider changes to the state Constitution convened in 2018. The American Lung Association in Florida was very engaged in two proposals, Proposal 94 and Proposal 65, being considered by the Constitution Revision Commission (CRC). Proposal 94, sponsored by Commissioner Jeannette Nunez from Miami, would have eliminated a requirement in the State Constitution that 15 percent of the funds from Florida's landmark tobacco settlement agreement be used for Tobacco Free Florida, the state's tobacco prevention program. Proposal 65, sponsored by Commissioner Lisa Carlton, would have updated Florida's Clean Indoor Air law to prohibit the use of e-cigarettes in areas where the use of cigarettes and other tobacco products are already prohibited.

With the help of advocates, the Lung Association and its partners were able to defeat CRC Proposal 94 and maintain the funding dedication for Tobacco Free Florida. Proposal 65 was successful in becoming a proposal of the Constitutional Revision Commission and appeared on the November 2018 ballot as Amendment 9. With support from 69 percent of Florida voters, Amendment 9 passed on November 6, 2018. Existing smokefree protections will now expand to include e-cigarettes as part of the Florida Clean Indoor Air law.

During the 2018 Legislative Session, the Lung Association was able to protect funding for Tobacco Free Florida and increase the total budget for the program to $70.4 million for fiscal year 2019. This funding includes a wide variety of services free of charge for people who smoke, including $13.8 million allocated for quitline services and implementation of a referral program, and an additional $7.8 million for in-person cessation counseling. The Lung Association in Florida will continue to advocate that the allocation of these dollars follows the Centers for Disease Control and Prevention (CDC)'s Best Practices for Comprehensive Tobacco Control Programs, are competitively procured and that rigorous performance measures are included in any contracts.

The Lung Association is the lead agency of the Florida Tobacco Cessation Alliance. In partnership with the Florida Department of Health, the Alliance maintains an educational website and implements a business recognition program which provides an award for employers who provide tobacco cessation coverage through their health plans.

During 2019, the American Lung Association in Florida will continue to ensure the state has a highly effective and well-funded tobacco prevention and control program, vigilantly work to improve the Clean Indoor Air Act and work to increase the minimum age of sale for tobacco products to 21 years.

## Florida State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $8,643,645,763 |
| Adult Smoking Rate: | 16.1% |
| Adult Tobacco Use Rate: | 20.3% |
| High School Smoking Rate: | 3.6% |
| High School Tobacco Use Rate: | 29.3% |
| Middle School Smoking Rate: | 1.3% |
| Smoking Attributable Deaths: | 32,300 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use and middle school smoking rates are taken from the 2018 Florida Youth Tobacco Survey. High school tobacco use includes cigarettes, cigars, smokeless tobacco, and electronic vapor products, as well as hookah, making it incomparable to other states.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Florida**
(904) 743-2933
www.lung.org/florida

# Georgia Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

GEORGIA

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $750,000 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $2,200,138* |
| FY2019 Total Funding for State Tobacco Control Programs: | $2,950,138 |
| CDC Best Practices State Spending Recommendation: | $106,000,000 |
| Percentage of CDC Recommended Level: | 2.8% |
| State Tobacco-Related Revenue: | $393,300,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: D

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Restricted**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Restricted**

Bars: **Restricted**

Casinos/Gaming Establishments: **N/A**

Retail Stores: **Restricted**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: GA. CODE ANN. §§ 31-12A-1 et seq. (2005).

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$0.37**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: No; Weight-Based: No**

Tax on large cigars: **Equalized: Yes; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: N/A**

For more information on tobacco taxes, go to: www.lung.org/slati

Thumbs down for Georgia for having the third lowest cigarette tax in the country at 37 cents per pack.

## Access to Cessation Services: F

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **Most medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **No**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$1.06; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Georgia Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Georgia** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Georgia. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Georgia's elected officials:

1. Increase tobacco control program funding;
2. Increase the number of local comprehensive smokefree air laws; and
3. Substantially increase the price of tobacco products, including electronic smoking devices.

Georgia continues to provide little state funding to programs to prevent and reduce tobacco use. Georgia's state tobacco prevention program and quitline run on less than $1 million in state funding compared to previous years when tobacco Master Settlement Agreement dollars first came into the state. Georgia ranks 49th compared to other states plus the District of Columbia in the amount of taxes levied on cigarettes. Ahead of only Virginia and Missouri, Georgia's cigarette tax is 37 cents per pack; the national state average is $1.78 per pack as of October 2018. Georgia has a growing population with increasing health needs. State leaders should strongly consider a tobacco tax increase as a source of funds to meet these challenges and reduce smoking rates.

The 2018 legislative session saw a marked increase in tobacco industry attempts to weaken Georgia's efforts to improve public health. Urged by the Lung Association and many public health advocates, the Georgia General Assembly voted down several bills introduced by tobacco industry allies. Senate Bill 418 and House Bill 948 would have preempted local governments from regulating tobacco products in any form. House Bill 877 sought to reduce tobacco taxes by 50 percent for potential future modified risk tobacco products if an order is issued by the Secretary of the U.S. Department of Health & Human Services. House Bill 835 aimed to provide special-event tobacco licenses at festivals and events at a measly $10.00 per permit.

Local elected officials took a leadership role in protecting workers and those frequenting public places from exposure to secondhand smoke. The city of Augusta passed a smokefree ordinance in June 2018 by a vote of 6 to 4, and the city of Canton expanded its smokefree ordinance to prohibit smoking in public areas in its downtown district. Work began in Atlanta, and the city of Rome on comprehensive smokefree air ordinances in the Winter of 2018.

The American Lung Association in Georgia will continue to push for increased tobacco taxes and increased funding levels for tobacco control programs as well as local smokefree ordinances in 2019.

The Georgia Legislature is overdue in increasing the state's 49th lowest in the nation cigarette tax. Also overdue are funding improvements for the state tobacco prevention program and Georgia's Quitline. These steps are proven to prevent kids from smoking and help smokers quit, saving lives and money. The American Lung Association in Georgia and tobacco control supporters will continue to educate General Assembly members on the benefits of these actions.

## Georgia State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $3,182,695,641 |
| Adult Smoking Rate: | 17.5% |
| Adult Tobacco Use Rate: | 21.9% |
| High School Smoking Rate: | 8.2% |
| High School Tobacco Use Rate: | N/A |
| Middle School Smoking Rate: | 3.2% |
| Smoking Attributable Deaths: | 11,690 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2017 Youth Tobacco Survey. A current high school tobacco use rate is not available for this state. Middle school smoking rate is taken from the 2013 Youth Tobacco Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Georgia**
(770) 434-5864
www.lung.org/georgia

# Hawaii Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

HAWAII

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $4,509,229 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $1,435,886* |
| FY2019 Total Funding for State Tobacco Control Programs: | $5,945,115 |
| CDC Best Practices State Spending Recommendation: | $13,700,000 |
| Percentage of CDC Recommended Level: | 43.4% |
| State Tobacco-Related Revenue: | $160,300,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: A

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

Casinos/Gaming Establishments: **N/A**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **Yes**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: HAW. REV. STAT. §§ 328J-1 to 328J-15 (2016).

## Tobacco Taxes: B

### CIGARETTE TAX:

Tax Rate per pack of 20: **$3.20**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: B

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **Most medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Most medications are covered**

Counseling: **Most counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$5.03; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Hawaii Tobacco Cessation Coverage page for specific sources.

## Minimum Age: A

Minimum Age of Sale for Tobacco Products: **21**

# **Hawaii** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in Hawaii. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Hawaii's elected officials:

1. Repeal preemption of local tobacco sales laws that was added in 2018;
2. Increase tobacco taxes by $1.00 per pack or more; and
3. Maintain funding for tobacco prevention and cessation programs.

During the 2018 legislative session, one victory in the fight to reduce tobacco use was registered when Senate Bill 134 was passed by the legislature, making all ten University of Hawaii campuses tobacco-free, including electronic smoking devices.

Senate Bill 2654 would have added additional protections to prevent youth from purchasing electronic smoking devices and failed to pass. Senate Bill 2304 also failed, this legislation would have prohibited retailers from selling tobacco products within 750 feet of schools and playgrounds.

At the last-minute, and behind closed doors, a preemption provision was included likely at the request of the tobacco industry in House Bill 1895, a must pass bill to provide funding for kidney dialysis centers in the state. This provision preempts local governments from passing their own laws to reduce tobacco sales, including addressing candy-flavored tobacco products, and nullifies all existing local tobacco sales laws. Smoking is one of the major risk factors for kidney cancer, so ironically this legislation that will improve kidney dialysis treatment could also worsen prevention of kidney-related disease. The legislation does require retailers selling electronic smoking devices to register with the Attorney General and establishes some youth access restrictions.

During the 2019 legislative session, the main priority of the American Lung Association in Hawaii will be to work to remove the tobacco sales preemption that was added in 2018 to ensure local governments can enact policies to protect youth and their communities from tobacco.

## Hawaii State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $526,253,732 |
| Adult Smoking Rate: | 12.8% |
| Adult Tobacco Use Rate: | 17.2% |
| High School Smoking Rate: | 6.0% |
| High School Tobacco Use Rate: | 23.2% |
| Middle School Smoking Rate: | 3.1% |
| Smoking Attributable Deaths: | 1,420 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use and middle school smoking rates are taken from the 2017 Youth Tobacco Survey. High school tobacco use includes cigarettes, cigars, smokeless tobacco, and electronic vapor products, as well as pipe, bidis, roll-your-own cigarettes, hookah, snus, dissolvable tobacco products, or other new tobacco products not listed, making it incomparable to other states.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Hawaii**
(808) 537-5966
www.lung.org/hawaii

# Idaho Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

IDAHO

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $3,627,600 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $1,155,048* |
| FY2019 Total Funding for State Tobacco Control Programs: | $4,782,648 |
| CDC Best Practices State Spending Recommendation: | $15,600,000 |
| Percentage of CDC Recommended Level: | 30.7% |
| State Tobacco-Related Revenue: | $76,700,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: C

**OVERVIEW OF STATE SMOKING RESTRICTIONS:**

Government Worksites: **Prohibited**

Private Worksites: **Restricted**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **No provision**

Casinos/Gaming Establishments: **Prohibited (tribal establishments exempt)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: IDAHO CODE §§ 39-5501 et seq. (2007).

Note: The Smokefree Air grade only examines state tobacco control law and does not reflect local smokefree ordinances. Idaho has made great strides in protecting people from secondhand smoke by passing comprehensive local smokefree ordinances that cover 13.1% of the state's population.

## Tobacco Taxes: F

**CIGARETTE TAX:**

Tax Rate per pack of 20: **$0.57**

OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: Yes; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: C

**OVERVIEW OF STATE CESSATION COVERAGE:**

STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Limited counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **No counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

STATE QUITLINE:

Investment per Smoker: **$4.52; the median investment per smoker is $2.21**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Idaho Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Idaho** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Idaho. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Idaho's elected officials:

1. Increase funding for tobacco prevention and control work in Idaho;
2. Raise the legal sale age for tobacco products to 21; and
3. Pass comprehensive smokefree air laws at the local and statewide levels.

During the 2018 legislative session, funding for tobacco control programs including tobacco cessation and tobacco prevention was dramatically reduced. In total, tobacco prevention and cessation initiatives funded by the Idaho Millennium Fund dropped from about $4.7 million in fiscal year 2018 to about $3.45 million in fiscal year 2019. The Idaho Millennium Fund is where Idaho's Master Settlement Agreement dollars are directed. The American Lung Association in Idaho will continue to work with elected officials to advocate for increased funding to keep Idaho youth from picking up their first cigarette or e-cigarette and to help those who already use tobacco and nicotine products to quit.

The effort to raise Idaho's legal sale age for tobacco products to 21 was also introduced during the 2018 legislative session and was narrowly defeated in the Senate State Affairs Committee. The Lung Association and other coalition partners will continue to educate communities and elected officials about the importance of this tool in reducing youth tobacco use and improving the health of our communities and our state.

As a member of the Smoke Free Idaho coalition, the American Lung Association in Idaho continues to advocate for the adoption of local smokefree ordinances throughout the state. More progress needs to be made at passing local smokefree ordinances before a statewide law is pursued.

The American Lung Association in Idaho will continue working to increase appropriations for tobacco prevention and cessation programs, to raise the legal sale of tobacco products to 21, and to expand local smokefree ordinances in 2019.

## Idaho State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $508,053,436 |
| Adult Smoking Rate: | 14.3% |
| Adult Tobacco Use Rate: | 20.2% |
| High School Smoking Rate: | 9.1% |
| High School Tobacco Use Rate: | 18.5% |
| Middle School Smoking Rate: | N/A |
| Smoking Attributable Deaths: | 1,800 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data come from the 2017 Youth Risk Behavior Surveillance System. A current middle school smoking rate is not available for this state.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Idaho**
(208) 345-5896
www.lung.org/idaho

# **Illinois** Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

ILLINOIS

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $9,100,000 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $3,091,979* |
| FY2019 Total Funding for State Tobacco Control Programs: | $12,191,979 |
| CDC Best Practices State Spending Recommendation: | $136,700,000 |
| Percentage of CDC Recommended Level: | 8.9% |
| State Tobacco-Related Revenue: | $1,068,800,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: A

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

Casinos/Gaming Establishments: **Prohibited**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: 410 ILL. COMP. STAT. 82/1 et seq. (2014).

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$1.98**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

Thumbs up for the city of Chicago for having the highest combined state and local cigarette tax in the country.

## Access to Cessation Services: F

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **Some medications are covered**

Counseling: **Limited counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **All 3 forms of counseling are covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$2.11; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Cessation bulletin issued**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Illinois Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

Thumbs down for Governor Rauner for vetoing legislation in 2018 that would have increased the age of sale for tobacco products to 21.

## **Illinois** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Illinois. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Illinois elected officials:

1. Increase the age of sale for all tobacco products to 21;
2. Maintain statewide funding for tobacco prevention and cessation efforts; and
3. Continue to pass smokefree air policies/laws in all workplaces, medical facilities, college campuses, multi-unit housing, parks, playgrounds, festivals, fairs, and other outdoor facilities.

During the 2018 state legislative session the main priority of the American Lung Association in Illinois was to pass a bill to increase the minimum age of sale for all tobacco products from 18 to 21. Even though there was strong opposition from all of the tobacco companies, e-cigarette companies, the Illinois Association of Wholesale Distributors, the Illinois Chamber of Commerce, the Illinois Licensed Beverage Association, the Illinois Manufacturer's Association, the Illinois Petroleum Marketers Association, the Illinois Retail Merchants Association and the Smoke Free Alternatives Coalition of Illinois, the bill passed the Illinois Senate on April 25, 2018 with 35 Yes votes and 20 No votes.

When called for an initial vote in the Illinois House of Representatives on May 29, 2018 it did not receive a majority of Yes votes and was placed on Postponed Consideration. A second House vote was taken on May 30, 2018 and Tobacco 21 passed the Illinois House of Representatives with a bipartisan 61 Yes votes, 49 No votes and 1 Present vote. Then, on August 24, 2018 Governor Bruce Rauner vetoed the bill. And unfortunately, while an override of Governor Rauner's veto did succeed in the Senate, it did not get the necessary three-fifths vote in the House during the November veto override session. On a more positive note, 16 new local Tobacco 21 ordinances were passed in 2018, bringing the total number of local Tobacco 21 laws to 28, covering over one-third of the state's population.

With new Governor J.B. Pritzker taking office, the American Lung Association in Illinois and partners hope to pass and get signed into law a Tobacco 21 bill during 2019. The Lung Association will also continue to work with our partners to ensure tobacco control programs are adequately funded, defend the Smoke Free Illinois Act from any weakening attempts and continue to create a norm of smokefree workplaces, multi-unit housing and outdoor recreational areas.

### Illinois State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $5,495,627,110 |
| Adult Smoking Rate: | 15.5% |
| Adult Tobacco Use Rate: | 19.2% |
| High School Smoking Rate: | 7.6% |
| High School Tobacco Use Rate: | 18.6% |
| Middle School Smoking Rate: | 2.0% |
| Smoking Attributable Deaths: | 18,280 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use rates are taken from the 2017 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the 2015 Youth Tobacco Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Illinois**
(217) 971-7274
www.lung.org/illinois

# Indiana Report Card

AMERICAN LUNG ASSOCIATION.

STATE OF TOBACCO CONTROL 2019

INDIANA

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $7,500,000 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $2,236,579* |
| FY2019 Total Funding for State Tobacco Control Programs: | $9,736,579 |
| CDC Best Practices State Spending Recommendation: | $73,500,000 |
| Percentage of CDC Recommended Level: | 13.2% |
| State Tobacco-Related Revenue: | $556,900,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

Thumbs up for Indiana for increasing funding for its tobacco control program by over $2.5 million this year from the previous two-year state budget.

## Smokefree Air: C

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Restricted***

Casinos/Gaming Establishments: **No provision**

Retail Stores: **Prohibited (retail tobacco and cigar specialty stores exempt)**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: IND. CODE. §§ 7.1-5-12 et seq. (2015).

*Smoking is allowed in bars/taverns that do not employ persons under age 18 and do not allow persons under age 21 to enter.

Note: The Smokefree Air grade only examines state tobacco control law and does not reflect local smokefree ordinances. Indiana has made great strides in protecting people from secondhand smoke by passing comprehensive local smokefree ordinances that cover 33.5% of the state's population.

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$0.995**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: Yes; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: D

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **All 3 forms of counseling are covered**

Barriers to Coverage: **Substantial barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$1.39; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **Tobacco surcharge for Medicaid enrollees**

Citation: See Indiana Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Indiana** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in Indiana. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Indiana elected officials:

1. Raise the cigarette excise tax by $2.00 per pack;
2. Restore funding for tobacco education and cessation programs; and
3. Pass a comprehensive smokefree air law that covers bars, clubs, and gaming venues.

During the 2018 legislative session, the American Lung Association in Indiana continued working toward a goal of raising the cigarette tax. Alongside partners in the "Raise It for Health" campaign, the Lung Association's goal is to significantly increase the cigarette tax in order to drive down smoking rates, prevent youth from becoming addicted, and to generate funding for tobacco education and other crucial health programs.

In 2018, the bill supported by our coalition made a strong statement by proposing a $2.00 addition to the cigarette tax, plus an increase in the legal tobacco sales age from 18 to 21. The bill passed unanimously from the House Public Health Committee and was referred to the House Ways and Means Committee for further consideration. Unfortunately, it did not advance any further. Notably in 2018, Indiana gained the dubious distinction of having the lowest cigarette tax in the region after Kentucky's legislature raised that state's tax rate. The urgency for action on this issue in Indiana continues to rise.

At the municipal level, support continues to grow for smokefree public spaces. Austin and North Manchester enacted comprehensive smokefree air laws that included bars, clubs, and e-cigarettes. Zionsville updated its comprehensive smokefree air policy to become completely tobacco-free, including e-cigarettes. Several other cities and towns expanded smokefree public spaces like parks and adopted restrictions on e-cigarettes: Seymour, North Vernon, Lafayette, Fishers, and Goshen. Lawmakers have not seriously considered stronger secondhand smoke protections at the state level since passing a weak law in 2012.

An independent study released from the Richard M. Fairbanks Foundation in 2018 analyzed Indiana's tobacco control program. Among the report's key findings: the State's tobacco control program, once a national leader, is now "woefully underfunded" and lags behind other states due to years of declining investment. Even after a $2.5 million increase in the program's budget appropriation in 2017, Indiana spends less than half the national average per capita. Fortunately, polling shows strong support for a higher cigarette tax among Hoosiers.

2019 will be an important year for tobacco control in the Indiana legislature. As the biennial state budget bill is negotiated, the American Lung Association in Indiana will continue to advocate for a significant increase in the cigarette tax. Raising the cigarette tax will lower smoking rates and generate funding for life-saving health programs. Legislators have an opportunity to once again make Indiana a leader in the fight against tobacco.

## Indiana State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $2,930,404,456 |
| Adult Smoking Rate: | 21.8% |
| Adult Tobacco Use Rate: | 27.4% |
| High School Smoking Rate: | 11.2% |
| High School Tobacco Use Rate: | 32.4% |
| Middle School Smoking Rate: | 1.8% |
| Smoking Attributable Deaths: | 11,070 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data is taken from the 2015 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the 2016 Youth Tobacco Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Indiana**
(317) 819-1181
www.lung.org/indiana

# Iowa Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

IOWA

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $4,021,225 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $1,588,630* |
| FY2019 Total Funding for State Tobacco Control Programs: | $5,609,855 |
| CDC Best Practices State Spending Recommendation: | $30,100,000 |
| Percentage of CDC Recommended Level: | 18.6% |
| State Tobacco-Related Revenue: | $274,200,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: A

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

Casinos/Gaming Establishments: **Restricted (tribal establishments exempt)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: IOWA CODE §§ 142D.1 to 142D.9 (2008).

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$1.36**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: D

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **All 3 types of counseling are covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$1.84; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Iowa Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Iowa** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Iowa. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Iowa's elected officials:

1. Increase the cigarette tax by $1.50 per pack;
2. Reduce exposure to secondhand smoke through comprehensive smokefree and tobacco-free laws and policies in all public places; and
3. Increase funding to the Iowa Department of Public Health, Division of Tobacco Use Prevention and Control.

In 2018, the American Lung Association in Iowa advocated for an increase in funding for the Division of Tobacco Use Prevention and Control. To assist in revenue generation, partners proposed a $1.50 per pack increase to the cigarette tax. A House bill to increase the tax by $1.50 was introduced but ultimately, the bill did not move forward.

Other efforts in the 2018 legislative session included a bill to increase the minimum sales age of tobacco from 18 to 21. The bill also did not move forward. The American Lung Association in Iowa enters the 2019 Legislative session with a newly elected governor, Governor Kim Reynolds. Previously, Reynolds was appointed following the appointment of Governor Terry Branstad as Ambassador to China in 2017.

Iowans continue to face significant barriers to receiving tobacco cessation services. Iowans who rely on Medicaid for their healthcare coverage are members of Managed Care Organizations (MCO). People who want to quit using tobacco must go through their MCO to receive tobacco cessation services. MCOs require prior authorization for cessation medications. This can lead to delays in treatment and patients abandoning their plans to quit using tobacco as well as administrative burdens for physicians. These processes result in limiting Iowans' access to the resources they need to quit.

Community Partnerships continue to make a significant impact in every Iowa County. Local organizations provide support for youth prevention, tobacco cessation and policy change to reduce tobacco use and eliminate exposure of secondhand smoke. Continuing to protect and working to increase funding for these effective programs is vital in efforts to prevent youth from ever starting to use tobacco products in the first place and help current users quit.

On July 1, 2018, Iowa celebrated 10 years smokefree as a state. Although this victory is one to be celebrated, our state still has much more work to do. In 2019, the American Lung Association in Iowa, along with our partners, will advocate for an increase in the cigarette tax by $1.50 per pack and ask that a portion of the new revenue go to tobacco prevention and cessation programs. The Lung Association will also continue to advocate for closing loopholes in the Smoke Free Air Act, as casino workers and patrons continue to be put at serious health risks due to secondhand smoke exposure because smoking is still allowed in Iowa casinos.

## Iowa State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $1,285,256,462 |
| Adult Smoking Rate: | 17.1% |
| Adult Tobacco Use Rate: | 23.0% |
| High School Smoking Rate: | 9.9% |
| High School Tobacco Use Rate: | 19.9% |
| Middle School Smoking Rate: | 2.0% |
| Smoking Attributable Deaths: | 5,070 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use rates are taken from the 2017 Youth Risk Behavior Surveillance System. Middle school (8th grade only) smoking rates are taken from the 2016 Iowa Youth Survey; results are rounded to the nearest whole number.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Iowa**
(515) 309-9507
www.lung.org/iowa

# Kansas Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

KANSAS

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $847,014 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $1,469,625* |
| FY2019 Total Funding for State Tobacco Control Programs: | $2,316,639 |
| CDC Best Practices State Spending Recommendation: | $27,900,000 |
| Percentage of CDC Recommended Level: | 8.3% |
| State Tobacco-Related Revenue: | $190,000,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: A

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

Casinos/Gaming Establishments: **Restricted (casino floors and tribal establishments exempt)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: KAN. STAT. ANN. §§ 21-6109 to 21-6116 (2015).

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$1.29**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: No; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: F

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **All 3 forms of counseling are covered**

Barriers to Coverage: **Few barriers exist to access care**

Medicaid Expansion: **No**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Most counseling is covered**

Barriers to Coverage: **Limited barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$0.44; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

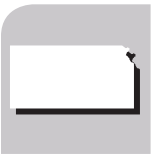
Citation: See Kansas Tobacco Cessation Coverage page for specific sources.

Thumbs up for Kansas for implementing comprehensive coverage for all tobacco cessation medications and types of counseling to Medicaid enrollees with limited barriers in 2018.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Kansas** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in Kansas. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Kansas' elected officials:

1. Increase funding for tobacco prevention to Centers for Disease Control and Prevention recommended levels;
2. Pass local or state laws raising the tobacco sales age to 21; and
3. Increase taxes on tobacco products by significant amounts.

During the 2018 legislative session, the American Lung Association in Kansas partnered with The Dollars and Sense 4 Kansas coalition to advocate for a $1.50 per pack increase in the tax on cigarettes and an equal tax on other tobacco products. These measures would have generated $5 million of new revenue devoted to tobacco prevention and cessation efforts. In addition to generating $80-$110 million in new annual revenue (that can fund essential state investments like KanCare Expansion), this tax is projected to prevent 10,200 premature smoking-caused deaths and prevent 16,200 Kansas kids from ever becoming adult smokers. This is a proven way to save lives that has strong support from Kansas voters across the political spectrum. Unfortunately, no action was taken during the 2018 legislative session. The American Lung Association in Kansas will continue to advocate for an increase in the 2019 legislative session.

The Lung Association teamed up with the Greater Kansas City Chamber of Commerce and other partners to promote Tobacco 21 in the Kansas City metro area in 2018. Tobacco 21 raises the legal age of sale for tobacco products from 18 to 21. Thirty-three communities in the greater metropolitan Kansas City area have adopted Tobacco 21 ordinances, including 23 communities in Kansas and ten communities in Missouri.

This represents more than 1.5 million residents of the greater Kansas City metropolitan area now living in Tobacco 21 communities with more on the way. The Lung Association has been asked to make presentations on Tobacco 21 to multiple other communities in Kansas and Missouri since adoption of these initial ordinances.

The Lung Association received funding to work on tobacco point of sale issues in the Kansas City area. The grant rallies partners, advocates and supporters to implement policies in Jackson County, Missouri and Johnson County, Kansas to restrict the sale of flavored tobacco products (i.e. candy, menthol, etc.) to adult-only tobacco stores.

During year one of the grant, youth and community engagement events were held to educate the community on best practices for these youth protection measures.

During the 2019 legislative session, the American Lung Association in Kansas will continue to focus on lung health and work with partners to push for increased tobacco taxes and funding for tobacco control programs. The Lung Association will also continue to advocate for passage of Tobacco 21 laws at the local and statewide levels.

## Kansas State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $1,128,040,688 |
| Adult Smoking Rate: | 17.4% |
| Adult Tobacco Use Rate: | 23.6% |
| High School Smoking Rate: | 7.2% |
| High School Tobacco Use Rate: | 17.1% |
| Middle School Smoking Rate: | 1.2% |
| Smoking Attributable Deaths: | 4,390 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use rates are taken from the 2017 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the 2013 Youth Tobacco Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Kansas**
(913) 353-9165
www.lung.org/kansas

# Kentucky Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

KENTUCKY

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $3,773,000 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $2,114,376* |
| FY2019 Total Funding for State Tobacco Control Programs: | $5,887,376 |
| CDC Best Practices State Spending Recommendation: | $56,400,000 |
| Percentage of CDC Recommended Level: | 10.4% |
| State Tobacco-Related Revenue: | $507,300,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

Thumbs up for Kentucky for increasing funding for its state tobacco prevention program by over $1 million this fiscal year.

## Smokefree Air: F

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Restricted (prohibited in state government buildings)**

Private Worksites: **No provision**

Schools: **Restricted**

Child Care Facilities: **No provision**

Restaurants: **No provision**

Bars: **No provision**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **No provision**

Recreational/Cultural Facilities: **No provision**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **No**

Preemption: **No**

Citation: KY REV. STAT. ANN. §§ 61.165 (2006), 61.167 (2004), 438.050 (1988) & EXEC. ORDER 2014-0747 (2014).

Note: The Smokefree Air grade only examines state tobacco control law and does not reflect local smokefree ordinances. Kentucky has made great strides in protecting people from secondhand smoke by passing comprehensive local smokefree ordinances that cover 34.3% of the state's population.

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$1.10***

*On July 1, 2018, the cigarette tax increased from $0.60 to $1.10 per pack.

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: No; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: C

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **All 3 types of counseling are covered**

Barriers to Coverage: **No barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Most counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$0.64; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **Limits tobacco surcharges**

Citation: See Kentucky Tobacco Cessation Coverage page for specific sources.

Thumbs up for Kentucky for providing comprehensive coverage for all tobacco cessation medications and types of counseling to Medicaid enrollees with no barriers.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Kentucky** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States. In Kentucky, both the smoking rate and the smoking-related death rate are one of the highest in the nation. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Kentucky's elected officials:

1. Increase funding for the Kentucky Tobacco Prevention and Cessation Program;
2. Support a statewide law to make all K-12 schools 100 percent tobacco-free; and
3. Enact legislation to raise the retail sales age of tobacco products to 21 years old.

During the 2018 legislative session, a provision in the 2018 budget bill enacted by the Kentucky legislature increased the state cigarette tax from 60 cents to $1.10 per pack. A compromise from the proposed $1.00 per pack tax increase supported by the American Lung Association and other public health partners in the state, this provision falls short of the goal of significantly reducing Kentucky's smoking rates and smoking-related death and disease rates.

Other provisions included in the 2018 budget package provided funding for important lung cancer research conducted at the University of Kentucky and the University of Louisville and boosted funding for the Kentucky Tobacco Prevention and Cessation program to $3.77 million. This represents over a $1 million increase in funding for the program, which is a step in the right direction. However, it is still $52.6 million short of the recommended spending level by the Centers for Disease Control and Prevention.

Separately, legislation to repeal Kentucky's state law that prohibits local regulation of the distribution, sales, or display of tobacco products died in committee.

Polling conducted by the Foundation for a Healthy Kentucky shows that more than 7 in 10 Kentuckians support a statewide smokefree law in most public places, the highest level of support ever recorded by the Foundation. Importantly, such a law is supported in every region of the state and across party lines.

Simultaneously, the state Tobacco Prevention and Cessation Program continues to distribute funds to local and district health departments across the state to support educators' and tobacco coordinators' efforts to provide education in schools, conduct cessation programs, and finance media outreach.

The American Lung Association in Kentucky will continue to work with our many health coalition partners and others to grow and activate our grassroots network statewide, and to advance tobacco control and prevention initiatives at the state and local levels. As the legislature begins its work in 2019, the Lung Association will continue our efforts to educate policy makers, business leaders and the media on the importance of the American Lung Association's goals to reduce tobacco use and protect public health.

## Kentucky State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $1,926,976,238 |
| Adult Smoking Rate: | 24.6% |
| Adult Tobacco Use Rate: | 32.1% |
| High School Smoking Rate: | 14.3% |
| High School Tobacco Use Rate: | 26.0% |
| Middle School Smoking Rate: | N/A |
| Smoking Attributable Deaths: | 8,860 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data come from the 2017 Youth Risk Behavior Surveillance System. A current middle school smoking rate is not available for this state.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Kentucky**
(502) 363-2652
www.lung.org/kentucky

# Louisiana Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

LOUISIANA

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $14,846,511 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $1,233,018* |
| FY2019 Total Funding for State Tobacco Control Programs: | $16,079,529 |
| CDC Best Practices State Spending Recommendation: | $59,600,000 |
| Percentage of CDC Recommended Level: | 27.0% |
| State Tobacco-Related Revenue: | $459,600,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: C

**OVERVIEW OF STATE SMOKING RESTRICTIONS:**

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **No provision**

Casinos/Gaming Establishments: **Restricted (tribal establishments exempt)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: LA REV. STAT. ANN. §§ 40:1291.1 to 1291.24 (2015).

Note: The Smokefree Air grade only examines state tobacco control law and does not reflect local smokefree ordinances. Louisiana has made great strides in protecting people from secondhand smoke by passing comprehensive local smokefree ordinances that cover 26.1% of the state's population.

## Tobacco Taxes: F

**CIGARETTE TAX:**

Tax Rate per pack of 20: **$1.08**

OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: No; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: D

**OVERVIEW OF STATE CESSATION COVERAGE:**

STATE MEDICAID PROGRAM:

Medications: **Some medication is covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Limited counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

STATE QUITLINE:

Investment per Smoker: **$1.27; the median investment per smoker is $2.21**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Insurance Commissioner bulletin**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Louisiana Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Louisiana** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in Louisiana. To address this enormous toll, the American Lung Association in Louisiana calls for the following actions to be taken by our elected officials:

1. Strengthen the existing statewide smokefree law to include bar and casino worker protections;
2. Ensure smokefree protections for all bars and casino workers in municipalities throughout Louisiana; and
3. Sustain tobacco prevention and cessation funding.

Tobacco prevention and control legislation was once again not a priority for the members of the Louisiana Legislature in 2018. Representative Dustin Miller introduced House Bill 881 that would have extended public health protections from secondhand smoke exposure to all workers in workplaces and public places, including bars and gaming facilities. It would have updated the existing Louisiana Smokefree Air Act. Due to multiple factors, the HB 881 was unable to move out of committee.

In follow-up to House Bill 881, House Continuing Resolution 76 was introduced by Representative Miller to allow for further evaluation of tobacco-related illnesses resulting from secondhand smoke exposure. The Study Committee is composed of 22 representatives from state agencies, public health institutions, nonprofit organizations and the business community impacted by tobacco use in Louisiana. The Committee will meet to review the literature on tobacco use and impact of secondhand smoke exposure in Louisiana with a final report submitted to the Legislature in early 2019.

Despite the lack of support for a statewide smokefree law, there is support within local municipalities for public health protections from secondhand smoke. The East Baton Rouge Parish implemented an ordinance on June 1, 2018 to protect all residents and workers in the city, including all bar and casino workers, from the dangers of secondhand smoke exposure. The City of Abbeville and the Town of Roseland have also passed and implemented comprehensive smokefree air protections for all workers and residents.

Louisiana has had significant success with cessation efforts through Quit with Us, LA and the Smoking Cessation Trust. Quit with Us, LA is the free statewide cessation program offering telephone and online services to Louisiana residents age 13 and older who are ready to quit within the next 30 days. The Smoking Cessation Trust ("SCT") is the result of a 2011 court judgment in a class action lawsuit that established a 10-year smoking cessation program to benefit all Louisiana residents who smoked a cigarette before September 1, 1988. The program began registering eligible recipients in 2012 and, to date, has registered nearly 100,000 Louisiana citizens. SCT members receive no cost cessation services, including medications, individual and group cessation counseling or telephone quit-line support.

In 2019, the American Lung Association in Louisiana will join our tobacco control partners to educate state legislators about the health and economic benefits of strong tobacco control policies, including a comprehensive statewide smokefree air law. The Lung Association will also continue to work with partners in the Coalition for a Tobacco Free Louisiana to ensure successful passage and preservation of comprehensive local smokefree ordinances.

## Louisiana State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $1,891,666,196 |
| Adult Smoking Rate: | 23.1% |
| Adult Tobacco Use Rate: | 29.2% |
| High School Smoking Rate: | 12.3% |
| High School Tobacco Use Rate: | 25.2% |
| Middle School Smoking Rate: | 3.8% |
| Smoking Attributable Deaths: | 7,210 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use rates are taken from the 2017 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the 2017 Youth Tobacco Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Louisiana**
(504) 828-5864
www.lung.org/louisiana

# Maine Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

MAINE

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $4,850,514 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $1,526,813* |
| FY2019 Total Funding for State Tobacco Control Programs: | $6,377,327 |
| CDC Best Practices State Spending Recommendation: | $15,900,000 |
| Percentage of CDC Recommended Level: | 40.1% |
| State Tobacco-Related Revenue: | $188,500,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

Thumbs down for Maine for reducing funding for its tobacco control program by over $2.5 million from the previous two-year state budget.

## Smokefree Air: A

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

Casinos/Gaming Establishments: **Restricted (tribal establishments exempt)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **Partially**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: ME REV. STAT. ANN. Tit. 22, §§ 1541 to 1545 (2015), 1547 (2007), 1580-A (2009) & CODE of ME RULES 10-144, Ch. 249 (2006).

## Tobacco Taxes: D

### CIGARETTE TAX:

Tax Rate per pack of 20: **$2.00**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: No; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: A

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **All 3 types of counseling are covered**

Barriers to Coverage: **Limited barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Most medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$14.64; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Maine Tobacco Cessation Coverage page for specific sources.

Thumbs up for Maine for providing comprehensive coverage for all tobacco cessation medications and types of counseling with minimal barriers to Medicaid enrollees.

## Minimum Age: A

Minimum Age of Sale for Tobacco Products: **21**

Thumbs up for Maine for implementing its law to increase the tobacco sales age to 21.

# **Maine** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Maine. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Maine's elected officials:

1. Restore the funding cut from the Maine tobacco control program and increase funding to the Centers for Disease Control and Prevention recommended level;
2. Raise the cigarette tax by a minimum of $1.50 per pack and equalize the excise tax across all tobacco products.
3. Enact legislation prohibiting flavors in all tobacco products

2018 was the "short session" of the Maine Legislature and as a result saw fewer bills being introduced that focused on tobacco. A major victory was realized in the early days of the 2018 session when a perennial bad bill that would have allowed the licensing of tobacco retailers to serve alcohol in their establishments was defeated by an overwhelming margin. This measure has been introduced regularly with the margin of defeat growing thus protecting Maine's strong smokefree laws from rollbacks.

During 2018, now former Governor LePage continued to object to the state's Tobacco 21 law approved over his veto in 2017. However, the legislature made no serious attempts to revisit the issue, and the law was implemented on July 1, 2018 without any delays. This is a big victory for the Lung Association and the state of Maine. The Lung Association thanks our supporters in the legislature for standing strong on this issue.

The Lung Association also spent a significant amount of time in 2018 engaging and educating legislators who were working on Maine's recreational marijuana implementation to ensure that their efforts did not undermine the state's smokefree laws.

The American Lung Association in Maine will continue to work with our coalition partners the Maine Public Health Association, the American Heart Association, Maine Medical Association, American Cancer Society and others to advance tobacco control and prevention efforts and defend our successful programs and smokefree policies against rollbacks. As the legislature begins its work in 2019 we will continue to grow our coalition to educate policy makers, business leaders and the media of the importance of the American Lung Association's goals to reduce tobacco use and protect public health.

## Maine State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $811,120,557 |
| Adult Smoking Rate: | 17.3% |
| Adult Tobacco Use Rate: | 21.1% |
| High School Smoking Rate: | 8.7% |
| High School Tobacco Use Rate: | 22.5% |
| Middle School Smoking Rate: | 1.9% |
| Smoking Attributable Deaths: | 2,390 |

Adult smoking and tobacco use data come from CDC's 2016 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data come from the 2017 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the 2017 Maine Integrated Youth Health Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Maine**
(207) 622-6394
www.lung.org/maine

# Maryland Report Card

AMERICAN LUNG ASSOCIATION.

STATE OF TOBACCO CONTROL 2019

MARYLAND

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $10,475,581 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $2,324,036* |
| FY2019 Total Funding for State Tobacco Control Programs: | $12,799,617 |
| CDC Best Practices State Spending Recommendation: | $48,000,000 |
| Percentage of CDC Recommended Level: | 26.7% |
| State Tobacco-Related Revenue: | $525,000,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: A

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

Casinos/Gaming Establishments: **Prohibited**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: MD. CODE ANN., HEALTH-GEN. §§ 24-501 to 24-511 (2008) & MD. CODE ANN., LAB. & EMPLOY. §§ 5-101 & 5-608 (2008).

## Tobacco Taxes: D

### CIGARETTE TAX:

Tax Rate per pack of 20: **$2.00**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: B

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Counseling coverage varies by plan**

Barriers to Coverage: **No barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$3.39; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Yes**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Maryland Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

Thumbs down for Maryland for failing to pass a law to increase the tobacco sales age to 21.

# **Maryland** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in Maryland. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Maryland's elected officials:

1. Increase the age of sale for tobacco products to 21 years of age;
2. Create parity between the tax on cigarettes and other tobacco products; and
3. Fund tobacco prevention and cessation programs at the Centers for Disease Control and Prevention-recommended level.

During the 2018 legislative session, identical bills supported by the American Lung Association in Maryland were introduced in the state House of Representatives and Senate to raise the minimum legal sales age of tobacco products to 21. Both bills received a hearing, which featured compelling testimony from youth in Maryland about how e-cigarette use in particular was widespread in their schools. Unfortunately, neither bill was acted on further by either the House or Senate during 2018.

A bill was also introduced to dedicate funding to tobacco prevention and cessation programs with a requirement to spend $21 million each year on tobacco control efforts. This bill also did not pass out of committee. Overall, state funding for tobacco prevention and cessation programs in Maryland for fiscal year 2019 was slightly below last year at $9.7 million. The program is funded by tobacco Master Settlement Agreement payments.

The American Lung Association in Maryland will continue to educate lawmakers on the ongoing fight against tobacco. Our goal is to build champions within the legislature and a groundswell of advocates to advance our goals: legislation to increase the minimum age of sale for tobacco products to 21, parity between the tax on cigarettes and other tobacco products, and increased funding for tobacco prevention and cessation programs.

With a new and high-ranking sponsor for the Tobacco 21 bill in the House and the bill's Senate sponsor taking over as chairperson of the main committee of jurisdiction in the Senate, the Lung Association is optimistic about the chances for that bill in 2019.

## Maryland State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $2,709,568,436 |
| Adult Smoking Rate: | 13.8% |
| Adult Tobacco Use Rate: | 16.7% |
| High School Smoking Rate: | 8.2% |
| High School Tobacco Use Rate: | 21.6% |
| Middle School Smoking Rate: | N/A |
| Smoking Attributable Deaths: | 7,490 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data come from the 2017 Youth Risk Behavior Surveillance System. A current middle school smoking rate is not available for this state.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Maryland**
(302) 565-2074
www.lung.org/maryland

# Massachusetts Report Card

AMERICAN LUNG ASSOCIATION.

STATE OF TOBACCO CONTROL 2019

MASSACHUSETTS

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $4,218,872 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $3,148,623* |
| FY2019 Total Funding for State Tobacco Control Programs: | $7,367,495 |
| CDC Best Practices State Spending Recommendation: | $66,900,000 |
| Percentage of CDC Recommended Level: | 11.0% |
| State Tobacco-Related Revenue: | $864,500,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: A

**OVERVIEW OF STATE SMOKING RESTRICTIONS:**

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited (allowed in smoking bars)**

Casinos/Gaming Establishments: **Prohibited**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **Yes**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: MASS. GEN. LAWS ch. 270, § 22 (2004).

## Tobacco Taxes: B

**CIGARETTE TAX:**

Tax Rate per pack of 20: **$3.51**

OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: C

**OVERVIEW OF STATE CESSATION COVERAGE:**

STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **All 3 types of counseling are covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers all 7 medications**

Counseling: **Covers all 3 forms of counseling**

Barriers to Coverage: **Some barriers exist to access care**

STATE QUITLINE:

Investment per Smoker: **$1.37; the median investment per smoker is $2.21**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **Prohibits tobacco surcharges**

Citation: See Massachusetts Tobacco Cessation Coverage page for specific sources.

## Minimum Age: A

Minimum Age of Sale for Tobacco Products: **21**

Thumbs up for Massachusetts for passing statewide legislation in 2018 to increase the tobacco sales age to 21.

# **Massachusetts** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Massachusetts. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Massachusetts's elected officials:

1. Fund tobacco prevention and cessation programs at the Centers for Disease Control and Prevention (CDC)-recommended level;
2. Enact legislation prohibiting the sale of flavored tobacco products; and
3. Pass a significant increase on the tax on cigarettes.

The Lung Association scored a big win in Massachusetts during the 2018 legislative session with the passage of legislation to raise the retail sales age of tobacco products to 21 statewide. Massachusetts was an early pioneer of the initiative with over 150 localities in the state passing ordinances; however, statewide efforts had been stymied in past years. In addition to raising the retail sales age, the same comprehensive tobacco control legislation added electronic cigarettes to the state's smokefree workplace law and prohibits tobacco sale in pharmacies. Massachusetts is the first state to prohibit tobacco sales in pharmacies statewide, and local communities were also trailblazers by approving local ordinances on this issue prior to state action.

Another small legislative victory was realized in Massachusetts when the Governor signed the state budget bill into law, which included a $500,000 increase in funding for tobacco control programs. This means the increased state funding is now officially in place for the current state fiscal year (2019). However, funding remains far short of historical levels as well as the CDC-recommended level in Massachusetts.

The American Lung Association in Massachusetts will continue to work with our state coalition partners to advance tobacco control and prevention efforts and defend our successful programs and smokefree policies against rollbacks. As the legislature begins its work in 2019 we will continue to grow our coalition to educate policy makers, business leaders and the media of the importance of the American Lung Association's goals to reduce tobacco use and protect public health.

## Massachusetts State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $4,080,690,302 |
| Adult Smoking Rate: | 13.7% |
| Adult Tobacco Use Rate: | 16.9% |
| High School Smoking Rate: | 6.4% |
| High School Tobacco Use Rate: | 24.6% |
| Middle School Smoking Rate: | 1.4% |
| Smoking Attributable Deaths: | 9,300 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data come from the 2017 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the 2015 Massachusetts Youth Health Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Massachusetts**
(781) 890-4262
www.lung.org/massachusetts

# Michigan Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

MICHIGAN

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $1,631,500 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $3,530,398* |
| FY2019 Total Funding for State Tobacco Control Programs: | $5,161,898 |
| CDC Best Practices State Spending Recommendation: | $110,600,000 |
| Percentage of CDC Recommended Level: | 4.7% |
| State Tobacco-Related Revenue: | $1,216,600,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: C

**OVERVIEW OF STATE SMOKING RESTRICTIONS:**

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited (allowed in cigar bars)**

Casinos/Gaming Establishments: **Restricted (tribal establishments exempt)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes (restaurants and bars only)**

Citation: MICH. COMP. LAWS §§ 333.12601 to 333.12615 & 333.12905 (2010).

## Tobacco Taxes: F

**CIGARETTE TAX:**

Tax Rate per pack of 20: **$2.00**

OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: No; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: D

**OVERVIEW OF STATE CESSATION COVERAGE:**

STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Most counseling is covered**

Barriers to Coverage: **Minimal barriers exist to access care**

Medicaid Expansion: **Yes**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

STATE QUITLINE:

Investment per Smoker: **$0.43; the median investment per smoker is $2.21**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Michigan Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Michigan** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in Michigan. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Michigan's elected officials:

1. Pass a state law to increase the minimum age of sale for tobacco products to 21 in Michigan;
2. Increase funding for tobacco prevention and cessation programs; and
3. Match the tax on non-cigarette forms of tobacco like spit tobacco, cigars and hookah to the cigarette tax.

2019 will bring a change in governor's office as term-limits prevented Governor Rick Snyder from running for a third term. The American Lung Association in Michigan hopes the new administration will be supportive of increasing funding for tobacco prevention and cession services. Michigan currently only spends 4.5 percent of what is recommended by the Centers for Disease Control and Prevention for a state of our size. The legislature is expected to remain resistant to tax increases, so support for an increase in tobacco taxes is not likely to be considered this year.

The American Lung Association in Michigan worked with a diverse group of stakeholders to help promote a statewide law in Michigan to increase the minimum age of sale for tobacco products to 21 often referred to as Tobacco 21 law. House Bill 4736, is a part of a four-bill bipartisan package that would also add restrictions on other smoking and tobacco products. In addition to raising the smoking age, the bill would raise the fines for those who sell tobacco or related items to underage customers. It would also make breaking the law a lower offense—from a misdemeanor to a civil infraction—and would raise fines from $50 to $1,000 for a first offense.

While the bill remained stuck in the House Committee on Regulatory Reform, it is hoped that the new legislature will hold a hearing on this legislation to begin the dialog on why this is important to the health of Michigan's youth. The local Genesee County Tobacco 21 Ordinance remains unenforceable due to a Circuit Court ruling that the ordinance is preempted by the state's Age of Majority Act. That ruling is being appealed, but it just reinforces the need for a statewide Tobacco 21 law.

Polls show that 65 percent of Michigan voters support raising the minimum age for the sale of tobacco products from 18 to 21. The Lung Association in Michigan believes now is the time to act.

As we look ahead to 2019, the American Lung Association in Michigan will continue to work with a broad coalition of stakeholders to advocate for increased funding for evidence-based tobacco prevention and cessation services, and to pass a state Tobacco 21 law in Michigan.

## Michigan State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $4,589,784,016 |
| Adult Smoking Rate: | 19.3% |
| Adult Tobacco Use Rate: | 24.0% |
| High School Smoking Rate: | 10.5% |
| High School Tobacco Use Rate: | 22.8% |
| Middle School Smoking Rate: | N/A |
| Smoking Attributable Deaths: | 16,170 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data come from the 2017 Youth Risk Behavior Surveillance System. A current middle school smoking rate is not available for this state.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Michigan**
(248) 784-2000
www.lung.org/michigan

# Minnesota Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

MINNESOTA

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $14,970,426 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $2,188,096* |
| FY2019 Total Funding for State Tobacco Control Programs: | $17,158,522 |
| CDC Best Practices State Spending Recommendation: | $52,900,000 |
| Percentage of CDC Recommended Level: | 32.4% |
| State Tobacco-Related Revenue: | $703,600,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: A

**OVERVIEW OF STATE SMOKING RESTRICTIONS:**

Government Worksites: **Prohibited (workplaces with two or fewer employees exempt)**

Private Worksites: **Prohibited (workplaces with two or fewer employees exempt)**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

Casinos/Gaming Establishments: **Prohibited (tribal establishments exempt)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: MINN. STAT. §§ 144.411 to 144.417 (2014).

## Tobacco Taxes: B

**CIGARETTE TAX:**

Tax Rate per pack of 20: **$3.04**

OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: A

**OVERVIEW OF STATE CESSATION COVERAGE:**

STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Most counseling is covered**

Barriers to Coverage: **Limited barriers exist to access care**

Medicaid Expansion: **Yes**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **All 3 types of counseling are covered**

Barriers to Coverage: **Some barriers exist to access care**

STATE QUITLINE:

Investment per Smoker: **$13.18*; the median investment per smoker is $2.21**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Minnesota Tobacco Cessation Coverage page for specific sources.

*The Minnesota quitline (QUITPLAN Helpline) is legally restricted to providing services for the uninsured and underinsured. Therefore, investment per smoker was calculated using the quitline budget as the numerator, and the number of uninsured tobacco users in Minnesota as the denominator. The Minnesota investment per smoker was not included in the calculation of the median investment per smoker.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Minnesota** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in Minnesota. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Minnesota's elected officials:

1. Secure funding for proven tobacco cessation and prevention strategies, including investing new money for tobacco cessation services and preserving existing funding for the Statewide Health Improvement Partnership;
2. Raise the tobacco sales age to 21; and
3. Reduce youth access to menthol-, fruit- and candy flavored tobacco products.

During the 2018 Legislative Session the American Lung Association in Minnesota as part of the Minnesotans for a Smoke-Free Generation statewide coalition focused on: securing funding for tobacco cessation services, increasing the tobacco sales age to 21, and protecting the historic tax increases on all tobacco products that passed in 2013.

Funded by the tobacco settlement, ClearWay MinnesotaSM provides QUITPLAN Services in Minnesota to help people quit. ClearWay Minnesota will end by 2022 and QUITPLAN Services will end in March of 2020. In order to assure Minnesotans continue to have access to free cessation services, funding for the Minnesota Department of Health was sought during the 2018 Legislative session. While funding was included in a final omnibus bill, the funding sources was not sustainable. Ultimately, Governor Dayton vetoed the entire omnibus supplemental budget bill. Securing funding for cessation services from long-term, sustainable funding sources will continue to be a top priority in 2019.

At the local level, a number of cities passed Tobacco 21 policies in 2018, bringing Minnesota's total number of Tobacco 21 cities to 21 as of December 2018. In addition, St. Paul, Duluth and Falcon Height passed policies limiting youth access to menthol and other flavored tobacco products as Minneapolis had done previously in 2017.

The Minnesota Department of Health released the Minnesota Youth Tobacco Survey in 2018 revealing for the first time in 17 years, the youth tobacco use rate have risen. Factors contributing to this increase include the explosion of e-cigarette use, flavors that appeal to youth, and aggressive marketing of e-cigarettes. This study confirmed the urgency of raising the tobacco sales age to 21 to prevent the initiation of tobacco use among youth and young adults, resulting in reduced tobacco prevalence over time.

Working together as part of the Minnesotans for a Smoke Free Generation, the American Lung Association in Minnesota will pursue legislation in 2019 that makes robust investments in tobacco cessation and prevention and raises the tobacco sales age to 21. Both measures are crucial to get youth tobacco use rates in Minnesota moving in the right direction again.

## Minnesota State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $2,519,011,064 |
| Adult Smoking Rate: | 14.5% |
| Adult Tobacco Use Rate: | 19.3% |
| High School Smoking Rate: | 9.6% |
| High School Tobacco Use Rate: | 26.4% |
| Middle School Smoking Rate: | 1.9% |
| Smoking Attributable Deaths: | 5,910 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use and middle school smoking rates are taken from the 2017 Youth Tobacco Survey. High school tobacco use includes cigarettes, cigars, smokeless tobacco, and electronic vapor products, as well as hookah, pipes, snus, and bidis, making it incomparable to other states

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Minnesota**
(218) 726-4723
www.lung.org/minnesota

# Mississippi Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $8,440,000* |
| FY2019 Federal Funding for State Tobacco Control Programs: | $1,866,711** |
| FY2019 Total Funding for State Tobacco Control Programs: | $10,306,711 |
| CDC Best Practices State Spending Recommendation: | $36,500,000 |
| Percentage of CDC Recommended Level: | 28.2% |
| State Tobacco-Related Revenue: | $248,400,000 |

*The Mississippi Legislature appropriated $20,000,000 to the Mississippi State Department of Health, Office of Tobacco Control; however, only $8,440,000 is allocated for tobacco prevention and control activities. The Office of Tobacco Control is mandated by law to distribute funding to other agencies. The total funding amount above includes the activities of the Mississippi State Department of Health Office of Tobacco Control, Attorney General's Office of Alcohol and Tobacco Enforcement Unit, and the University of Mississippi Medical Center, A Comprehensive Tobacco Center.

**Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: F

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Restricted**

Private Worksites: **No provision**

Schools: **Prohibited (public schools only)**

Child Care Facilities: **Prohibited**

Restaurants: **No provision**

Bars: **No provision**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **No provision**

Recreational/Cultural Facilities: **No provision**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: MISS. CODE ANN. §§ 29-5-161 (2007), 41-114-1 (2010), 97-32-29 (2000) & MS ADMIN CODE Tit. 15, Part III, Subpart 55 § 103.02 (2009).

The Smokefree Air grade only examines state tobacco control law and does not reflect local smokefree ordinances. Mississippi has made great strides in protecting people from secondhand smoke by passing comprehensive local smokefree ordinances that cover 31.6% of the state's population.

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$0.68**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: Yes; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: F

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Limited counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **No**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Most medications are covered**

Counseling: **Individual counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$2.30; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Mississippi Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Mississippi** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in Mississippi. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Mississippi's elected officials:

1. Increase Mississippi's cigarette tax by $1.50 per pack;
2. Ensure smokefree protections for all workers and residents with the passage of a comprehensive statewide smokefree law; and
3. Sustain tobacco control prevention and cessation funding for the Mississippi State Department of Health, Office of Tobacco Control.

Members of the Mississippi Legislature once again failed to consider legislation that would prohibit smoking in all public places, workplaces and casinos during the 2018 legislative session. Tobacco control partners continued to educate lawmakers on the harmful effects of secondhand smoke and the impact on health in Mississippi. A comprehensive statewide bill, House Bill 142, the Mississippi Smoke-free Air Act of 2018, was introduced, but did not garner the support needed for momentum through the policy process.

Numerous bills, including three Senate bills and one House bill, were introduced to increase the price of cigarettes by at least $1.00 per pack. Unfortunately, these bills were unable to move prior to the legislative deadlines. With the significant discussion and interest in increasing the price of tobacco products, the cigarette tax code section was brought forward into Senate Bill 3048, however, it did not include an amount for an increase to tobacco products. This bill was unable to pass. The House of Representatives and the Senate did pass legislation to sustain the amount of funding to the Mississippi State Department of Health's Office of Tobacco Control for youth prevention, tobacco free community coalitions, and adult cessation programs statewide.

There continues to be significant support in local municipalities for public health protections from secondhand smoke as evidenced by 150 cities adopting comprehensive smokefree ordinances. This accounts for approximately 34 percent of Mississippians being protected by smokefree policies.

In 2019, the American Lung Association in Mississippi will continue to educate and advocate state legislators about the benefits of tobacco control policies, including increasing the state's cigarette tax by $1.50 per pack. In order to meet the bold goals called for by the Lung Association in Mississippi, state legislators will need to recognize the health and economic burden of tobacco use and exposure to secondhand smoke. The Lung Association in Mississippi will continue to work with partners in the Smokefree Mississippi coalition to ensure successful passage and preservation of comprehensive local smokefree ordinances.

## Mississippi State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $1,236,940,761 |
| Adult Smoking Rate: | 22.2% |
| Adult Tobacco Use Rate: | 29.2% |
| High School Smoking Rate: | 7.2% |
| High School Tobacco Use Rate: | 37.6% |
| Middle School Smoking Rate: | 1.5% |
| Smoking Attributable Deaths: | 5,410 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school and middle school smoking rates are taken from the 2017 Youth Tobacco Survey. High school tobacco use rate is taken from the 2015 Youth Risk Behavior Surveillance System.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Mississippi**
(601) 206-5810
www.lung.org/mississippi

# Missouri Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

MISSOURI

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $48,500 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $2,164,063* |
| FY2019 Total Funding for State Tobacco Control Programs: | $2,212,563 |
| CDC Best Practices State Spending Recommendation: | $72,900,000 |
| Percentage of CDC Recommended Level: | 3.0% |
| State Tobacco-Related Revenue: | $258,900,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

Thumbs down for Missouri for providing little state funding for tobacco prevention and cessation programs despite smoking costing the state over $3 billion in healthcare costs each year.

## Smokefree Air: F

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Restricted**

Private Worksites: **Restricted**

Schools: **Prohibited (public schools only)**

Child Care Facilities: **Prohibited**

Restaurants: **Restricted**

Bars: **No provision**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **Restricted**

Recreational/Cultural Facilities: **Restricted**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: MO. REV. STAT. §§ 191.765 to 191.777 (1992).

Note: The Smokefree Air grade only examines state tobacco control law and does not reflect local smokefree ordinances. Missouri has made great strides in protecting people from secondhand smoke by passing comprehensive local smokefree ordinances that cover 28.8% of the state's population.

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$0.17**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: Yes; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

Thumbs down for Missouri for having the lowest cigarette tax in the country at 17 cents per pack.

## Access to Cessation Services: F

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **All 3 types of counseling are covered**

Barriers to Coverage: **No barriers exist to access care**

Medicaid Expansion: **No**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Most types of counseling are covered**

Barriers to Coverage: **No barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$0.51; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Missouri Tobacco Cessation Coverage page for specific sources.

Thumbs up for Missouri for providing comprehensive coverage without barriers for all tobacco cessation medications and types of counseling to Medicaid enrollees.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Missouri** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in Missouri. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Missouri's elected officials:

1. Increase state funding for tobacco prevention and cessation;
2. Pass comprehensive smokefree laws and policies on the local and statewide levels; and
3. Pass local laws that increase the tobacco sales age to 21.

During the 2018 legislative session the American Lung Association in Missouri focused on restoring state tobacco control funding and advocated for an increase. The Lung Association was successful in getting the tobacco control funding line item fully restored after being cut in the Governor's budget. However, the restored amount remains far short of what is truly needed to fight tobacco use in Missouri.

The American Lung Association teamed up with our partners to advocate for laws at the local level to raise the legal age of sale for tobacco products from 18 to 21. Communities that have done this are expected to see significant reductions in youth smoking as a result. Evidence is very clear that young people who reach the age of 21 without smoking are very likely to never start. Unfortunately, kids who can purchase tobacco products at 18 are often the source for younger teen's tobacco products. Raising the age to 21 makes it more difficult for those under 18 to get their hands-on tobacco products and increases the likelihood they will never start.

The American Lung Association also worked with our partners and local health organizations to pass comprehensive smokefree policies in St. Louis and St. Charles counties on the November 2018 ballot. The coalition collected more than 80,000 signatures in St. Charles and St. Louis Counties to ensure that everyone has the right to breathe clean smokefree air. Unfortunately, after an intensive legal battle, the courts ordered the strong comprehensive measures supported by the Lung Association off the ballot in both counties.

In the meantime, local officials, in St. Charles County, placed "Smokefree With Exemptions" on the November 2018 ballot that would continue to allow smoking in a number of workplaces. This measure was backed by the tobacco and casino industries. In St. Louis County, the casino industry collected signatures and placed their own language that would prohibit smoking on 50 percent of the gaming floors of casinos on the November 2018 ballot. The American Lung Association and Show Me Smoke-Free coalitions urged voters to vote no on the weak smokefree laws that remained on the ballot. However, both measures ended up being approved by voters and took effect immediately.

During the 2019 legislative session, the American Lung Association in Missouri will continue to focus on lung health and advocate for increased funding for tobacco prevention and cessation and comprehensive smokefree laws and policies. The Lung Association will also continue to advocate for Tobacco 21 laws at the local level in Missouri.

## Missouri State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $3,032,471,478 |
| Adult Smoking Rate: | 20.8% |
| Adult Tobacco Use Rate: | 27.0% |
| High School Smoking Rate: | 9.2% |
| High School Tobacco Use Rate: | 20.8% |
| Middle School Smoking Rate: | 3.5% |
| Smoking Attributable Deaths: | 10,970 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data come from the 2017 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the 2017 Youth Tobacco Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Missouri**
(314) 645-5505
www.lung.org/missouri

# Montana Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

MONTANA

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $4,958,279 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $1,092,860* |
| FY2019 Total Funding for State Tobacco Control Programs: | $6,051,139 |
| CDC Best Practices State Spending Recommendation: | $14,600,000 |
| Percentage of CDC Recommended Level: | 41.4% |
| State Tobacco-Related Revenue: | $108,500,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: A

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

Casinos/Gaming Establishments: **Prohibited (tribal establishments exempt)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: MONT. CODE ANN. §§ 50-40-101 et seq. (2011).

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$1.70**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: Yes; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: B

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Some medications are covered**

Counseling: **All 3 types of counseling are covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$4.69; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Montana Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Montana** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in Montana. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Montana's elected officials:

1. Defend funding for Montana's Tobacco Use Prevention Program;
2. Defend Montana's smokefree workplace laws; and
3. Protect Montana's youth by raising the age of sale for tobacco products to 21.

The Montana Legislature meets every other year (during odd-numbered years); so, there was no legislative session held in 2018.

Several pieces of legislation had been introduced in previous sessions to increase Montana's tobacco taxes. During the 2017 session, Senate Bill 354 proposed increasing the cigarette tax by $1.50 to $3.20 per pack. While this bill passed the state Senate, it faced an uphill battle in the state House of Representatives and the legislation died. Montana legislators have demonstrated little appetite to support large, meaningful tobacco tax increases.

Stakeholder groups, including the American Lung Association in Montana, began to research the possibility of increasing tobacco taxes through a ballot initiative process in early 2018. An exploratory workgroup found that a tobacco tax initiative campaign in Montana would be viable, and this option was pursued.

Initiative 185 would have increased the state's cigarette tax by $2.00 to $3.70 per pack, increase other tobacco product taxes and establish a new tax on electronic smoking devices. The revenue from this initiative would have maintained health insurance for 100,000 Montanans, provided additional funding to tobacco prevention and cessation programs and supported other health services for seniors and veterans. Unfortunately, the Initiative was narrowly not approved by voters. The tobacco industry spent a staggering $18 million opposing the ballot measure to protect their profits at the expense of public health.

The American Lung Association in Montana will continue to support policies to reduce tobacco use in Montana in the 2019 legislative session.

## Montana State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $440,465,233 |
| Adult Smoking Rate: | 17.2% |
| Adult Tobacco Use Rate: | 25.0% |
| High School Smoking Rate: | 12.1% |
| High School Tobacco Use Rate: | 32.7% |
| Middle School Smoking Rate: | 6.2% |
| Smoking Attributable Deaths: | 1,570 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data are taken from the 2017 Youth Risk Behavior Surveillance System. Middle school smoking rate (8th grade only) is taken from the 2014 Montana Prevention Needs Assessment Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Montana**
(206) 441-5100
www.lung.org/montana

# Nebraska Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

NEBRASKA

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $2,579,000 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $1,049,133* |
| FY2019 Total Funding for State Tobacco Control Programs: | $3,628,133 |
| CDC Best Practices State Spending Recommendation: | $20,800,000 |
| Percentage of CDC Recommended Level: | 17.4% |
| State Tobacco-Related Revenue: | $104,000,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: A

**OVERVIEW OF STATE SMOKING RESTRICTIONS:**

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited (allowed in cigar shops)**

Casinos/Gaming Establishments: **Prohibited**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Limited**

Citation: NEB. REV. STAT. §§ 71-5716 to 71-5734 (2015).

## Tobacco Taxes: F

**CIGARETTE TAX:**

Tax Rate per pack of 20: **$0.64**

OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: Yes; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: F

**OVERVIEW OF STATE CESSATION COVERAGE:**

STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **No counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

STATE QUITLINE:

Investment per Smoker: **$1.62; the median investment per smoker is $2.21**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Nebraska Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Nebraska** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Nebraska. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Nebraska's elected officials:

1. Increase funding for tobacco control programs;
2. Increase tobacco taxes by $1.00 per pack or more; and
3. Increase the minimum age of sale for tobacco products to 21.

During the 2018 legislative session, the American Lung Association in Nebraska advocated for increased state funding for tobacco control and an increase in taxes on tobacco products. While funding for tobacco control and prevention remains below the Center for Disease Control recommended level, the Lung Association did score a minor victory with a budget increase of $500,000 for the 2017-2018 fiscal year for tobacco control and prevention during the 2018 legislative session.

The American Lung Association in Nebraska supported Legislative Bill 438, a bill that would have increased Nebraska's tobacco taxes by $1.50 per pack. The Lung Association and partner organizations sponsored a joint lobby day to educate Senators on the importance of increased tobacco taxes. Unfortunately, the bill did not advance during the 2018 session.

On November 6, 2018 Nebraska residents voted yes on Initiative 427, a law that will bring $1.1 billion tax dollars back to Nebraska, sustain 10,000 jobs, and give Nebraskans a voice in expanding Medicaid. The American Lung Association in Nebraska supports Initiative 427 for a number of reasons, including that it could extend access to quit smoking treatments and services to a subset of Nebraskans that smoke at higher rates than the general population. A cigarette tax increase could also be a natural funding source for the Medicaid expansion if one is needed and promote additional reductions in tobacco use.

The American Lung Association in Nebraska and coalition partners will continue to press for passage of a substantial cigarette tax increase and increased funding for tobacco prevention and cessation programs in the 2019 legislative session to prevent kids from starting to smoke and to motivate adult smokers to quit. The Lung Association will also continue our work defending our state law that protects all Nebraskans from the dangers of secondhand smoke, and continue to educate legislators about the benefits to increasing the tobacco sales age to 21.

## Nebraska State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $795,185,324 |
| Adult Smoking Rate: | 15.4% |
| Adult Tobacco Use Rate: | 21.3% |
| High School Smoking Rate: | 7.2% |
| High School Tobacco Use Rate: | 16.1% |
| Middle School Smoking Rate: | N/A |
| Smoking Attributable Deaths: | 2,510 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use rates are taken from the 2017 Youth Risk Behavior Surveillance System. A current middle school smoking rate is not available for this state.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Nebraska**
(402) 502-4950
www.lung.org/nebraska

# Nevada Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

NEVADA

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $950,000 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $927,208* |
| FY2019 Total Funding for State Tobacco Control Programs: | $1,877,208 |
| CDC Best Practices State Spending Recommendation: | $30,000,000 |
| Percentage of CDC Recommended Level: | 6.3% |
| State Tobacco-Related Revenue: | $230,400,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: C

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Restricted (smoking allowed in bars or parts of bars if age-restricted)**

Casinos/Gaming Establishments: **Restricted (tribal establishments exempt)***

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: NEV. REV. STAT. § 202.2483 (2011).

*Smoking is allowed on casinos floors but is prohibited anywhere children are allowed to be.

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$1.80**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: No; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: F

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **Most medications are covered**

Counseling: **Limited counseling is covered**

Barriers to Coverage: **Limited barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **All three types of counseling are covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$0.75; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Nevada Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Nevada** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Nevada. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Nevada's elected officials:

1. Protect and expand the Nevada Clean Indoor Air Act;
2. Increase funding for the state's tobacco prevention and control program; and
3. Increase the tax on tobacco products by $1.00 per pack or more.

The American Lung Association in Nevada along with partners from the Nevada Tobacco Prevention Coalition continued to lead state and local tobacco control initiatives. Priorities of the Coalition continue to center around expansion of the Nevada Clean Indoor Air Act and proper funding for the state's tobacco prevention and control program.

The Nevada legislature only meets in odd number of years, so in 2018 the American Lung Association in Nevada continued its work on the local smokefree workplace initiative in Mesquite, Nevada. A recent poll conducted showed that 61 percent of registered voters in Mesquite favored a local ordinance requiring 100 percent smokefree air in all workplaces including bars and casinos, with half (50%) strongly favoring such a policy to protect all workers. Additionally, 58 percent said they are more likely to patronize bars and casinos if they are smokefree.

During 2018, an attempt was made by the local tobacco prevention coalition in Mesquite to put a ballot measure before the city's voters that would have prohibited smoking in all public places and workplaces in the city, including bars and casinos as well as some outdoor areas. Unfortunately, the language of the ballot measure was challenged in court, and a local judge prevented the measure from being put before voters.

Moving forward in 2019, the American Lung Association in Nevada will continue to build support and political will in order to advance comprehensive smokefree protections at the local level. The Lung Association will also look to increase the price of tobacco products and raise the sale age on tobacco products to 21.

## Nevada State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $1,080,272,434 |
| Adult Smoking Rate: | 17.6% |
| Adult Tobacco Use Rate: | 23.1% |
| High School Smoking Rate: | 6.4% |
| High School Tobacco Use Rate: | 21.4% |
| Middle School Smoking Rate: | 2.2% |
| Smoking Attributable Deaths: | 4,050 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school and middle school smoking rates are taken from the 2017 Nevada Youth Risk Behavior Surveillance System. High school tobacco use rate is taken from the 2017 Youth Risk Behavior Surveillance System.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Nevada**
(702) 431-6333
www.lung.org/nevada

# New Hampshire Report Card

AMERICAN LUNG ASSOCIATION.

STATE OF TOBACCO CONTROL 2019

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $140,000 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $1,113,038* |
| FY2019 Total Funding for State Tobacco Control Programs: | $1,253,038 |
| CDC Best Practices State Spending Recommendation: | $16,500,000 |
| Percentage of CDC Recommended Level: | 7.6% |
| State Tobacco-Related Revenue: | $254,900,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

Thumbs down for New Hampshire for providing little state funding for tobacco prevention and cessation programs despite smoking costing the state close to $730 million in healthcare costs each year.

## Smokefree Air: F

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Restricted**

Private Worksites: **Restricted**

Schools: **Prohibited (public schools only)**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited (allowed in cigar bars and allows for an economic hardship waiver)**

Casinos/Gaming Establishments: **Restricted**

Retail Stores: **Restricted**

Recreational/Cultural Facilities: **Restricted**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: N.H. REV. STAT. ANN. §§ 155:64 to 155:78 (2009) & 178:20-a (2010).

## Tobacco Taxes: D

### CIGARETTE TAX:

Tax Rate per pack of 20: **$1.78**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: N/A**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: D

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$2.12; the average investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See New Hampshire Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **New Hampshire** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in New Hampshire. To address this enormous toll, the American Lung Association calls for the following actions to be taken by New Hampshire's elected officials:

1. Pass statewide legislation to raise the retail sales age of tobacco products to 21;
2. Increase tobacco control program and Quit Line state funding; and
3. Defend New Hampshire's smokefree laws from rollback attempts.

The 2018 legislative session began with the first statewide effort to raise the retail sales age of tobacco products to 21. Working with youth organizations, the American Lung Association in New Hampshire and partners began educating lawmakers and Granite Staters through the media of the importance of this initiative. The measure received a bipartisan vote of support out of the Senate Health Committee, however, was stalled on the floor of the full Senate.

Seizing the momentum of the statewide initiative, the Lung Association supported the efforts of the youth empowerment program Dover Youth 2 Youth to introduce and pass a local initiative which resulted in Dover becoming the first municipality in the state to pass Tobacco 21. Their efforts have resulted in several other communities beginning to consider local ordinances and paving the way for another statewide initiative in 2019.

The American Lung Association in New Hampshire will continue to work with our coalition partners the New Hampshire Public Health Association, the American Heart Association, Breathe New Hampshire, American Cancer Society and others to advance tobacco control and prevention efforts and defend our successful programs and smokefree policies against rollbacks. As the legislature begins its work in 2019 we will continue to grow our coalition to educate policy makers, business leaders and the media of the importance of the American Lung Association's goals to reduce tobacco use and protect public health.

## New Hampsire State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $728,895,693 |
| Adult Smoking Rate: | 15.7% |
| Adult Tobacco Use Rate: | 19.3% |
| High School Smoking Rate: | 7.8% |
| High School Tobacco Use Rate: | 30.3% |
| Middle School Smoking Rate: | N/A |
| Smoking Attributable Deaths: | 1,940 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2017 and tobacco use rate is taken from the 2015 Youth Risk Behavior Surveillance System. A current middle school smoking rate is not available for this state.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in New Hampshire**
(603) 410-5108
www.lung.org/newhampshire

# New Jersey Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

NEW JERSEY

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $7,232,000 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $3,643,631* |
| FY2019 Total Funding for State Tobacco Control Programs: | $10,875,631 |
| CDC Best Practices State Spending Recommendation: | $103,300,000 |
| Percentage of CDC Recommended Level: | 10.5% |
| State Tobacco-Related Revenue: | $919,600,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

Thumbs up for New Jersey for increasing funding for tobacco control programs by over $6.7 million this fiscal year.

## Smokefree Air: A

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited (allowed in cigar bars/lounges)**

Casinos/Gaming Establishments: **Restricted***

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **Yes**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: N.J. STAT. ANN. §§ 26:3D-55 to 26:3D-65 (2017).

*Smoking in indoor areas of horse tracks is prohibited by state law. Atlantic City, NJ where all the state's casinos are located, has an ordinance restricting smoking to 25 percent of the gaming floors of casinos.

## Tobacco Taxes: D

### CIGARETTE TAX:

Tax Rate per pack of 20: **$2.70**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: No; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: B

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **Most medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Limited barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Limited barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$2.87; the median investment per smoker is $2.21**

### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Yes**

Tobacco Surcharge: **Prohibits tobacco surcharges**

Citation: See New Jersey Tobacco Cessation Coverage page for specific sources.

## Minimum Age: A

Minimum Age of Sale for Tobacco Products: **21**

# **New Jersey** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in New Jersey. To address this enormous toll, the American Lung Association calls for the following actions to be taken by New Jersey's elected officials:

1. Pass a significant increase in the tax on cigarettes;
2. Fund tobacco prevention and cessation programs at the Centers for Disease Control and Prevention (CDC)-recommended level; and
3. Continue expanding tobacco cessation coverage for individuals on Medicaid.

2018 saw significant changes in New Jersey as Phil Murphy began his first year as governor. In the tobacco control arena, the American Lung Association in New Jersey saw solid progress on tobacco control program funding, smokefree air and helping smokers under the state Medicaid program quit. The most significant achievement was increasing tobacco control program funding by $6.7 million with the new funding being allocated from tobacco tax revenues. This was a major accomplishment which was implemented as part of the fiscal year 2019 state budget, following passage of legislation allocating one percent of tobacco tax revenues to tobacco control programs in 2017. This is the largest amount of funding going to New Jersey's tobacco control program since 2009, but it still remains far short of the level recommended by the CDC. A new tax on e-cigarettes was passed in 2018 that set the tax at ten cents per fluid milliliter of liquid nicotine.

The Murphy Administration also showed a commitment to helping smokers quit and expanding New Jersey's smokefree laws. By expanding counseling coverage for Medicaid recipients and removing prior authorization, New Jersey's fee-for-service program now provides coverage of all seven Food and Drug Administration-approved tobacco cessation medications and all three forms of counseling that help smokers quit. Governor Murphy also signed legislation that passed near unanimously to expand smokefree outdoor spaces. Specifically, the law will make all beaches, parks and boardwalks smokefree, except for designated outdoor areas of municipal or county beaches if allowed by local ordinance or resolution.

The American Lung Association in New Jersey will continue to work with the Murphy Administration and the legislature to push forward on the ongoing fight against tobacco. The Lung Association will be pushing for a significant increase in the cigarette tax, continue to move forward with increasing tobacco control funding, and continuing to remove remaining barriers which would make it easier for smokers to quit.

## New Jersey State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $4,065,531,641 |
| Adult Smoking Rate: | 13.7% |
| Adult Tobacco Use Rate: | 17.2% |
| High School Smoking Rate: | 4.7% |
| High School Tobacco Use Rate: | N/A |
| Middle School Smoking Rate: | 1.2% |
| Smoking Attributable Deaths: | 11,780 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2017 Youth Tobacco Survey. A current high school tobacco use rate is not available for this state. Middle school smoking rate is taken from the 2015 Youth Tobacco Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in New Jersey**
(610) 268-9788
www.lung.org/newjersey

# New Mexico Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

NEW MEXICO

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $5,684,500 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $947,463* |
| FY2019 Total Funding for State Tobacco Control Programs: | $6,631,963 |
| CDC Best Practices State Spending Recommendation: | $22,800,000 |
| Percentage of CDC Recommended Level: | 29.1% |
| State Tobacco-Related Revenue: | $131,500,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: B

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited (non-public workplaces with two or fewer employees exempt)**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited (allowed in cigar bars)**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: N.M. STAT. ANN. §§ 24-16-1 et seq. (2007).

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$1.66**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: C

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **Most medications are covered**

Counseling: **Limited counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Limited medications are covered**

Counseling: **Limited counseling is covered**

Barriers to Coverage: **Limited barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$6.31; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Yes**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See New Mexico Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **New Mexico** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in New Mexico. To address this enormous toll, the American Lung Association calls for the following actions to be taken by New Mexico's elected officials:

1. Raise the tax on cigarettes by $1.50 per pack and on other tobacco products including snuff, chew and cigarillos;
2. Maintain or increase funding for state's tobacco prevention and control program; and
3. Protect New Mexicans from secondhand smoke, including in multi-unit housing.

The American Lung Association in New Mexico provides leadership in convening partners and guiding public policy efforts to continue the state's success in reducing the impact of tobacco among New Mexicans. Together with our partners, the Lung Association works to ensure tobacco control and prevention remains a priority for state legislators and local decision makers.

In 2018, the Lung Association's focus was to continue to educate legislators, legislative staff, and the general public about smoking and the importance of providing tobacco cessation programs for adults and youth, and the dangers of secondhand smoke. During the legislative session the Lung Association along with our partners were unsuccessful in an effort to raise the state's cigarette tax by $1.50 per pack and impose an equivalent tax on other tobacco products including cigars, smokeless tobacco and electronic cigarettes. The legislation would have generated $43 million in new revenue for the state of New Mexico.

On a more positive note, funding for the New Mexico Tobacco Use Prevention and Control program was maintained at $5.68 million in fiscal year 2019, the same level as last year.

The American Lung Association in New Mexico's Smoke-Free at Home NM program provides education and support to property managers and owners on the economic and health benefits of implementing smoke-free policies in multi-unit housing. In 2018, the Lung Association continues to help public, affordable, and market rate housing implement smokefree policies building on our efforts from previous years. Smoke-Free at Home NM certified 8 properties representing approximately 1,471 residents as smokefree, while an additional 21 properties implemented our Thinking About Quitting workshops helping smokers who were interested in quitting seek to do so.

Moving forward in 2019, the American Lung Association in New Mexico will once again make it a priority to educate our legislature and communities about the dangers of tobacco use and the importance of a well-funded tobacco prevention and cessation program. Additionally, we will be working on raising the excise tax on tobacco products. With a new Governor recently taking office, the Lung Association hopes a cigarette tax increase will be able to gain more traction in 2019. The Lung Association will also continue to focus on creating smokefree multi-unit housing. It is our goal to provide all New Mexicans with a safe and healthy living environment, free from the dangers of secondhand smoke.

## New Mexico State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $843,869,235 |
| Adult Smoking Rate: | 17.5% |
| Adult Tobacco Use Rate: | 22.5% |
| High School Smoking Rate: | 10.6% |
| High School Tobacco Use Rate: | 31.9% |
| Middle School Smoking Rate: | N/A |
| Smoking Attributable Deaths: | 2,630 |

Adult smoking and tobacco use data come from CDC's 2016 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data come from the 2017 Youth Risk Behavior Surveillance System. A current middle school smoking rate is not available for this state.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in New Mexico**
(505) 265-0732
www.lung.org/newmexico

# New York Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

NEW YORK

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $39,769,600 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $3,155,603* |
| FY2019 Total Funding for State Tobacco Control Programs: | $42,925,203 |
| CDC Best Practices State Spending Recommendation: | $203,000,000 |
| Percentage of CDC Recommended Level: | 21.1% |
| State Tobacco-Related Revenue: | $2,037,100,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: A

**OVERVIEW OF STATE SMOKING RESTRICTIONS:**

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited (allowed in cigar bars and allows for an economic hardship waiver)**

Casinos/Gaming Establishments: **Prohibited (tribal establishments exempt)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **Yes**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: N.Y. [PUB. HEALTH] LAW §§ 1399-n to 1399-x (2017).

## Tobacco Taxes: B

**CIGARETTE TAX:**

Tax Rate per pack of 20: **$4.35**

OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: C

**OVERVIEW OF STATE CESSATION COVERAGE:**

STATE MEDICAID PROGRAM:

Medications: **Most medications are covered**

Counseling: **Most counseling is covered**

Barriers to Coverage: **Limited barriers exist to access care**

Medicaid Expansion: **Yes**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Some medications are covered**

Counseling: **Limited counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

STATE QUITLINE:

Investment per Smoker: **$2.34; the median investment per smoker is $2.21**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Insurance commissioner guidance**

Tobacco Surcharge: **Prohibits tobacco surcharges**

Citation: See New York Tobacco Cessation Coverage page for specific sources.

## Minimum Age: C*

Minimum Age of Sale for Tobacco Products: **18**

*New York has 75.8% of the state's population covered by Tobacco 21 ordinances/regulations. If a state has more than 50% of its population covered by local ordinances/regulations, the state is graded based on population covered by those local ordinances/regulations rather than the statewide law.

# **New York** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in New York. To address this enormous toll, the American Lung Association in New York calls for the following actions to be taken by our elected officials:

1. Raise the age of sale for tobacco products to 21;
2. Increase funding to New York's Tobacco Control Program; and
3. License and tax electronic cigarettes in New York.

2018 was a year of incremental progress for tobacco control in New York State. Tobacco 21 continued to have momentum at the state level, with the Senate voting Tobacco 21 out of the Senate Health committee, and the Assembly moving the bill through the Health and Codes Committee. Due to the volume of legislation at the end of the legislative session, the bill was not voted on by the full Assembly. However, the American Lung Association in New York expects the bill to move in 2019. On the budget side, this year the Lung Association saw a small increase in funding for tobacco control to $39.9 million, but no new taxes on tobacco products, including on electronic cigarettes, were enacted.

There continued to be significant progress on the local level for Tobacco 21 legislation. The Lung Association saw a number of counties pass Tobacco 21 in 2018, including Westchester and Suffolk counties. In fact, more than 75 percent of New Yorkers are now covered by local laws restricting the sale of tobacco to youth. This is a significant jump from the just over 55 percent of New Yorkers who were covered at the end of 2017. In addition, the smokefree public housing rule by the Department of Housing and Urban Development will protect 200, 000 New York families from secondhand smoke.

It is imperative that New York begin to counter the stagnation of funding that has plagued the tobacco control program for a number of years. Lack of funding has had a direct impact on the ability to fight the disparities in tobacco use that continue to exist in areas across our state. Increased funding will allow for interventions targeted to the specific populations that have smoking rates that are double or triple the rest of the population.

New York must also ensure that we see a bill passed that prohibits the sale of tobacco products to those under 21. Additionally, New York must continue to pursue legislation which would license and tax the sale of electronic cigarettes at the state level. Currently e-cigarette retailers are not subject to licensing or taxation. The American Lung Association in New York believes that New York must increase the cost of e-cigarettes to continue to reduce youth tobacco use. Taxing and licensing e-cigarettes would also provide revenue to the state. New York has a long history of leading on tobacco control efforts, it is time for decision-makers to take decisive action to save lives.

## New York State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $10,389,849,268 |
| Adult Smoking Rate: | 14.1% |
| Adult Tobacco Use Rate: | 17.7% |
| High School Smoking Rate: | 5.5% |
| High School Tobacco Use Rate: | 19.3% |
| Middle School Smoking Rate: | 1.2% |
| Smoking Attributable Deaths: | 28,170 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use rates are taken from the 2017 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the New York 2014 Youth Tobacco Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in New York**
(518) 465-2013
www.lung.org/newyork

# North Carolina Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

NORTH CAROLINA

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $2,800,000 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $3,253,615* |
| FY2019 Total Funding for State Tobacco Control Programs: | $6,053,615 |
| CDC Best Practices State Spending Recommendation: | $99,300,000 |
| Percentage of CDC Recommended Level: | 6.1% |
| State Tobacco-Related Revenue: | $450,400,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: F

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Restricted (prohibited in state government buildings)**

Private Worksites: **No provision**

Schools: **Prohibited (public schools only)**

Child Care Facilities: **Restricted**

Restaurants: **Prohibited**

Bars: **Prohibited (allowed in cigar bars)**

Casinos/Gaming Establishments: **N/A (tribal casinos only)**

Retail Stores: **No provision**

Recreational/Cultural Facilities: **No provision**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes (private workplaces and other specific venues)**

Citation: N.C. GEN. STAT. §§ 130A-491 to 130A-498 (2010), 115C-407 (2007), 131D-4.4 (2007) & 131E-114.3 (2007).

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$0.45**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: Yes; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

Thumbs down for North Carolina for having the fifth lowest cigarette tax in the country.

## Access to Cessation Services: D

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Most counseling is covered**

Barriers to Coverage: **Minimal barriers exist to access care**

Medicaid Expansion: **No**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$3.16; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **Limits tobacco surcharges**

Citation: See North Carolina Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **North Carolina** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in North Carolina. To address this enormous toll, the American Lung Association calls for the following actions to be taken by North Carolina's elected officials:

1. Restore funding for tobacco use prevention and cessation programs, including QuitlineNC;
2. Increase the state cigarette tax to the national average of $1.78 per pack; and
3. Resist attempts to weaken the smokefree restaurants and bars law and expand the law to include all public places and private worksites.

There was good news for the state's tobacco use prevention and cessation programs in the 2018 session of the General Assembly. Advocates under the banner of the North Carolina Alliance for Health lead a successful campaign that increased state funding to over $2.8 million. While funding levels remain far from the $17.3 million the tobacco use prevention and cessation programs received in 2011 and before, these new dollars give a boost to QuitlineNC and youth prevention programs that are greatly challenged to meet the needs of a growing state with minimal resources. The American Lung Association in North Carolina is grateful that funding for these important programs is moving in a positive direction and urges this trend to continue.

The bad news is that in the final hours of budget negotiations, tobacco industry allies successfully attached a provision to the state budget reducing state tobacco taxes by 50 percent for any product included in a modified risk tobacco product order issued by the Secretary of the U.S. Department of Health and Human Services. That was an unfortunate move for North Carolina. The state has the fifth lowest cigarette tax in the country at 45 cents per pack. The national average for state taxes is $1.78 per pack. Despite an increasing population with ever-increasing health needs, state leaders have repeatedly overlooked a tobacco tax increase as a source of funds to meet these challenges and reduce smoking rates. A move in the right direction would be to increase North Carolina's cigarette tax by a $1.00 or more per pack to reduce both youth and adult smoking rates.

The American Lung Association in North Carolina will continue to partner with the North Carolina Alliance for Health as it defends against any threats or attempts to weaken the smokefree restaurants and bars law and seeks options for strengthening protections for nonsmokers. Price increases of $1.00 per pack or more have repeatedly been shown to reduce youth and adult smoking rates. The Lung Association in North Carolina, along with other partners, will also continue to advocate for increased funding for tobacco use prevention programs and for QuitlineNC.

## North Carolina State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $3,809,676,476 |
| Adult Smoking Rate: | 17.2% |
| Adult Tobacco Use Rate: | 22.6% |
| High School Smoking Rate: | 8.9% |
| High School Tobacco Use Rate: | 28.8% |
| Middle School Smoking Rate: | 2.5% |
| Smoking Attributable Deaths: | 14,220 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use and middle school smoking rates are taken from the 2017 Youth Tobacco Survey. High school tobacco use includes cigarettes, cigars, smokeless tobacco, and electronic vapor products, as well as pipes, bidis, roll-your-own cigarettes, hookah, snus, dissolvable tobacco products, and clove cigars, making it incomparable to other states.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in North Carolina**
(980)-237-6611
www.lung.org/northcarolina

# North Dakota Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

## Tobacco Prevention and Control Program Funding: C

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $5,286,666 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $928,674* |
| FY2019 Total Funding for State Tobacco Control Programs: | $6,215,340 |
| CDC Best Practices State Spending Recommendation: | $9,800,000 |
| Percentage of CDC Recommended Level: | 63.4% |
| State Tobacco-Related Revenue: | $53,600,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

Thumbs down for North Dakota for eliminating the Center for Tobacco Prevention and Policy and reducing funding for tobacco control programs by over $3.2 million this year from the previous two-year state budget.

## Smokefree Air: A

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

Casinos/Gaming Establishments: **Prohibited (tribal establishments exempt)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **Yes**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: N.D. CENT. CODE §§ 23-12-9 to 23-12-11 (2013).

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$0.44**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: Yes; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

Thumbs down for North Dakota for having the fourth lowest cigarette tax in the country.

## Access to Cessation Services: C

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Limited counseling is covered**

Barriers to Coverage: **Significant barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **All 3 types of counseling are covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$8.38; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Yes**

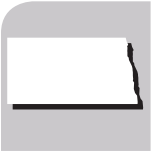
Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See North Dakota Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **North Dakota** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in North Dakota. To address this enormous toll, the American Lung Association calls for the following actions to be taken by North Dakota's elected officials:

1. Raise the state tobacco tax currently at 44 cents per pack; and
2. Raise the sales age for all tobacco products to 21 years old.

There was no state legislative session in North Dakota during 2018. Funding for the state's tobacco control program in fiscal year 2019 remained almost identical to fiscal year 2018 under the two-year state budget approved in 2017. However, due to the elimination of the North Dakota Center for Tobacco Prevention and Control Policy in 2017 by the legislature, funding remains over $3 million dollars below previous levels.

North Dakota has the fourth lowest cigarette tax in the country at 44 cents per pack, a lower tax on cigarettes than several tobacco-growing states. The tax has not been raised since 1993. This low tax significantly hinders efforts in North Dakota to reduce tobacco use among youth.

The American Lung Association in North Dakota will continue its work in 2019 to educate both state and local decision makers about the benefits of a higher tobacco tax and increasing the sales age for tobacco products to 21.

## North Dakota State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $325,798,988 |
| Adult Smoking Rate: | 18.3% |
| Adult Tobacco Use Rate: | 24.6% |
| High School Smoking Rate: | 9.0% |
| High School Tobacco Use Rate: | 28.8% |
| Middle School Smoking Rate: | 2.4% |
| Smoking Attributable Deaths: | 980 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school and middle school smoking rates are taken from the 2017 Youth Tobacco Survey. High school tobacco use rate is taken from the 2017 Youth Risk Behavior Surveillance System.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in North Dakota**
(701) 223-5613
www.lung.org/northdakota

# Ohio Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

OHIO

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $13,000,000 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $1,805,544* |
| FY2019 Total Funding for State Tobacco Control Programs: | $14,805,544 |
| CDC Best Practices State Spending Recommendation: | $132,000,000 |
| Percentage of CDC Recommended Level: | 11.2% |
| State Tobacco-Related Revenue: | $1,292,500,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: A

**OVERVIEW OF STATE SMOKING RESTRICTIONS:**

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

Casinos/Gaming Establishments: **Prohibited**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: OHIO REV. CODE ANN §§ 3794.01 to 3794.09 (2017).

## Tobacco Taxes: F

**CIGARETTE TAX:**

Tax Rate per pack of 20: **$1.60**

OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: C

**OVERVIEW OF STATE CESSATION COVERAGE:**

STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **All 3 types of counseling are covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Some medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

STATE QUITLINE:

Investment per Smoker: **$1.25; the median investment per smoker is $2.21**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Ohio Tobacco Cessation Coverage page for specific sources.

Thumbs up for Ohio for providing comprehensive coverage for all tobacco cessation medications and types of counseling with minimal barriers to Medicaid enrollees.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Ohio** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Ohio. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Ohio's elected officials:

1. Pass laws to increase the minimum age of sale for tobacco products to 21 at the local or state level;
2. Match the tax on non-cigarette forms of tobacco like spit tobacco, cigars and hookah to the cigarette tax; and
3. Increase funding for tobacco prevention and cessation programs to 15 percent of the Centers for Disease Control and Prevention's recommendation for Ohio.

2019 brings change to Ohio State government. Governor Kasich was term limited and we have a new administration in the governor's office. The American Lung Association in Ohio will work with the new administration in hopes that they will be supportive of tobacco control efforts. Governor Kasich was supportive of increasing the tax on cigarettes and other tobacco products, however, he was unable to get his proposal through the legislature. The Ohio Legislature remains conservative and resistant to tax increases and government mandates, which makes any effort to increase taxes difficult.

While increasing the taxes on cigarettes may not be likely to happen in 2019, the Lung Association will continue to work with our partners to call for parity for taxes on non-cigarette forms of tobacco like spit tobacco, cigars, and e-cigarettes. These tobacco products attract younger, more price sensitive consumers and raising taxes on these products to achieve parity with cigarette taxes can prevent some kids from becoming addicted in the first place.

We also will advocate for an increase in funding for tobacco control and prevention programs. Ohio is currently spending just 11 percent of what is recommended by the Centers for Disease Control for a state of our size. Increasing spending to 15 percent of the CDC recommendation would mean a reasonable increase by about $5.2 million a year. The state is currently experiencing a budget surplus, so the argument can be made that now is the time to invest in the health of our residents.

The Lung Association worked with coalitions and other interested parties around the state to help move their cities closer to passing laws to increase the minimum sales age for tobacco products to 21 often referred to as Tobacco 21 laws. In December of 2018, Cincinnati, one of the largest cities in Ohio, became the 17th community in Ohio to pass a Tobacco 21 law. Fourteen other cities, such as Dayton and Toledo are currently working towards enacting their own local Tobacco 21 ordinances in 2019.

As we look to 2019, the American Lung Association in Ohio will continue to work with a broad coalition of stakeholders to increase funding for evidence-based tobacco prevention and cessation programs and pass Tobacco 21 laws in additional cities across Ohio.

## Ohio State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $5,647,310,236 |
| Adult Smoking Rate: | 21.1% |
| Adult Tobacco Use Rate: | 26.9% |
| High School Smoking Rate: | 8.4% |
| High School Tobacco Use Rate: | N/A |
| Middle School Smoking Rate: | 1.0% |
| Smoking Attributable Deaths: | 20,180 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school and middle school smoking rates are taken from the 2017 Youth Tobacco Survey. A current high school tobacco use rate is not available for this state.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Ohio**
(614) 279-1700
www.lung.org/ohio

# Oklahoma Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

OKLAHOMA

## Tobacco Prevention and Control Program Funding: D

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $21,289,167 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $1,259,463* |
| FY2019 Total Funding for State Tobacco Control Programs: | $22,548,630 |
| CDC Best Practices State Spending Recommendation: | $42,300,000 |
| Percentage of CDC Recommended Level: | 53.3% |
| State Tobacco-Related Revenue: | $525,600,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

Thumbs up for Oklahoma for constitutionally protecting its allocation of tobacco settlement dollars, so a consistent investment in tobacco prevention and cessation can be made.

## Smokefree Air: D

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Restricted (prohibited on state government property)**

Private Worksites: **Restricted**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Restricted**

Bars: **No provision**

Casinos/Gaming Establishments: **Restricted (tribal establishments exempt)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: OKLA. STAT. ANN. tit. 21, § 1247 & tit. 63, §§ 1-1521 et seq. (2015).

## Tobacco Taxes: D

### CIGARETTE TAX:

Tax Rate per pack of 20: **$2.03***

*On July 1, 2018, the cigarette tax increased from $1.03 to $2.03 per pack.

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

Thumbs up for Oklahoma for increasing its cigarette tax by $1.00 to $2.03 per pack.

## Access to Cessation Services: B

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Limited barriers exist to access care**

Medicaid Expansion: **No**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Most types of counseling are covered**

Barriers to Coverage: **Limited barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$11.50; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Oklahoma Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Oklahoma** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in Oklahoma. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Oklahoma's elected officials:

1. Maintain dedicated funding for tobacco prevention and cessation programs;
2. Pass a comprehensive statewide smokefree law that protects all workers and patrons from secondhand smoke; and
3. Increase the minimum age of sale for tobacco products to 21.

During the 2018 legislative session, the American Lung Association in Oklahoma along with our partners worked to pass House Bill 1010, which included an increase in the price of cigarettes by $1.50 per pack. The final version of the bill included a $1.00 increase in the cigarette tax, which was passed by the legislature and enacted by Gov. Mary Fallin. This is a big victory for the Lung Association and its public health partners in Oklahoma and should spark significant declines especially in youth smoking rates and initiation. After the 2018 legislative session, an attempt was made by anti-tax organizations to repeal the tax package that included the cigarette tax increase by ballot measure in November 2018, but thankfully the effort to put it on the ballot did not succeed. An increase in price provides big benefits to the state, including preventing nearly 30,000 Oklahoma kids from starting to smoke, prompting nearly as many adults to quit and preventing approximately 10,200 tobacco-related deaths.

Dedicated funding from the tobacco Master Settlement Agreement (MSA) for the Oklahoma Tobacco Settlement Endowment Trust (TSET) remained intact for fiscal year 2019, despite several attempts during the 2018 legislative session to divert funding. Oklahoma voters made a wise decision by putting 75 percent of MSA payments each year into TSET, and the Lung Association will oppose any attempts to raid these funds by the legislature.

Program initiatives of TSET and the Oklahoma Department of Health to prevent and reduce tobacco use include the Oklahoma Tobacco Helpline at 1-800-QUIT-NOW, cessation systems grants, community grants covering over 85 percent of the state's population, funding for tribal nations and other priority populations and statewide media campaigns intended to change the social norms related to tobacco use.

Oklahoma remains one of 22 states that still does not have a comprehensive statewide smokefree law. In 2019, the American Lung Association in Oklahoma, along with public health partners, will continue to raise public awareness regarding the need for a comprehensive statewide smokefree law. The Lung Association will also continue to protect funding for TSET and the Oklahoma Department of Health.

## Oklahoma State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $1,622,429,589 |
| Adult Smoking Rate: | 20.1% |
| Adult Tobacco Use Rate: | 28.6% |
| High School Smoking Rate: | 12.5% |
| High School Tobacco Use Rate: | 25.6% |
| Middle School Smoking Rate: | 4.1% |
| Smoking Attributable Deaths: | 7,490 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data come from the 2017 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the 2016 Youth Tobacco Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Oklahoma**
(405) 748-4674
www.lung.org/oklahoma

# Oregon Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

OREGON

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $10,045,640 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $1,165,203* |
| FY2019 Total Funding for State Tobacco Control Programs: | $11,210,843 |
| CDC Best Practices State Spending Recommendation: | $39,300,000 |
| Percentage of CDC Recommended Level: | 28.5% |
| State Tobacco-Related Revenue: | $338,800,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: A

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited (allowed in cigar bars)**

Casinos/Gaming Establishments: **Prohibited (tribal establishments exempt)**

Retail Stores: **Prohibited (allowed in smoke shops)**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **Yes**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: OR. REV. STAT. §§ 433.835 to 433.990 (2017).

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$1.33**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: D

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **All 3 types of counseling are covered**

Barriers to Coverage: **Limited barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Some medications are covered**

Counseling: **All 3 types of counseling are covered**

Barriers to Coverage: **Limited barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$0.80*; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Yes**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Oregon Tobacco Cessation Coverage page for specific sources.

*Investment per smoker amount does not include money contributed by Coordinated Care Organizations (CCOs) to the state quitline.

## Minimum Age: A

Minimum Age of Sale for Tobacco Products: **21**

## **Oregon** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Oregon. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Oregon's elected officials:

1. Increasing funding for Oregon's Tobacco Prevention and Education program;
2. Defending Oregon's Indoor Clean Air Act; and
3. Increasing tobacco taxes by a significant amount.

The 2018 legislative session was a short session for Oregon's legislators. The compressed time frame limits the numbers of bills that are debated and passed.

Several bills were introduced during the 2018 legislative session that would have weakened Oregon's Indoor Clean Air Act, and many of these were targeted and designed to allow the public use of marijuana. House Bill 4110 would have allowed sampling at newly licensed marijuana fairs. This legislation thankfully didn't receive a hearing. The City of Portland has established an office to explore opportunities to expand opportunities for marijuana use. The American Lung Association in Oregon expects to see continued attacks on clean indoor air laws related to allowing marijuana use indoors during the 2019 legislative session.

Oregon's Tobacco Prevention and Education Program (TPEP) received a one-time funding allocation of $3 million from a budget reconciliation in fiscal year 2019 bringing total funding for the program to a little over $10 million. This is an increase from $8.15 million in fiscal year 2018. This will allow the program to enhance technical assistance contracts and expand evaluation support and communications.

The American Lung Association in Oregon will continue to work with partners and the main state tobacco coalition, Oregon Partners for Tobacco Prevention to support policies to prevent and reduce tobacco use. This includes pushing for a significant increase in Oregon's tobacco taxes, which remain significantly lower than most of its neighboring states.

### Oregon State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $1,547,762,592 |
| Adult Smoking Rate: | 16.1% |
| Adult Tobacco Use Rate: | 20.9% |
| High School Smoking Rate: | 7.7% |
| High School Tobacco Use Rate: | 18.9% |
| Middle School Smoking Rate: | 3.0% |
| Smoking Attributable Deaths: | 5,470 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school (11th grade only) smoking and tobacco use and middle school (8th grade only) smoking rates are taken from the 2017 Oregon Healthy Teens Survey. High school tobacco use includes cigarettes, cigars, smokeless tobacco, and electronic vapor products, as well as hookah, making it incomparable to other states.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Oregon**
(503) 924-4094
www.lung.org/oregon

# Pennsylvania Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

PENNSYLVANIA

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $15,539,000 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $2,992,001* |
| FY2019 Total Funding for State Tobacco Control Programs: | $18,531,001 |
| CDC Best Practices State Spending Recommendation: | $140,000,000 |
| Percentage of CDC Recommended Level: | 13.2% |
| State Tobacco-Related Revenue: | $1,688,200,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: D

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Restricted**

Bars: **No provision**

Casinos/Gaming Establishments: **Restricted (tribal establishments exempt)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: 35 PA. STAT §§ 637.1 to 637.11 (2008).

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$2.60**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: N/A**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: Yes**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: F

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **Most medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Some medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$1.47; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Pennsylvania Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Pennsylvania** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in Pennsylvania. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Pennsylvania's elected officials:

1. Increase the age of sale for all tobacco products to age 21;
2. Fund tobacco prevention and cessation programs at the Centers for Disease Control and Prevention (CDC)-recommended level; and
3. Closing loopholes in Pennsylvania's Clean Indoor Air Act and make all public places and workplaces smokefree.

During the 2018 legislative session, the Pennsylvania budget passed with $15.539 million being allocated for the Pennsylvania Tobacco Prevention and Control program. The previous year saw these funds borrowed against to fill the budget gap by selling the rights to part of the state's future annual tobacco Master Settlement Agreement (MSA) payments for a lump sum payment up front. While Governor Wolf's budget allocated what remained from the annual MSA payment towards the Commonwealth's tobacco prevention and cessation programs, the funds still stand at risk of not being appropriated to these lifesaving services in the future.

Alarmingly, an amendment attached to the state budget bill eliminated the city of Philadelphia's ability to pass additional regulations on tobacco sales, giving the state legislature preemptive control. While this will not impact ordinances and regulations adopted prior to implementation, any pending or future legislation, such as a proposed flavored tobacco ordinance, will be prevented from moving forward.

Despite a strong grassroots effort, including a youth-driven campaign, while the 2017 session had introduced a Tobacco 21 co-sponsor memo in the state Senate, that legislation stalled, and a bill was not introduced in the 2018 legislative session.

Findings from a representative survey of over 3,000 Pennsylvania voters who voted in the 2016 election indicate that more than two thirds (68.4%) favor raising the legal sales age for tobacco products from 18 to 21. The majority of both current and former smokers favor Tobacco 21. Additionally, over 72 percent of Democrats and over 67 percent of Republicans support the change. Only about 1 in 10 Pennsylvania voters strongly oppose raising the legal sales age for tobacco products.

The strategic plan for Pennsylvania's Tobacco Prevention and Control Program 2018–2022 was introduced and implemented. Serving as a roadmap for the next five years to decrease tobacco-related morbidity, mortality, and economic costs in Pennsylvania, the strategic plan outlines a framework to inform program goals and activities specific to tobacco control policy priorities throughout the Commonwealth.

The American Lung Association in Pennsylvania will continue to educate lawmakers on the ongoing fight against tobacco. Our goal is to identify champions within the legislature and mobilize advocates to advance our advocacy goals, including increasing the age of sale for all tobacco products to 21, increasing funding for tobacco prevention and control programs, and putting in place legislation to make all workplaces smokefree.

## Pennsylvania State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $6,383,194,368 |
| Adult Smoking Rate: | 18.7% |
| Adult Tobacco Use Rate: | 23.0% |
| High School Smoking Rate: | 8.7% |
| High School Tobacco Use Rate: | 18.7% |
| Middle School Smoking Rate: | 1.3% |
| Smoking Attributable Deaths: | 22,010 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use rates are taken from the 2017 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the 2015 Youth Tobacco Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Pennsylvania**
(717) 971-1130
www.lung.org/pennsylvania

# Rhode Island Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

RHODE ISLAND

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $390,926 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $2,083,442* |
| FY2019 Total Funding for State Tobacco Control Programs: | $2,474,368 |
| CDC Best Practices State Spending Recommendation: | $12,800,000 |
| Percentage of CDC Recommended Level: | 19.3% |
| State Tobacco-Related Revenue: | $195,000,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

Thumbs down for Rhode Island for spending little state money on tobacco prevention and cessation programs despite smoking costing the state close to $640 million in healthcare costs each year.

## Smokefree Air: A

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited (allowed in smoking bars)**

Casinos/Gaming Establishments: **Restricted**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **Yes**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: R.I. GEN. LAWS §§ 23-20.10-1 et seq. (2015).

## Tobacco Taxes: B

### CIGARETTE TAX:

Tax Rate per pack of 20: **$4.25**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: C

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **All three types of counseling are covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$1.00; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Yes**

Tobacco Surcharge: **Prohibits tobacco surcharges**

Citation: See Rhode Island Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Rhode Island** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in Rhode Island. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Rhode Island's elected officials:

1. Raise the minimum age of sale for tobacco products from 18 to 21;
2. Increase funding to the Rhode Island Department of Health's tobacco control program; and
3. Increase the number of local ordinances that license and/or limit the sale or use of tobacco products.

The 2018 Rhode Island legislative session included the passage of legislation that adds ENDS (electronic nicotine delivery systems) devices to the Rhode Island Public Health and Workplace Safety Act that prohibits smoking in most public places and workplaces statewide. Unfortunately, the legislation also included a provision that allows for bars/lounges where e-cigarettes can be used indoors if they meet a certain threshold of e-cigarette sales. During the legislative consideration of this measure, the American Lung Association in Rhode Island and other public health and governmental organizations expressed concerns with this provision. However, the provision was retained and the bill became law taking effect on January 1, 2019.

Other tobacco-related bills that were introduced, but not passed included: adding sales and use taxes to ENDS products and little cigars and raising the minimum age of sale for tobacco products from 18 to 21.

On the local level, there were numerous victories. Cranston, East Greenwich and Pawtucket strengthened their existing outdoor smokefree ordinances by including ENDS products. Woonsocket and West Warwick enacted restrictions on product placement. West Warwick also strengthened their local tobacco retail ordinance by substantially increasing their annual tobacco licensing fee. But Rhode Island also saw our fair share of challenges which the Lung Association and other partners aided in. There were several proposed rollbacks to pre-existing tobacco ordinances in Central Falls that were successfully defended. This included enforcement of their tobacco retail license as well as their flavored tobacco ordinance. Barrington is fighting a lawsuit to defend being able to locally raise the minimum tobacco sales age to 21. Johnston and Middletown are also fighting lawsuits to continue enforcing local tobacco licensing.

On January 1, 2018, state legislation that added ENDS devices to the Smoke-Free Schools Laws took effect.

With a strong partnership and funding from CVS Health, Tobacco Free Rhode Island (a grant administered through the Lung Association) printed and distributed updated outdoor signage to every public, private and charter, elementary, middle and high school in Rhode Island.

The American Lung Association in Rhode Island will build on positive hearings in 2018 and support legislation that raises the age of sale for tobacco products to 21; increases funding for the state's tobacco control program; and strengthens local tobacco control regulations. Strong public support exists for these measures, which the Lung Association will seek to publicize and leverage with legislators and policy makers.

## Rhode Island State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $639,604,224 |
| Adult Smoking Rate: | 14.9% |
| Adult Tobacco Use Rate: | 19.2% |
| High School Smoking Rate: | 6.1% |
| High School Tobacco Use Rate: | 25.9% |
| Middle School Smoking Rate: | 1.9% |
| Smoking Attributable Deaths: | 1,780 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data come from the 2017 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the Rhode Island 2017 Youth Risk Behavior Surveillance System.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Rhode Island**
(401) 533-5179
www.lung.org/rhodeisland

# South Carolina Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

SOUTH CAROLINA

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $5,000,000 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $1,461,223* |
| FY2019 Total Funding for State Tobacco Control Programs: | $6,461,223 |
| CDC Best Practices State Spending Recommendation: | $51,000,000 |
| Percentage of CDC Recommended Level: | 12.7% |
| State Tobacco-Related Revenue: | $238,200,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: F

**OVERVIEW OF STATE SMOKING RESTRICTIONS:**

Government Worksites: **Restricted**

Private Worksites: **No provision**

Schools: **Restricted**

Child Care Facilities: **Prohibited**

Restaurants: **No provision**

Bars: **No provision**

Casinos/Gaming Establishments: **N/A (tribal casinos only)**

Retail Stores: **No provision**

Recreational/Cultural Facilities: **Restricted**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: S.C. CODE ANN. §§ 44-95-10 et seq. (2012).

Note: The Smokefree Air grade only examines state law and does not reflect local smokefree ordinances. South Carolina has made great strides in protecting people from secondhand smoke by passing comprehensive local smokefree ordinances that cover 36.6% of the state's population.

## Tobacco Taxes: F

**CIGARETTE TAX:**

Tax Rate per pack of 20: **$0.57**

OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: No; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: B

**OVERVIEW OF STATE CESSATION COVERAGE:**

STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **All 3 forms counseling are covered**

Barriers to Coverage: **Minimal barriers exist to access care**

Medicaid Expansion: **No**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Some medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

STATE QUITLINE:

Investment per Smoker: **$5.63; the median investment per smoker is $2.21**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See South Carolina Tobacco Cessation Coverage page for specific sources.

Thumbs up for South Carolina for providing comprehensive coverage for all tobacco cessation medications and types of counseling with minimal barriers to Medicaid enrollees.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **South Carolina** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in South Carolina. To address this enormous toll, the American Lung Association calls for the following three actions to be taken by South Carolina's elected officials:

1. Increase the price of tobacco products to reduce tobacco use among youth and adults;
2. Increase the number of comprehensive local smokefree air laws; and
3. Increase funding for the state's tobacco prevention program.

South Carolina has completed its first year of full tobacco cessation coverage for Medicaid beneficiaries. In July 2017, the South Carolina Department of Health and Human Services (SC DHHS) enhanced tobacco cessation coverage for full-benefit Medicaid beneficiaries to align with recommendations from the Centers for Disease Control and Prevention and the American Lung Association. SC DHHS and the SC Department of Health and Environmental Control (DHEC) worked together to craft a plan to benefit both fee-for-service and managed care Medicaid benefits. The American Lung Association produced a case study and webinar detailing the South Carolina success.

The American Lung Association in South Carolina and partners in the South Carolina Tobacco-Free Collaborative continue to support passage of smokefree air ordinances at the local level. The state has 65 local comprehensive smokefree air ordinances covering about 40 percent of the state's population. State funding for DHEC's Tobacco Prevention and Control programs remained at $5 million for fiscal year 2019. Tobacco industry supporters tried to attach an amendment to preempt local governments from regulating tobacco products in any form to the state budget bill toward the end of the 2018 session of the legislature, but it failed to gain traction. The Lung Association opposes tobacco industry attempts to preempt local elected officials from passing tobacco use prevention laws and policies.

The Lung Association is part of a growing number of organizations under the umbrella of the South Carolina Tobacco-Free Collaborative to urge consideration of a significant increase in the state's 57-cent cigarette tax with comparable increases for other tobacco products. Significant increases in the price of cigarettes result in reductions in smoking especially among youth. The South Carolina 2017 Youth Tobacco Survey found that 1 out of 4 high school students currently use some form of tobacco. For the first time, current e-cigarette use (13%) surpassed conventional cigarette smoking (12%). In addition, current smokeless tobacco use has dramatically increased among females (6%). For middle school students 1 out of 10 currently use some form of tobacco. Current e-cigarette use (6%) nearly doubles conventional cigarette smoking (3%).

The American Lung Association in South Carolina will continue to advocate for comprehensive smokefree air ordinances, increased tobacco taxes and increased funding for the state tobacco prevention program.

## South Carolina State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $1,906,984,487 |
| Adult Smoking Rate: | 18.8% |
| Adult Tobacco Use Rate: | 24.0% |
| High School Smoking Rate: | 10.0% |
| High School Tobacco Use Rate: | 21.6% |
| Middle School Smoking Rate: | 3.2% |
| Smoking Attributable Deaths: | 7,230 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data come from the 2017 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the 2017 Youth Tobacco Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in South Carolina**
(843) 556-8451
www.lung.org/southcarolina

# South Dakota Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

SOUTH DAKOTA

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $4,500,000 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $880,166* |
| FY2019 Total Funding for State Tobacco Control Programs: | $5,380,166 |
| CDC Best Practices State Spending Recommendation: | $11,700,000 |
| Percentage of CDC Recommended Level: | 46.0% |
| State Tobacco-Related Revenue: | $86,900,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: C

**OVERVIEW OF STATE SMOKING RESTRICTIONS:**

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited (smoking of certain tobacco products allowed in certain bars)**

Casinos/Gaming Establishments: **Prohibited**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: S.D. CODIFIED LAWS §§ 34-46-13 to 34-46-19 (2010).

## Tobacco Taxes: F

**CIGARETTE TAX:**

Tax Rate per pack of 20: **$1.53**

OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: Yes; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: F

**OVERVIEW OF STATE CESSATION COVERAGE:**

STATE MEDICAID PROGRAM:

Medications: **Limited medications are covered**

Counseling: **Limited counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **No**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Some medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

STATE QUITLINE:

Investment per Smoker: **$15.07; the median investment per smoker is $2.21**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

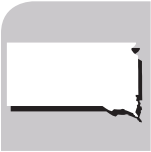
Citation: See South Dakota Tobacco Cessation Coverage page for specific sources.

Thumbs down for South Dakota for providing the worst cessation coverage for Medicaid enrollees in the country.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **South Dakota** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in South Dakota. To address this enormous toll, the American Lung Association calls for the following actions to be taken by South Dakota's elected officials:

1. Increase the tax on cigarettes and other tobacco products by $1.00 or more per pack;
2. Raise the age of sale for all tobacco products to 21 years old; and
3. Fully fund South Dakota's tobacco control program.

The South Dakota Department of Health along with national, state and local partners continue to work together on the implementation of the five-year tobacco strategic plan. The four goal areas of the plan include: preventing initiation of tobacco use, promoting quitting among adults and youth, eliminating exposure to secondhand smoke and identifying and eliminating tobacco-related disparities among population groups. Priority populations include: American Indians, Medicaid clients, pregnant women, people with mental illness and substance use disorders, spit tobacco users, youth and young adults.

South Dakota placed a tobacco tax increase on the fall ballot by collecting over 19,000 signatures in support of the ballot initiative. Measure 25 would have increased the state tax on tobacco products by $1.00 per pack of 20 cigarettes along with the tax on other types of tobacco products such as cigars, roll-your-own, and chewing tobacco from the current rate of 35 percent of the wholesale price to 55 percent.

The measure would have created a postsecondary technical institute fund for the purposes of lowering student tuition and providing financial support to state postsecondary technical institutes. Under current law, the first $30 million of tobacco tax collected annually goes to the general fund, the next $5 million into the tobacco prevention and reduction fund. This measure would require the next $20 million to be deposited into the technical institute fund. Unfortunately, the ballot measure was not approved by South Dakota voters with the tobacco industry spending over $6 million to defeat the measure. The last increase in tobacco tax in South Dakota was in 2006, which was also a $1.00 increase done by a statewide ballot initiative.

The coalition in South Dakota has strong roots across the state and is working together to support tobacco control best practices and continues to work together to implement the strategic plan to reduce the harm from tobacco in South Dakota.

## South Dakota State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $373,112,273 |
| Adult Smoking Rate: | 19.3% |
| Adult Tobacco Use Rate: | 24.8% |
| High School Smoking Rate: | 10.1% |
| High School Tobacco Use Rate: | 30.3% |
| Middle School Smoking Rate: | 2.0% |
| Smoking Attributable Deaths: | 1,250 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data come from the 2015 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the 2017 Youth Tobacco Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC)software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in South Dakota**
(218) 726-4723
www.lung.org/southdakota

# Tennessee Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

TENNESSEE

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $0 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $1,506,829* |
| FY2019 Total Funding for State Tobacco Control Programs: | $1,506,829 |
| CDC Best Practices State Spending Recommendation: | $75,600,000 |
| Percentage of CDC Recommended Level: | 2.0% |
| State Tobacco-Related Revenue: | $422,000,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

Thumbs down for Tennessee for providing no state funding for tobacco prevention programs despite smoking costing the state close to $2.7 billion in healthcare costs each year.

## Smokefree Air: D

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited (non-public workplaces with three or fewer employees exempt)**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Restricted***

Bars: **Restricted***

Casinos/Gaming Establishments: **N/A**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: TENN. CODE ANN. §§ 39-17-1801 to 39-17-1810 (2008).

*Smoking is allowed in restaurants and bars that do not allow persons under 21 to enter at any time.

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$0.62**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: F

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Minimal counseling is covered**

Barriers to Coverage: **Substantial barriers exist to access care**

Medicaid Expansion: **No**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Limited barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$0.39; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Tennessee Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Tennessee** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Tennessee. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Tennessee's elected officials:

1. Restore funding in the 2019-2020 budget for statewide tobacco control programs
2. Support legislation to remove local preemption language for smokefree laws; and
3. Build momentum on the importance of raising the retail sales age of tobacco products to 21 years old.

Unfortunately, during the 2018 legislative session, state funding for tobacco education programs within the Tennessee Department of Health was stripped from the state budget. Tobacco Master Settlement Agreement funds were deleted from the program and diverted to non-tobacco related projects. Restoring funding in the 2019-2020 budget for statewide tobacco control will be a top priority.

While efforts to remove preemption of local smokefree ordinances in Tennessee failed in 2018, the American Lung Association in Tennessee and our health advocate partners will work to further engage with the Tobacco Free Tennessee Coalition in a broad education effort about county and municipal government support for local options. With a newly-elected governor, and likely changes in legislative leadership positions, a strong strategic public education campaign will be critical.

As Medicaid expansion in Tennessee continues to evolve, the Lung Association will be actively engaged in the process to minimize barriers to tobacco cessation-related coverages.

Also, in 2018 the University of Tennessee Knoxville joined the University of Tennessee Chattanooga and the University of Tennessee Health Science Center in Memphis in going smokefree in all locations on campus. UT Knoxville's policy includes cigarettes, vapes and e-cigarettes.

The American Lung Association in Tennessee will continue to work with our many health coalition partners and others and will work to grow and activate our grassroots network statewide, to advance tobacco control and prevention initiatives at the state and local levels. As the legislature begins its work in 2019, the Lung Association will continue our efforts to educate policy makers, business leaders and the media on the importance of the Lung Association's goals to reduce tobacco use and protect public health.

## Tennessee State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $2,672,824,085 |
| Adult Smoking Rate: | 22.6% |
| Adult Tobacco Use Rate: | 29.3% |
| High School Smoking Rate: | 9.4% |
| High School Tobacco Use Rate: | 20.3% |
| Middle School Smoking Rate: | N/A |
| Smoking Attributable Deaths: | 11,380 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use rates are taken from the 2017 Youth Risk Behavior Surveillance System. A current middle school smoking rate is not available for this state.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Tennessee**
(502) 363-2652
www.lung.org/tennessee

# Texas Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

TEXAS

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $4,246,909 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $4,571,762* |
| FY2019 Total Funding for State Tobacco Control Programs: | $8,818,671 |
| CDC Best Practices State Spending Recommendation: | $264,100,000 |
| Percentage of CDC Recommended Level: | 3.3% |
| State Tobacco-Related Revenue: | $1,933,300,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

Thumbs down for Texas for cutting funding for its state tobacco control program by close to $6 million this fiscal year compared to the previous two-year state budget.

## Smokefree Air: F

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **No provision**

Private Worksites: **No provision**

Schools: **Restricted**

Child Care Facilities: **Prohibited**

Restaurants: **No provision**

Bars: **No provision**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **No provision**

Recreational/Cultural Facilities: **Restricted**

E-Cigarettes Included: **Yes**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: TEX. PENAL CODE ANN. § 48.01 (2015); TX EDUC. CODE § 38.006 (2015); and TX ADMIN. CODE tit. 40, Part 19, Subchapter S, Div. 1 §§ 746.3703(d) (1995) & 747.3503(d) (1990).

Note: The Smokefree Air grade only examines state tobacco control law and does not reflect local smokefree ordinances. Texas has made great strides in protecting people from secondhand smoke by passing comprehensive local smokefree ordinances that cover 45.2% of the state's population.

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$1.41**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: No; Weight-Based: Yes**

Tax on large cigars: **Equalized: No; Weight-Based: Yes**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: Yes**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: F

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **No**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$0.60; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Texas Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Texas** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Texas. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Texas' elected officials:

1. Restore funding for tobacco prevention and cessation programs that was significantly cut in 2017;
2. Continue to pass comprehensive local smokefree ordinances to builds towards a statewide smokefree law; and
3. Increase the minimum sales age for tobacco products to 21.

The American Lung Association in Texas along with our partners at Smoke-Free Texas provides leadership and guidance for public policy efforts to continue the state's success in reducing the impact of tobacco among Texans. Together with our partners, the American Lung Association in Texas works to ensure tobacco control and prevention remains a priority for state legislators and local decision makers.

The Texas Legislature only meets in odd numbered years, so in 2018 the American Lung Association in Texas and its partners in the Smokefree Texas coalition worked in communities around the state to pass local smokefree ordinances. Fort Worth implemented its local smokefree law in March 2018 becoming the last major city in Texas to prohibit smoking in virtually all public places and workplaces. Texas currently has 104 cities with comprehensive smokefree ordinances protecting more than 12.5 million citizens from the harmful effects of secondhand smoke.

State funding for Texas' tobacco prevention program in the Texas Department of State Health Services was severely cut in the two-year state budget approved in 2017, leaving only $4.2 million in funding to prevent and reduce tobacco use across the entire state in fiscal year 2019.

Moving forward in 2019, the Lung Association will work with its partners to once again pursue an increase in the minimum legal sales age of tobacco products to 21. In 2017 this bill passed an initial House Committee but failed to get additional committee hearings. The Lung Association will also work to restore funding to the Tobacco Education and Enforcement Fund that was cut during the 2017 legislative session.

## Texas State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $8,855,602,443 |
| Adult Smoking Rate: | 15.7% |
| Adult Tobacco Use Rate: | 20.9% |
| High School Smoking Rate: | 7.4% |
| High School Tobacco Use Rate: | 16.8% |
| Middle School Smoking Rate: | 2.4% |
| Smoking Attributable Deaths: | 28,030 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use rates are taken from the 2017 Youth Risk Behavior Surveillance System. Middle school (8th grade only) smoking rates are taken from the 2016 Texas School Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Texas**

Dallas Office: (214) 631-5864

Houston office: (713) 629-5864

www.lung.org/texas

# Utah Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

UTAH

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $7,006,800 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $1,074,415* |
| FY2019 Total Funding for State Tobacco Control Programs: | $8,081,215 |
| CDC Best Practices State Spending Recommendation: | $19,300,000 |
| Percentage of CDC Recommended Level: | 41.9% |
| State Tobacco-Related Revenue: | $141,900,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: A

**OVERVIEW OF STATE SMOKING RESTRICTIONS:**

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

Casinos/Gaming Establishments: **N/A**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **Yes**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: UTAH CODE ANN. §§ 26-38-1 et seq. (2012).

## Tobacco Taxes: F

**CIGARETTE TAX:**

Tax Rate per pack of 20: **$1.70**

OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: Yes; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: C

**OVERVIEW OF STATE CESSATION COVERAGE:**

STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Limited counseling is covered**

Barriers to Coverage: **Substantial barriers exist to access care**

Medicaid Expansion: **Yes**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

STATE QUITLINE:

Investment per Smoker: **$5.03; the median investment per smoker is $2.21**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Insurance Commissioner bulletin**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Utah Tobacco Cessation Coverage page for specific sources.

## Minimum Age: D

Minimum Age of Sale for Tobacco Products: **19**

# **Utah** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Utah. To address this enormous toll, the American Lung Association in Utah calls for the following actions to be taken by our elected officials:

1. Maintain or increase funding for state's tobacco prevention and control program;
2. Increase the minimum legal sales age for tobacco products to 21; and
3. Raise Utah's tobacco tax to encourage an even further reduction in tobacco use.

In 2018, the American Lung Association in Utah supported legislation that would have increased the age to legally purchase tobacco products to 21 years of age from age 19 currently. Although the legislation did not make it out committee, legislators were educated on the issue for when the bill is introduced in future legislative sessions.

House bill 324 was approved by the legislature and signed into law during the 2018 legislative session, which added e-cigarettes and hookah to the definition of smoking in Utah's Clean Indoor Air Act and made a number of changes to state and municipal licensing requirements for retailers of tobacco products.

Funding for the Utah Tobacco Prevention and Control Program at the state Department of Health was again maintained at about the same level as previous years in fiscal year 2019. The program is funded by a combination of tobacco Master Settlement Agreement dollars and tobacco tax revenue.

In November 2018, Utah voters approved an initiative supported by the Lung Association expanding the Medicaid program in the state. Once implemented, this will potentially give a lower income population that smokes at higher rates than the general population access to at least some tobacco cessation treatments and services at low or no cost.

In 2019, the American Lung Association in Utah will continue pushing to increase the sales age for tobacco products to 21, and to maintain or increase funding for the Utah Tobacco Prevention and Control Program.

## Utah State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $542,335,526 |
| Adult Smoking Rate: | 8.9% |
| Adult Tobacco Use Rate: | 14.0% |
| High School Smoking Rate: | 3.8% |
| High School Tobacco Use Rate: | 9.7% |
| Middle School Smoking Rate: | N/A |
| Smoking Attributable Deaths: | 1,340 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use rates are taken from the 2017 Youth Risk Behavior Surveillance System. A current middle school smoking rate is not available for this state.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Utah**
(602) 429-0002
www.lung.org/utah

# Vermont Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

VERMONT

## Tobacco Prevention and Control Program Funding: D

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $3,167,021 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $1,097,073* |
| FY2019 Total Funding for State Tobacco Control Programs: | $4,264,094 |
| CDC Best Practices State Spending Recommendation: | $8,400,000 |
| Percentage of CDC Recommended Level: | 50.8% |
| State Tobacco-Related Revenue: | $99,800,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: A

**OVERVIEW OF STATE SMOKING RESTRICTIONS:**

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

Casinos/Gaming Establishments: **N/A**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **Yes**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: VT STAT. ANN. tit. 18, §§ 28-1421 to 28-1428 & 37-1741 et seq. (2016).

## Tobacco Taxes: B

**CIGARETTE TAX:**

Tax Rate per pack of 20: **$3.08**

OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: Yes; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: B

**OVERVIEW OF STATE CESSATION COVERAGE:**

STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Limited counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Most counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

STATE QUITLINE:

Investment per Smoker: **$4.58; the median investment per smoker is $2.21**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Yes**

Tobacco Surcharge: **Prohibits tobacco surcharges**

Citation: See Vermont Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Vermont** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Vermont. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Vermont's elected officials:

1. Enact legislation to raise the retail sales age of tobacco products to 21;
2. Maintain past additional $1 million increase in tobacco control program funding; and
3. Implement an excise tax on electronic cigarettes equal to cigarettes and other tobacco products.

The 2018 session of the Vermont legislature ended with a significant tobacco win with $1 million from a one-time tobacco Master Settlement Agreement payment that Vermont received in April due to settlement of a dispute over a portion of past MSA payments with tobacco companies being added to the fiscal year 2019 budget bill for the state's tobacco control program. This is the first increase to the tobacco control budget in ten years and the American Lung Association in Vermont and partners will look to sustain this increase in 2019.

The Vermont Department of Health will use most of the one-time appropriation to enhance mass-reach health communication interventions. These interventions will include a multi-media campaign to encourage adult cessation, misperceptions of the harm of JUUL and other electronic nicotine devices focused on youth and a new campaign based on formative research targeting women who smoke during pregnancy. Reducing smoking during pregnancy is a high priority for the state given the rate of smoking during pregnancy in Vermont is twice the national average.

The American Lung Association in Vermont will continue to work with our coalition partners including the American Heart Association, American Cancer Society Cancer Action Network and others to advance tobacco control and prevention efforts. As the legislature begins its work in 2019 we will continue to grow our coalition to educate policy makers, business leaders and the media of the importance of the American Lung Association's goals to reduce tobacco use and protect public health. A renewed effort by the Lung Association and partners to increase the minimum legal age of sale for tobacco products to 21 is likely in 2019.

## Vermont State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $348,112,248 |
| Adult Smoking Rate: | 15.8% |
| Adult Tobacco Use Rate: | 19.5% |
| High School Smoking Rate: | 9.3% |
| High School Tobacco Use Rate: | 18.9% |
| Middle School Smoking Rate: | 2.0% |
| Smoking Attributable Deaths: | 960 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use rates are taken from the 2017 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the Vermont 2017 Youth Risk Behavior Surveillance System; results are rounded to the nearest whole number.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Vermont**
(802) 876-6860
www.lung.org/vermont

# Virginia Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

VIRGINIA

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $10,784,678 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $1,330,054* |
| FY2019 Total Funding for State Tobacco Control Programs: | $12,114,732 |
| CDC Best Practices State Spending Recommendation: | $91,600,000 |
| Percentage of CDC Recommended Level: | 13.2% |
| State Tobacco-Related Revenue: | $304,400,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: F

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Restricted**

Private Worksites: **No provision**

Schools: **Prohibited (public schools only)**

Child Care Facilities: **Prohibited (excludes home-based child care providers)**

Restaurants: **Restricted**

Bars: **Restricted**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **Restricted**

Recreational/Cultural Facilities: **Restricted**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: VA. CODE ANN. §§ 15.2-2820 to 15.2-2828 (2009).

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$0.30**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: Yes; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

Thumbs down for Virginia for having the second lowest cigarette tax in the country at 30 cents per pack.

## Access to Cessation Services F

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **Some medications are covered**

Counseling: **Limited counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Some medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$0.51; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Virginia Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Virginia** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Virginia. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Virginia's elected officials:

1. Increase the cigarette excise tax by at least $1.00 per pack;
2. Create parity between taxes on cigarettes and other tobacco products; and
3. Fund tobacco prevention and cessation programs at the Centers for Disease Control and Prevention (CDC)-recommended level.

In the 2018 legislative session, a bill for Medicaid Expansion was introduced. This legislation passed and was signed by the Governor. With the implementation of this legislation an additional 400,000 people will be eligible for Medicaid in Virginia. Expansion will provide critical treatment and services to this newly covered population, including preventive services such as tobacco cessation and lung cancer screening. This legislation implements in January 2019.

Multiple bills to prohibit tobacco products in schools, including on school grounds and to strengthen the state's Clean Indoor Air Act were also introduced in the state House of Representatives and Senate. Current law prohibits smoking in some public places but allows separately-ventilated smoking rooms in restaurants and bars, and completely leaves out workplaces that are not open to the public. Unfortunately, all bills were left in their respective legislative committees and died.

Funding for tobacco prevention and cessation programs in Virginia increased by about $2 million in fiscal year 2019 from the previous fiscal year. Unfortunately, this is likely to be an increase only for this year as the increase was due to a one-time settlement of a dispute with tobacco companies over a portion of tobacco Master Settlement Agreement payments.

In 2019, priorities for the American Lung Association in Virginia will include working to ensure prevention and cessation programs are funded at a minimum at historic levels, a significant increase in the cigarette excise tax, and parity between taxes on cigarettes and other tobacco products.

## Virginia State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $3,113,009,298 |
| Adult Smoking Rate: | 16.4% |
| Adult Tobacco Use Rate: | 21.5% |
| High School Smoking Rate: | 6.5% |
| High School Tobacco Use Rate: | 16.3% |
| Middle School Smoking Rate: | 2.4% |
| Smoking Attributable Deaths: | 10,310 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data come from the 2017 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the Virginia 2017 Youth Risk Behavior Surveillance System.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Virginia**
(202) 785-3355
www.lung.org/virginia

# Washington Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

WASHINGTON

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $1,527,607 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $2,740,647* |
| FY2019 Total Funding for State Tobacco Control Programs: | $4,268,254 |
| CDC Best Practices State Spending Recommendation: | $63,600,000 |
| Percentage of CDC Recommended Level: | 6.7% |
| State Tobacco-Related Revenue: | $552,600,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: A

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

Casinos/Gaming Establishments: **Prohibited (tribal establishments exempt)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: WASH. REV. CODE § 70.345.150 (2016).

## Tobacco Taxes: C

### CIGARETTE TAX:

Tax Rate per pack of 20: **$3.025**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: F

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **Some medications are covered**

Counseling: **Limited counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Most medications are covered**

Counseling: **All three types of counseling are covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$0.43; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Washington Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

Thumbs down for Washington for failing to pass legislation to increase the tobacco sales age to 21.

# **Washington** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Washington. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Washington's elected officials:

1. Increase funding for tobacco prevention and cessations programs;
2. Raise the sales age to 21 for tobacco products; and
3. Defend smokefree workplace laws.

Three bills were introduced in the legislature to raise the legal age of sale for tobacco products to 21 (House Bill 1054, Senate Bill 5025 and Senate Bill 6048). House Bill 1054 was legislation requested by the state Attorney General and the Department of Health.

During the 2017 legislative session, House Bill 1054 had passed out of both the House Committee on Health Care and Wellness and the House Finance Committee. At the beginning of the 2018 regular session, by resolution, the legislation was retained in the Rules Committee, and referred to the Finance committee, where it was again passed out of the committee. On March 7, 2018, the bill was debated on the House Floor with very passionate floor speeches on tobacco and the effect tobacco has had on members' families and friends. The bill passed the House with bipartisan support with 63 yes votes and 35 no votes. Unfortunately, the 2018 session ended before the bill could begin its process through the Senate.

House Bill 1919 would establish licensing for cigar lounges and retail tobacconist shops. This legislation saw no activity during the 2018 session.

The spending authority for Washington's Youth Tobacco & Vapor Products Prevention Account was reduced by $1.6 million by the legislature. Despite this, funding for tobacco prevention and cessation in fiscal year 2019 was roughly the same as the previous year at about $1.5 million. However, this small amount of state funding is wholly inadequate for the task of effectively preventing and reducing tobacco use.

The American Lung Association in Washington will continue to work with stakeholders and engaged grassroot supporters to advocate for policies to reduce tobacco use and its health impact on Washington residents. Building on our momentum from the 2018 legislative session, the Lung Association will continue to support Tobacco 21 and use the increased awareness of tobacco to provide the foundation to increase appropriations for tobacco prevention programs.

## Washington State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $2,811,911,987 |
| Adult Smoking Rate: | 13.5% |
| Adult Tobacco Use Rate: | 17.9% |
| High School Smoking Rate: | 6.3% |
| High School Tobacco Use Rate: | N/A |
| Middle School Smoking Rate: | 3.1% |
| Smoking Attributable Deaths: | 8,290 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school (10th grade only) and middle school (8th grade only) smoking rates are taken from the 2016 Washington State Healthy Youth Survey. A current high school tobacco use rate is not available for this state.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Washington**
(206) 441-5100
www.lung.org/washington

# West Virginia Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

WEST VIRGINIA

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $0 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $1,837,400* |
| FY2019 Total Funding for State Tobacco Control Programs: | $1,837,400 |
| CDC Best Practices State Spending Recommendation: | $27,400,000 |
| Percentage of CDC Recommended Level: | 6.7% |
| State Tobacco-Related Revenue: | $238,000,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

Thumbs down for West Virginia for spending no state money on tobacco prevention and cessation programs despite smoking costing the state over $1 billion in healthcare costs each year.

## Smokefree Air: D*

### OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Restricted**

Private Worksites: **No provision**

Schools: **Prohibited (public schools only)**

Child Care Facilities: **Restricted**

Restaurants: **No provision**

Bars: **No provision**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **No provision**

Recreational/Cultural Facilities: **No provision**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **No**

Preemption: **No**

Citation: W. VA. CODE §§ 16-9A-4 (1987) & 31-20-5b (1997); WV Div. of Personnel Policy, Smoking Restrictions in the Workplace (2004); WV CSR §§ 64-21-10 (1997), 64-21-20 (1997) & 126-66-1 et seq. (1998).

*West Virginia has 60.4% of the state's population covered by comprehensive local smokefree workplace regulations. If a state has more than 50% of its population covered by local smokefree ordinances/regulations, the state is graded based on population covered by those local ordinances/regulations rather than the statewide law.

## Tobacco Taxes: F

### CIGARETTE TAX:

Tax Rate per pack of 20: **$1.20**

### OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: No; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: F

### OVERVIEW OF STATE CESSATION COVERAGE:

#### STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **Yes**

#### STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

#### STATE QUITLINE:

Investment per Smoker: **$1.04; the median investment per smoker is $2.21**

#### OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See West Virginia Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **West Virginia** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in West Virginia. To address this enormous toll, the American Lung Association calls for the following actions to be taken by West Virginia's elected officials:

1. Restoration of West Virginia state funding for tobacco prevention and cessation;
2. Protect smokefree air regulations as they currently exist throughout the state; and
3. Increase the age of sale for all tobacco products to 21.

During the 2018 legislative session, tobacco prevention and control funding failed to be restored. The House of Delegates had proposed funding for tobacco education in the state budget that was presented to the House Finance committee. However, after Governor Justice announced a 5 percent salary increase for teachers and all state employees, the tobacco prevention and control funding was deleted from the budget.

The Senate Finance Committee Chairman announced, while discussing the Senate budget in committee, that an agreement had been reached and that no amendments to the budget would be offered, and in return, he would support future funding be restored for tobacco control.

A bill introduced by Senator Stollings, to increase the age of sale for tobacco products to 21, stalled in the Senate Judiciary Committee. In the House, a bill was similarly introduced by Representative Rowe to raise the legal age of sale for tobacco products to 21 but failed to move forward in the House Health and Human Resources Committee.

The Board of Health in Hancock County took a deeply disappointing action in 2018 amending its Clean Indoor Air regulation to allow smoking at casinos and gaming sections of local video lottery cafes. This will once again expose thousands of workers and patrons to toxic secondhand smoke. The Lung Association discourages other counties from following Hancock's bad example.

New leadership and direction from the Coalition for Tobacco Free West Virginia (CTFWV) has placed an emphasis on the need for shared information, collaboration throughout the state, and building local support.

The Lung Association is working on bi-partisan sponsorship of a Tobacco 21 bill to introduce during the 2019 legislative session. Findings from a representative survey of over 3,000 West Virginian voters who voted in the 2016 election indicate that almost two thirds (63.2%) favor raising the legal sales age for tobacco products from 18 to 21. Additionally, the survey found that the majority of both Democrats and Republicans support Tobacco 21. Only about 1 in 7 West Virginia voters strongly oppose raising the legal sales age for tobacco products.

The American Lung Association in West Virginia will continue to educate lawmakers in the ongoing fight against tobacco. Our goal is to identify champions within the legislator and continue to build a strong state coalition to advance our advocacy goals, including restoration of West Virginia state funding for tobacco prevention and cessation, protection of smokefree indoor air regulations, and increasing the age of sale for all tobacco products to 21.

## West Virginia State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $1,008,474,499 |
| Adult Smoking Rate: | 26.0% |
| Adult Tobacco Use Rate: | 35.0% |
| High School Smoking Rate: | 10.3% |
| High School Tobacco Use Rate: | 26.6% |
| Middle School Smoking Rate: | 4.5% |
| Smoking Attributable Deaths: | 4,280 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school and middle school smoking rates are taken from the 2017 Youth Tobacco Survey. High school tobacco use rate is taken from the 2017 Youth Risk Behavior Surveillance System.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in West Virginia**
(717) 971-1130
www.lung.org/westvirginia

# Wisconsin Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

WISCONSIN

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $5,300,000 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $2,687,204* |
| FY2019 Total Funding for State Tobacco Control Programs: | $7,987,204 |
| CDC Best Practices State Spending Recommendation: | $57,500,000 |
| Percentage of CDC Recommended Level: | 13.9% |
| State Tobacco-Related Revenue: | $757,800,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: A

**OVERVIEW OF STATE SMOKING RESTRICTIONS:**

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited (allowed in existing tobacco bars)**

Casinos/Gaming Establishments: **Prohibited (tribal establishments exempt)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

E-Cigarettes Included: **No**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Limited**

Citation: WI STAT. ANN. § 101.123 (2010).

## Tobacco Taxes: D

**CIGARETTE TAX:**

Tax Rate per pack of 20: **$2.52**

OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: No**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: F

**OVERVIEW OF STATE CESSATION COVERAGE:**

STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Some counseling is covered**

Barriers to Coverage: **Limited barriers exist to access care**

Medicaid Expansion: **No**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Most counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

STATE QUITLINE:

Investment per Smoker: **$1.43; the median investment per smoker is $2.21**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **Medicaid enrollees are subject to a tobacco surcharge**

Citation: See Wisconsin Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

# **Wisconsin** State Highlights:



Tobacco use remains the leading cause of preventable death and disease in the United States and in Wisconsin. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Wisconsin's elected officials:

1. Protect and increase funding for the Tobacco Prevention and Control Program;
2. Equalize the tax on little cigars (brown cigarettes) with regular cigarettes; and
3. Pass legislation that places ALL tobacco products behind the counter or in a locked cabinet.

Meaningful tobacco control policy advancement continued to be stymied on the state level in 2018. Assembly Bill 159, a bill that would have required all Wisconsin schools to adopt a strong policy prohibiting e-cigarette use on school property passed the Assembly Committee on Education, 14-1 but then was denied a full floor vote in the Assembly.

Even more disappointing, Senate Bill 307/Assembly Bill 225, which would have required all tobacco products to be placed behind the counter or in a locked cabinet, did not pass. The bill had strong, bi-partisan co-sponsorship in both house and overwhelming support from numerous statewide health organizations. After a hearing before the Senate Committee on Agriculture, Small Business, and Tourism, it was passed 9-0 and moved to the Senate floor where it passed on a voice vote. The Assembly Committee on State Affairs also held a public hearing where numerous individuals testified in support and none against, but then stalled. Subsequently, the bill did not advance before the end of the session.

Work continued on the local level with several major e-cigarette victories in 2018. The City of Milwaukee passed an ordinance that prohibits the use of e-cigarettes anywhere that smoking isn't allowed. That city was joined by the cities of Oak Creek, Beaver Dam, Neenah and Grant County. Other communities, such as Appleton and Juneau made advances in clean outdoor air by passing laws limiting the use of cigarettes, e-cigarettes and other tobacco products in parks and recreational areas.

Due to the skyrocketing rise in e-cigarette and other tobacco products use, particularly flavored products, Wisconsin has created an awareness campaign aimed at parents, Tobacco is Changing, with a tagline that says, "Tobacco is Changing, parents. We've got to keep up." The campaign includes paid advertising and on-line videos, social media and a website that familiarizes parents and adults with the new products and the issues surrounding them, provides opportunities to take action, and connects viewers with resources available through the state Tobacco Prevention and Control Program.

While the American Lung Association in Wisconsin will continue to work with local tobacco control coalitions to strengthen community tobacco control ordinances, the most sweeping progress is still made at the state level. The Lung Association will continue to focus on passing legislation that requires that ALL tobacco sales be clerk assisted, create tax parity between cigarettes and little cigars and advocate to increase funding for the state Tobacco Prevention and Control Program. The Lung Association hopes that new governor Tony Evers and the legislature can work together to make positive advancements in tobacco control in 2019.

## Wisconsin State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $2,663,227,988 |
| Adult Smoking Rate: | 16.0% |
| Adult Tobacco Use Rate: | 20.9% |
| High School Smoking Rate: | 7.8% |
| High School Tobacco Use Rate: | 17.3% |
| Middle School Smoking Rate: | 1.3% |
| Smoking Attributable Deaths: | 7,850 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use rates are taken from the 2017 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the 2016 Youth Tobacco Survey.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Wisconsin**
(262) 703-4200
www.lung.org/wisconsin

# Wyoming Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2019

WYOMING

## Tobacco Prevention and Control Program Funding: F

| | |
|---|---|
| FY2019 State Funding for Tobacco Control Programs: | $3,045,522 |
| FY2019 Federal Funding for State Tobacco Control Programs: | $835,432* |
| FY2019 Total Funding for State Tobacco Control Programs: | $3,880,954 |
| CDC Best Practices State Spending Recommendation: | $8,500,000 |
| Percentage of CDC Recommended Level: | 45.7% |
| State Tobacco-Related Revenue: | $40,200,000 |

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

## Smokefree Air: F

**OVERVIEW OF STATE SMOKING RESTRICTIONS:**

Government Worksites: **Restricted**

Private Worksites: **No provision**

Schools: **No provision**

Child Care Facilities: **No provision**

Restaurants: **No provision**

Bars: **No provision**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **No provision**

Recreational/Cultural Facilities: **No provision**

E-Cigarettes Included: **N/A**

Penalties: **No**

Enforcement: **No**

Preemption: **No**

Citation: Wyoming State Govt. Non-Smoking Policy (1989).

## Tobacco Taxes: F

**CIGARETTE TAX:**

Tax Rate per pack of 20: **$0.60**

OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: Yes; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: Yes; Weight-Based: Yes**

Tax on pipe/RYO tobacco: **Equalized: Yes; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: Yes; Weight-Based: Yes**

For more information on tobacco taxes, go to: www.lung.org/slati

## Access to Cessation Services: D

**OVERVIEW OF STATE CESSATION COVERAGE:**

STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Limited counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **No**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Some medications are covered**

Counseling: **No counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

STATE QUITLINE:

Investment per Smoker: **$10.13; the median investment per smoker is $2.21**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Wyoming Tobacco Cessation Coverage page for specific sources.

## Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

## **Wyoming** State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Wyoming. To address this enormous toll, the American Lung Association calls for the following actions to be taken by Wyoming's elected officials:

1. Increase tobacco taxes by a $1.00 or more per pack;
2. Maintain funding for tobacco prevention and cessation programs; and
3. Pass additional local or state legislation eliminating smoking in public places and workplaces.

During the short 2018 legislative session focused on the two-year state budget, the Joint Revenue Interim Committee sponsored House Bill 43 which would increase taxes on cigarettes and other tobacco products by varying amounts, including a $1.00 per pack increase on cigarettes. Unfortunately, the House of Representatives decided not to introduce the legislation, effectively killing any chance of increasing tobacco taxes during the 2018 session.

Funding for tobacco prevention and cessation programs also took a reduction in the fiscal year 2019 and 2020 two-year budget with about a $1.4 million reduction over the two years or $700,000 each year. Funding that previously came from the state general fund was redirected to suicide prevention.

Wyoming's cigarette tax remains one of the lowest in the nation at $0.60 per pack. The American Lung Association in Wyoming will continue working with partners to support increases in tobacco taxes and additional appropriations for tobacco prevention and cessation programs. The Lung Association will also support any efforts to pass local or statewide smokefree workplace laws in Wyoming.

### Wyoming State Facts

| | |
|---|---|
| Health Care Costs Due to Smoking: | $257,674,019 |
| Adult Smoking Rate: | 18.7% |
| Adult Tobacco Use Rate: | 28.1% |
| High School Smoking Rate: | 15.7% |
| High School Tobacco Use Rate: | 38.4% |
| Middle School Smoking Rate: | 5.4% |
| Smoking Attributable Deaths: | 800 |

Adult smoking and tobacco use data come from CDC's 2017 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data come from the 2015 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the Wyoming 2013 Youth Risk Behavior Surveillance System.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

**American Lung Association in Wyoming**
(206) 441-5100
www.lung.org/wyoming

We will breathe easier when the air in every
American community is clean and healthy.
We will breathe easier when people are free from the addictive
grip of tobacco and the debilitating effects of lung disease.
We will breathe easier when the air in our public spaces and
workplaces is clear of secondhand smoke.
We will breathe easier when children no longer
battle airborne poisons or fear an asthma attack.
***Until then, we are fighting for air.***

**About the American Lung Association**

The American Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease, through research, education and advocacy. The work of the American Lung Association is focused on four strategic imperatives: to defeat lung cancer; to improve the air we breathe; to reduce the burden of lung disease on individuals and their families; and to eliminate tobacco use and tobacco-related diseases. For more information about the American Lung Association, a holder of the Better Business Bureau Wise Giving Guide Seal, or to support the work it does, call 1-800-LUNGUSA (1-800-586-4872) or visit: www.Lung.org.

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