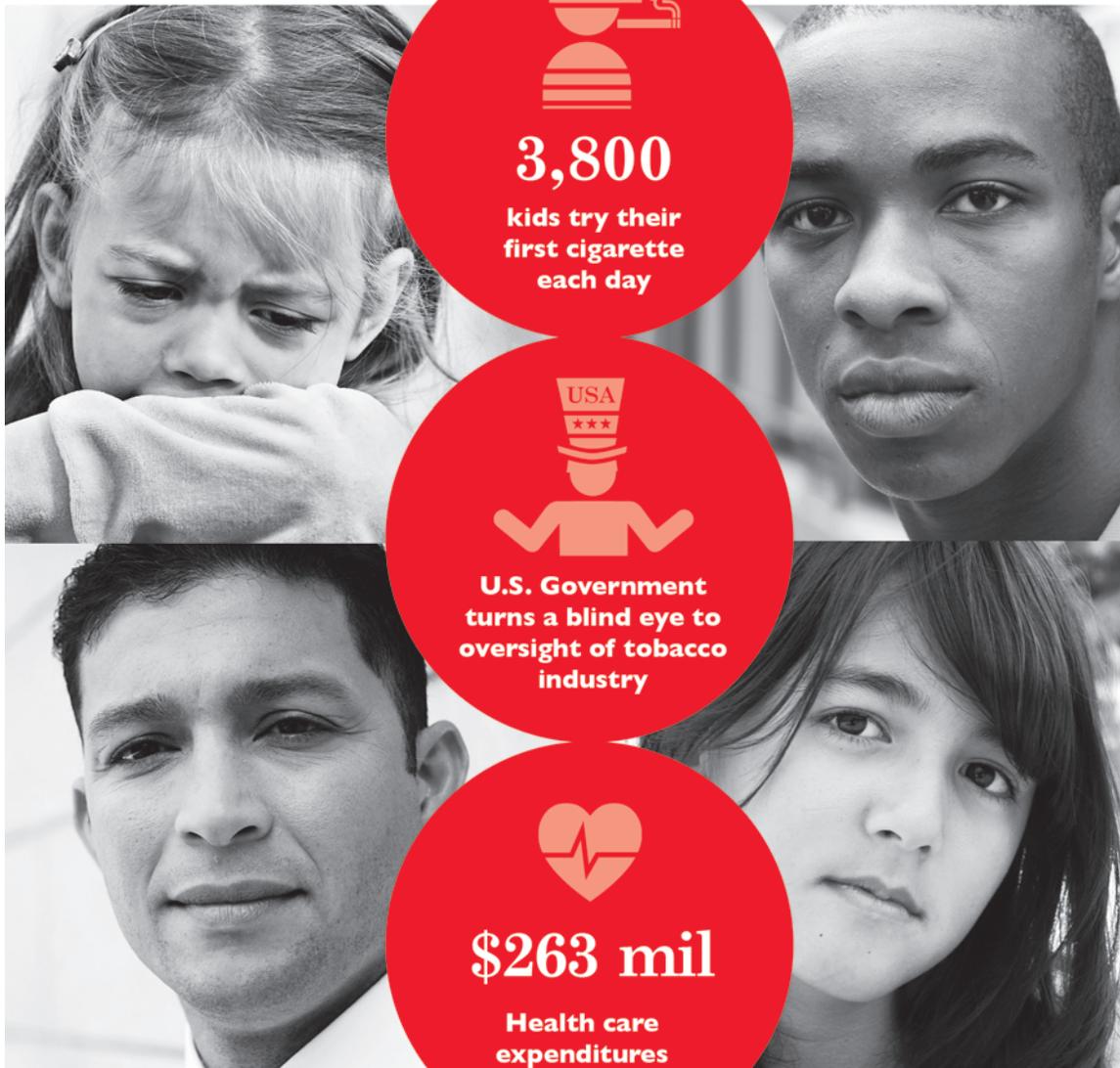


State of Tobacco Control[®] 2013

† AMERICAN LUNG ASSOCIATION. Lung.org / 1-800-LUNGUSA



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Disclaimer

The *American Lung Association State of Tobacco Control*® 2013 report is for informational purposes only. The American Lung Association does not guarantee the accuracy of the contents of this book. Laws change, often quite rapidly, and interpretations of statutes may vary from court to court. Legislation may have been acted upon, or cases decided, after this book went to press. The cut-off date for new laws to be considered was January 2, 2013.

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Our Mission: To save lives by improving lung health and preventing lung disease

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State of Tobacco Control Overview

The American Lung Association's *State of Tobacco Control* report tracks progress on key tobacco control policies at the state and federal levels, and assigns grades based on tobacco control laws and regulations in effect as of January 2, 2013. The federal government, all 50 state governments and the District of Columbia are graded to determine if tobacco control laws are adequately protecting citizens from the enormous toll tobacco use takes on lives and the economy. This is the eleventh year the report has been issued by the American Lung Association.

Money emerges as the core theme in *State of Tobacco Control 2013*—specifically how states fail to invest in preventing and reducing tobacco use, and how the tobacco industry spends money to make more in profits at the expense of the health of the American people. Although smoking alone costs our nation nearly \$200 billion in healthcare costs and lost productivity each year, the federal government has also failed to aggressively pursue the tobacco industry. Specifically:

- ◆ State governments continue to look the other way as they fail to invest billions of dollars from tobacco taxes and tobacco settlement payments that should be directed to effectively prevent kids from starting to use tobacco and help current tobacco users quit;
- ◆ An ever-expanding and evolving tobacco industry pursues new users with ruthless zeal and strengthens its grasp on its current victims by creating new products and new ways to market them;
- ◆ With the exception of the federal government's first-ever paid quit smoking campaign, 2012 can best be summarized as a missed opportunity for the Obama Administration to curb the leading cause of preventable death. The Obama Administration's actions to regulate the tobacco industry through the U.S. Food and Drug Administration (FDA) over the past several years ground to a halt in 2012.

A new report, "[Big Tobacco Wins Tax Battles](#)," released concurrently with "State of Tobacco Control 2013" from the National Institute on Money in State Politics finds that candidates running for re-election in the 2012 election cycle were flush with cash from the tobacco industry. The industry spent over \$53 million total on candidates for state office, political parties and to oppose ballot measures, including over \$46 million to defeat a \$1.00 cigarette tax increase on the ballot in California.ⁱ According to the Center for Responsive Politics, the tobacco industry spent more than \$3.7 million on supporting federal candidates.ⁱⁱ

ⁱ Campaign contribution data is as of December 1, 2012, and may increase as more data becomes available.

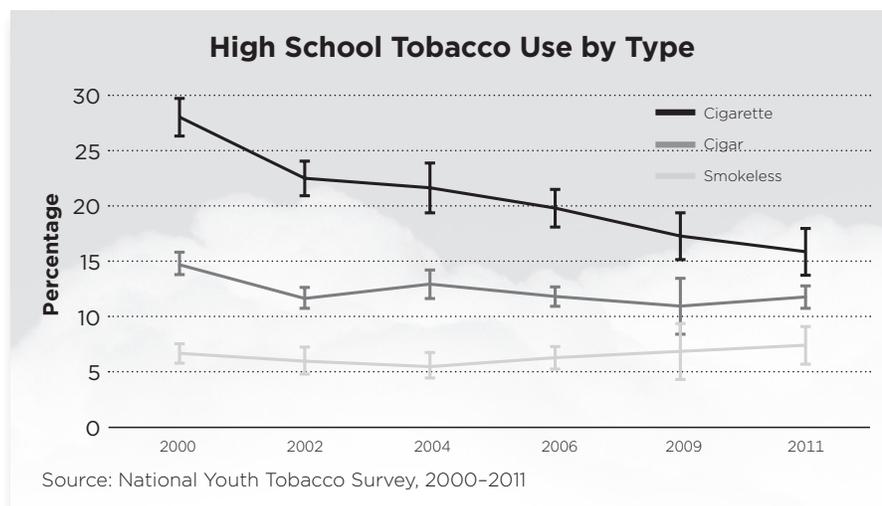
ⁱⁱ Center for Responsive Politics, <http://www.opensecrets.org/industries/totals.php?cycle=2012&ind=A02>, accessed December 7, 2012.

More details about the state and federal grading areas and the methodology behind the grades are available starting on p. 37 of the report

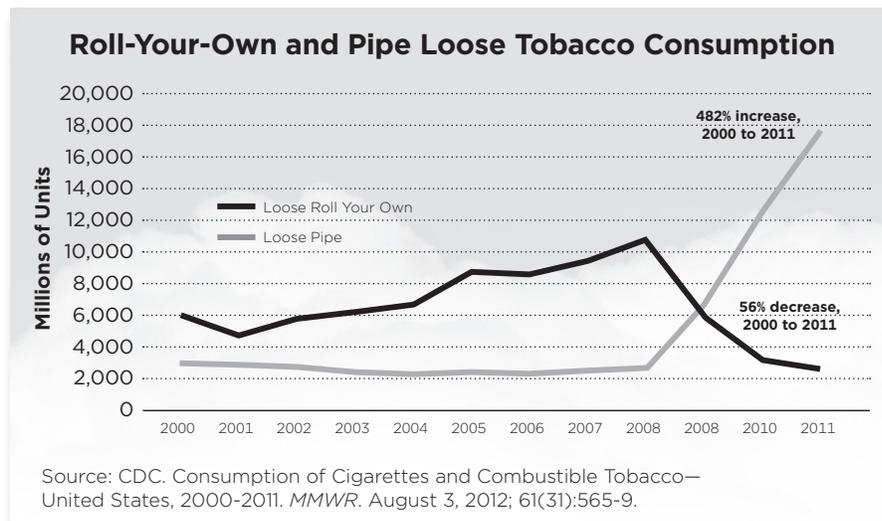
The grades in *State of Tobacco Control 2013* reflect how well federal and state tobacco control laws and policies measure up to the best in the nation or to goals set by agencies such as the Centers for Disease Control and Prevention (CDC). Many states have hard-working tobacco control coalitions that encounter stiff resistance from state legislators and powerful tobacco interests. *The grades in this report in no way reflect the level of effort invested by the public health community.* Instead, it is the responsibility of elected officials to muster the political will to enact these life- and money-saving policies.

As Cigarette Use Declines, Tobacco Industry Follows the Money to Other Tobacco Products

In August, CDC released results of the 2011 National Youth Tobacco Survey which found youth cigarette use continues to decline and now stands at 15.8 percent among high school students and 4.3 percent among middle school students. These reductions can be attributed to implementing the evidence-based policies proven to reduce tobacco use evaluated in [“State of Tobacco Control.”](#) These include increasing tobacco taxes, passing comprehensive smokefree laws, helping smokers quit and investing in tobacco prevention programs.



However, instead of remaining tobacco-free in the wake of these policies, young people are turning to cheaper tobacco products due to the failure of federal and state governments to equalize tobacco taxes, so that other tobacco products, like cigars and smokeless tobacco, are taxed at a rate comparable to cigarettes. Earlier this year, the U.S. Government Accountability Office (GAO) released a study that found unequal tax rates among all tobacco products has led to “significant market shifts” as tobacco users switch from cigarettes to lower-priced products.



This failure by states and the federal government to equalize tobacco taxes has led to a surge in the popularity and consumption of other tobacco products. Manufacturers of these products are also spending millions of dollars per day on marketing and capitalizing on the failure of the Obama Administration and the FDA to move forward with regulating tobacco products other than smokeless tobacco and cigarettes.

Working to fill the tax and regulatory voids created by federal and state governments, the three largest cigarette manufacturers—Altria, Reynolds American and Lorillard—have acquired companies making other tobacco products to sustain their deadly profits and maintain the tobacco addiction of millions of Americans.

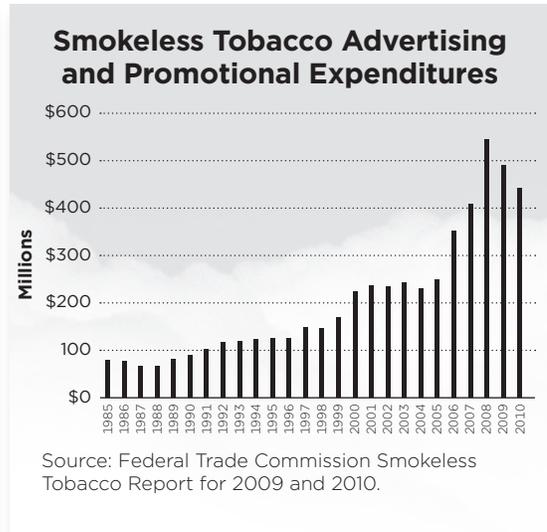
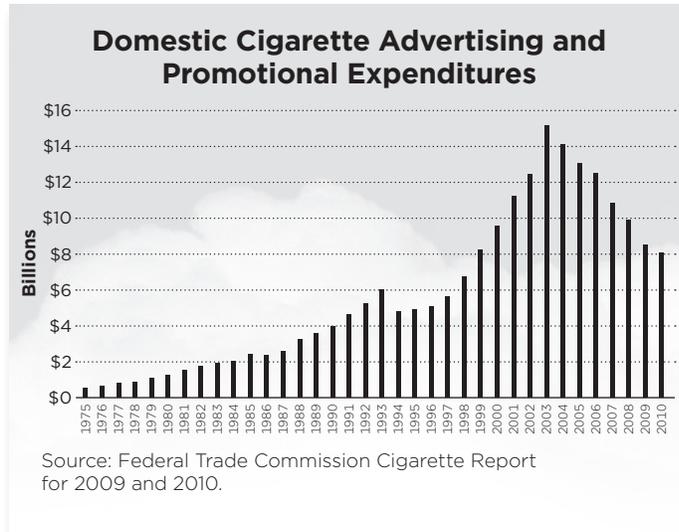
- ◆ Altria, owner of Phillip Morris USA and maker of Marlboro cigarettes, owns U.S. Smokeless Tobacco Company and John Middleton Cigars, which like Marlboro, have brands that are some of the most popular among youth.
- ◆ Reynolds American, owner of R.J. Reynolds, includes American Snuff Company and Sante Fe Tobacco in its addiction empire.
- ◆ Lorillard, maker of Newport—the most popular and deadly menthol cigarette, acquired BluCigs, an electronic cigarette company in 2012. BluCigs has recently begun advertising on television.

Indeed, Altria saw its greatest profits in the first half of 2012 come from combined sales of its Copenhagen and Skoal smokeless brands, followed by Black and Mild, its cigar brand and then Marlboro.¹ Second quarter results from Reynolds American showed that volume from its American Snuff smokeless line increased by 11 percent while its cigarette volume decreased by 6.7 percent.²

In September, the Federal Trade Commission released its regular report showing declines in industry marketing expenditures in both cigarette and smokeless marketing. Cigarette companies spent \$8.05 billion in 2010, down from \$9.94 in 2008.³ Smokeless marketing expenditures in 2010—which

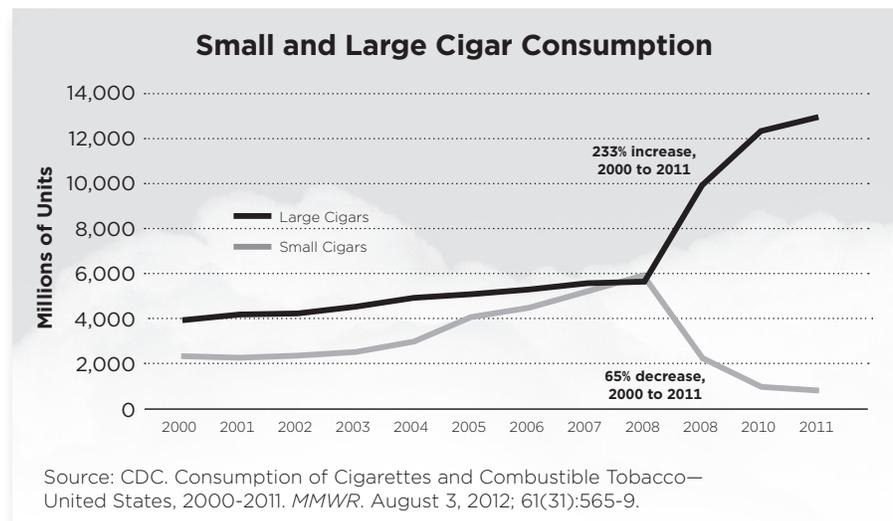
State of Tobacco Control Overview

had been increasing for a number of years—dropped to \$444.2 million from \$547.9 million in 2008.⁴ Unfortunately, no similar reports exist for the marketing of other tobacco products.



Large Cigar Consumption Increases as Cigar Industry Joins Big Tobacco's Inner Circle

Three studies released in August highlight a disturbing trend, a dramatic increase in the consumption of large cigars. This trend is almost certainly due to the unequal taxes on tobacco products other than cigarettes at the federal and state level.



- ◆ On August 2, a study in the CDC's Morbidity and Mortality Weekly Report (MMWR), titled "Consumption of Cigarettes and Combustible Tobacco, 2000-2011," showed that while cigarette use has declined 33 percent since 2000, the use of large cigars has increased 233 percent over this period.

- ◆ Another MMWR study released by CDC on August 10, showed that current rates of cigar and smokeless tobacco use—particularly among high school boys—nearly match the rates of cigarette smoking, and that cigar use among African American high school students increased from 7.1 percent in 2009 to 11.7 percent in 2011.
- ◆ The journal *Nicotine & Tobacco Research* published “Flavored Cigar Smoking Among U.S. Adults: Findings from the 2009–2010 National Adult Tobacco Survey,” which found the use of flavored cigars among cigar smokers is highest among young, poor, Hispanic, and lesbian, gay, bisexual, transgendered (LGBT) populations.

The money trail continues onward to the cigar industry and its attempts to build support via political contributions. According to the Center for Responsive Politics, ten cigar companies and associations and three cigar political party political action committees (PAC) have made campaign contributions to Members of Congress. In July, the Center wrote an article highlighting the super PAC created by the cigar industry to build support for taking away FDA’s authority over cigars.⁵

The cigar industry was also present in Tampa, Fla., and Charlotte, N.C., for the Republican and Democratic Presidential nominating conventions, according to the Cigar Advisor, a website about cigars. An advisor to presidential candidate Governor Mitt Romney even ran a private, VIP cigar lounge in Tampa during the Republican National Convention, according to a Washington Post report.⁶

Cigarette Industry Looks to Hold onto Remaining Profits with Old Moves

The cigarette industry used aggressive and familiar tactics to successfully strike against California’s proposed cigarette tax—an evidence-based strategy proven to reduce tobacco use. The tobacco industry spent more than \$46 million to successfully defeat California’s Proposition 29 in June, according to the National Institute on Money in State Politics report. Had it been successful, Proposition 29 would have increased the state’s cigarette tax to \$1.87 per pack to raise money for cancer research and the state’s effective tobacco prevention program.

The cigarette industry continued its obstructive judicial strategies as well—continuing its pursuit to block graphic cigarette warning labels. In August, the U.S. Court of Appeals for the District of Columbia upheld a lower court ruling blocking the FDA from moving forward with its 2011 graphic warning label proposal. Earlier this year, the U.S. Court of Appeals for the 6th Circuit affirmed the FDA’s authority to require graphic warning labels on cigarette packages, foreshadowing a future showdown at the U.S. Supreme Court.

Lorillard and R.J. Reynolds filed another lawsuit against FDA, alleging that some members of the agency’s Tobacco Products Scientific Advisory Board (TPSAC) are biased against the tobacco industry. TPSAC is a committee of scientific experts set up to assist FDA with scientific questions surrounding tobacco products and use. In March of 2011, TPSAC submitted a [report](#) to FDA, which found that public health would benefit if menthol cigarettes were removed from the marketplace. In March 2012, TPSAC [found](#) that dissolvable tobacco products could prove to be less harmful to users than cigarettes, but that they could lead to an increase in overall tobacco use prevalence.

States Collect Billions in Tobacco-Related Revenue, But Fail to Use It to Fight Tobacco Use

2012 saw state elected officials taking in millions in tobacco industry campaign contributions, state coffers receiving billions in tobacco revenues from excise taxes and tobacco settlement payments, and almost no progress in implementing tobacco control measures across the country.

- ◆ States collected \$25.7 billion in tobacco excise tax and Master Settlement payments while sinking to a new low in failing to fund tobacco prevention and quit smoking programs;
- ◆ Only Illinois significantly increased its cigarette tax by \$1.00 to \$1.98 per pack;
- ◆ North Dakota voters made their state the 28th smokefree state in the U.S. through approval of a ballot initiative in November. No state legislature passed a comprehensive smokefree law in 2012;
- ◆ States only minimally increased efforts to help smokers quit, despite unprecedented opportunities to do much more through the implementation of the Affordable Care Act.

The dismal performance by state officials to put in place proven ways to reduce tobacco use—the leading cause of preventable death in the United States—has been a repeated theme of previous “State of Tobacco Control” reports. Tragically, that trend continues into 2013.

States Collect Tobacco Revenue Dollars...But Don't Spend Them on Reducing Tobacco Use

Most states have two dedicated streams of tobacco-related revenue:

1. Revenue collected from state excise taxes on tobacco products.
2. Payments received from the tobacco industry as part of the [Master Settlement Agreement](#)ⁱⁱⁱ or separate tobacco settlement agreement.^{iv}

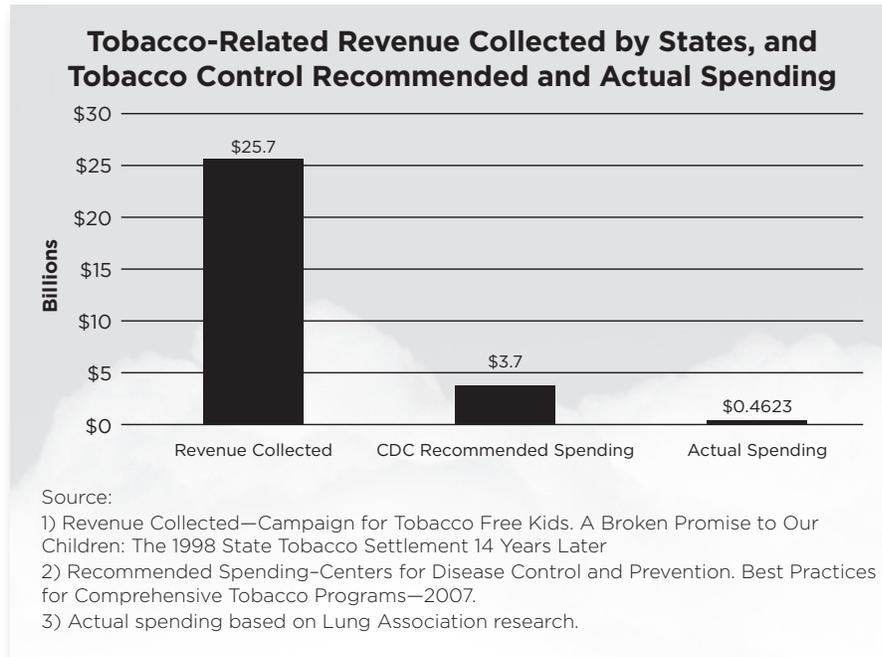
While close to 20 states and the District of Columbia chose to sell part or all of their annual settlement payments for a one-time payment up front, many still receive yearly payments from cigarette manufacturers as part of the tobacco settlement agreements and will continue to do so indefinitely. Both sources provide states a logical way to fully fund state tobacco control programs at levels recommended by the [Centers for Disease Control and Prevention \(CDC\)](#). States receive \$25.7 billion from tobacco-related revenue annually, and CDC recommends states invest about \$3.7 billion or about 14.4 percent of this revenue on tobacco prevention and control programs each year. However, states spent a meager \$462.5 million on tobacco prevention and control programs total in fiscal year 2013, about 12.5 percent of the CDC recommendation.

In 2012, just two states—Alaska and North Dakota—earned As for sufficiently investing in their tobacco prevention and control programs. One

ⁱⁱⁱ Some states have securitized their MSA payments, or sold future payments for pennies on the dollar in exchange for a one-time payment like a person has the option of doing when they win the lottery.

^{iv} Four states: Florida, Minnesota, Mississippi and Texas settled separately with the tobacco industry prior to the 1998 Master Settlement Agreement.

other state—Delaware—earned a B. However, the overwhelming majority of states—42 plus the District of Columbia—earned an F because they failed to invest even 50 percent of what is recommended by the CDC in proven prevention programs, that save lives and reduce the terrible health burden caused by tobacco use.



U.S. Surgeon General Dr. Regina Benjamin released “[Preventing Tobacco Use Among Youth and Young Adults](#)” in March of 2012. The report found that the failure of states to invest in policies and programs to reduce tobacco use has resulted in 3 million new youth and young adult smokers, at least a third of whom will ultimately die from their addiction. The report also concluded that if states begin to invest in comprehensive programs today, youth tobacco use can be cut in half in just six years.⁷

By Failing to Equalize Tobacco Taxes, States Lose Revenue And Fail to Reduce Tobacco Use

The American Lung Association has long advocated for higher tobacco taxes, recognizing that higher prices reduce smoking rates, particularly among youth. The average cigarette tax has reached \$1.49 and all but three states—California, Missouri and North Dakota—have increased their tax at least once since 2000. However, states have not moved to increase taxes on other tobacco products, including smokeless tobacco, cigars, little cigars and roll-your-own tobacco products to the same degree. No states have equalized their taxes on other tobacco products with their taxes on cigarettes. Lower taxes on certain tobacco products promote their use, which puts lives at risk and leaves money for states on the table.

In 2012, only Illinois increased its cigarette tax by a meaningful amount, more than doubling it from 98 cents to \$1.98 per pack. In Missouri, voters narrowly voted down Proposition B, which would have increased Missouri’s

state cigarette tax from 17 cents, the lowest in the nation, to 90 cents per pack. Only Maryland and Illinois acted this year to increase taxes on other tobacco products. Pennsylvania remains the only state in the U.S. that does not tax tobacco products other than cigarettes.

The GAO study about the consequences of the federal government failing to equalize tax rates across all tobacco products mentioned previously, found the federal government lost up to \$1.1 billion annually. While the dollar amounts are not at those same levels, states face the same consequences.

1. By not equalizing tax rates, the federal government “created opportunities” for tax avoidance.
2. Customers concerned about prices switched to lower-taxed products, which led to “significant market shifts.”

The most recent [National Youth Tobacco Survey](#) shows the consequences of states failing to equalize tobacco tax rates. The percentage of high school students who smoke cigars and use smokeless tobacco has remained unchanged in recent years. Most troubling is that high school boys now smoke cigars at rates almost equal to cigarettes (15.7 percent report smoking cigars) and 12.9 percent of high school boys use smokeless tobacco.

These new data highlight the urgent need for states to tax all tobacco products at similar rates, which would also increase revenue that should be used to fund comprehensive tobacco prevention programs.

“Large federal excise tax disparities among tobacco products...created opportunities for tax avoidance and led to significant market shifts by manufacturers and price sensitive consumers toward the lower-taxed products.”

—U.S. Government
Accountability Office

North Dakota Meets the Smokefree Air Challenge

On November 6, North Dakota citizens voted overwhelmingly (67% to 33%) to make their state the 28th state to go smokefree. However, 2012 paled in comparison to 2006, when six states and the District of Columbia successfully met the American Lung Association’s [Smokefree Air Challenge](#).

Unfortunately, state lawmakers’ inaction in protecting all workers and patrons from exposure to secondhand smoke in the remaining 22 states is a severely troubling trend. According to the [U.S. Surgeon General](#), there is no safe level of exposure to secondhand smoke, and the only way to fully protect people is to eliminate exposure in all public places and workplaces.⁸ Indiana did pass a law in 2012 that protects workers in many public places and workplaces from secondhand smoke, but left out bars and gaming establishments where the most exposure to secondhand smoke occurs.

Developments to protect people from secondhand smoke at the local level in 2012 were more positive. The biggest cities in Alabama (Birmingham) and Indiana (Indianapolis) as well as the 2nd largest city in Wyoming (Casper) passed comprehensive smokefree ordinances. Combined, these cities are home to more than 1 million people.

In 2013, legislatures in Kentucky, Mississippi and Texas are expected to take up bills that could add these states to the ranks of smokefree states. Texas, the second largest state in the country, previously considered a comprehensive law in 2009 and 2011, but efforts failed in both legislative sessions.

States Are Mixed When It Comes to Helping Smokers Quit

State activity to help smokers quit was mixed in 2012. A few states, including Colorado, Kansas, North Dakota and South Dakota added coverage of tobacco cessation counseling for pregnant women on Medicaid, to bring them into compliance with the Affordable Care Act. Additionally, new tobacco cessation benefits for all Medicaid enrollees began in Connecticut and Tennessee on January 1, 2012. A few states also added new help for state employees who want to quit smoking, including Florida, Georgia, Nebraska and New Jersey. Despite these positive developments, no state receives an A or B in 2012 for cessation coverage.

However, not all states stepped forward to help their smokers this year. The most troubling example is Maine, which cut coverage for all tobacco cessation medications from Medicaid coverage, except federally required coverage for pregnant women. This move, done to save money, is tragic and incredibly short-sighted. The Maine Medicaid program will be paying for the financial and health consequences for years if this coverage is not reinstated. In 2011, the American Lung Association named Maine the nation's most "quit-friendly" state, and it earned a B grade in cessation coverage. Because of this change in coverage, Maine's grade drops to a D in 2012.

States have a crucial opportunity in the coming two years to help many more smokers quit, as states implement major portions of the federal Affordable Care Act. People currently on Medicaid and people that are currently uninsured smoke at rates significantly higher than the general population—and these are the very people who will be gaining new healthcare coverage and benefits under the Act. States will see lives and money saved if they ensure that all new enrollees in Medicaid and participants in health insurance exchanges have access to the help they need to quit. One crucial way states must do this is by including a comprehensive tobacco cessation benefit in the Essential Health Benefit, which is a set of minimum standards for coverage in plans in state health insurance exchanges and Medicaid programs.

Tobacco Interests Contribute Near Record Amount to State Candidates And Ballot Initiatives in 2011 and 2012

As the National Institute on Money in State Politics found in their report, the tobacco industry and its allies were active in funding their preferred candidates for office, and opposing ballot measures that threatened their profits in 2012. More than \$53 million was spent by the tobacco industry and its allies in all 50 states^v, including \$46.3 million in California to defeat a \$1.00 per pack increase in the cigarette tax on the ballot in June 2012. More than \$825,000 was spent in Missouri, primarily by convenience stores and other industry allies, to defeat the 73 cent tobacco tax increase on the November 2012 ballot in that state.

^v Campaign contribution data is as of December 1, 2012, and may increase as more data becomes available.

Federal Government Largely Absent in Fight to Reduce Tobacco Use in 2012

“Missed opportunities to save lives” is perhaps the best way to describe the federal government’s actions—or lack thereof—to reduce death and disease caused by tobacco use in 2012. While the Obama Administration deserves great credit for its first-term accomplishments in implementing policies that will reduce tobacco use across the nation, in 2012 almost all meaningful action by the Administration to reduce the leading cause of preventable death in the U.S. ground to a halt. The complete lack of action by the U.S. Food and Drug Administration (FDA) was particularly noteworthy.

Food And Drug Administration Largely Absent with Its Failure to Assert Authority over All Tobacco Products

The Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act), which President Obama signed into law in 2009, gave FDA immediate authority over cigarettes and smokeless tobacco products. The Tobacco Control Act also gave FDA the ability to then assert authority or “deem” jurisdiction over all other tobacco products, including cigars, e-cigarettes, hookah and pipe tobacco, many of which are included in a report published by the American Lung Association about the next generation of tobacco products that are being used to target kids. Despite announcing two years ago that it would assert jurisdiction over tobacco products other than cigarettes and smokeless tobacco products, FDA has yet to publish a proposed rule.

As a result of FDA not moving to assert its authority over cigars, a well-funded industry effort has launched in Congress to completely exempt large and so-called premium cigars from all of FDA’s authority. Working with Representatives Eric Posey (R-FL) and Kathy Castor (D-FL) and Senators Bill Nelson (D-FL) and Marco Rubio (R-FL), the cigar industry introduced HR 1639 and S. 1461. These bills would completely take away FDA’s authority to regulate most cigars, including the cigars that are the most popular among youth. If either of these two bills were to become law, it would mean FDA could not require warning labels on cigars, require cigars to be put behind the counter away from kids, or tell cigar manufacturers to take out candy-flavors that are appealing to youth smokers. As of December 1, the cigar bills had 220 cosponsors in the House and 13 in the U.S. Senate. The public health community has strongly pushed back against these attempts and has urged FDA to move forward so that the industry cannot continue to make baseless claims.

Also in the absence of FDA action, Altria, the parent company of Philip Morris, began selling Verve, a product described as a non-tobacco nicotine product. According to press sources, Altria is seeking weaker warning labels on its Verve product. The American Lung Association is concerned about the increasing presence of smokeless tobacco and other nicotine products that can sustain a user’s addiction to nicotine and tobacco products instead of the user quitting. Verve could be marketed as a product for smokers to use when in a smokefree environment—instead of that environment prompting the smoker to try to quit.

Use of E-Cigarettes Seemingly on the Rise as FDA Again Looks the Other Way

The lack of regulation over other tobacco products has also led to the rapid proliferation of electronic cigarettes or e-cigarettes. E-cigarette companies are blatantly marketing their products as safer than cigarettes and aggressively promoting their products as a way to quit smoking. Following the resolution of a court case in 2011 that determined most e-cigarettes will be regulated as tobacco products, FDA's Center for Drug Evaluation and Research (CDER) and the Center for Tobacco Products (CTP) issued a [joint letter to stakeholders](#) outlining a potential regulatory framework. While CTP cannot act until it deems authority over all other tobacco products, CDER has immediate authority to require any e-cigarette that makes therapeutic claims, such as promoting them as an aide to quit smoking, to have its safety and efficacy proven in order to remain in the marketplace.

E-cigarettes now come in dozens of flavors, including candy flavors such as [Atomic Fireball](#), cherry cola, cherry limeade, caramel candy, blueberry and orange cream soda, and are now advertised on [television](#) and have been sold by [Groupon](#), an online company that advertises business and products by selling discount vouchers. FDA's failure to act to regulate e-cigarettes before they became widely accessible is likely to have long-lasting implications on what FDA might do to regulate these products in the future, and will likely be seen as a missed public health opportunity.

FDA Must Be Proactive to Combat the New Ways Industry Is Targeting Kids

FDA also must ensure it is keeping pace with new tobacco industry and tobacco industry surrogate marketing techniques. As the use of social media as well as handheld devices such as smartphones continues to grow, FDA must take aggressive action to ensure it is out in front of the curve to prevent kids from becoming victims to the tobacco industry. An October study from the journal *Tobacco Control* found that 107 pro-smoking apps can be found in both the Apple App store and the Android app Market which simulate smoking a cigarette, teach the user how to roll a cigarette, and provide images of cigarettes to serve as a phone background.⁹ The researchers also found that little regulation exists on the reach of these apps, with the exception of a warning of mature content found on certain apps in the Apple App store. With the ready availability of these pro-smoking apps to adults and kids alike, the fear is that it provides a new avenue for the tobacco industry to market its deadly products and could possibly lead to an increase in the number of kids trying smoking.

Issues Around New Products and Substantial Equivalence Claims Loom

The Tobacco Control Act requires tobacco companies that are introducing products to market for the first time to go through one of two processes. If the product is "substantially equivalent" or the same as a product that was being sold before February 15, 2007 based on the provisions established in the Tobacco Control Act, the manufacturer must submit research and data to FDA in order to establish this. If it is a new product and one that is not substantially equivalent to one being sold before the above date, the manu-

What is an e-cigarette?

According to FDA, electronic cigarettes, or e-cigarettes, are devices that allow users to inhale a vapor containing nicotine or other substances. Unlike traditional cigarettes, e-cigarettes are battery-operated and use an atomizer to heat a refillable cartridge that then releases a chemical-filled vapor. For more information, see this [FDA Q&A document](#).

facturer must submit its product to FDA for authorization before it is sold and go through the new product review process outlined in the Tobacco Control Act.

The tobacco industry has expressed its frustration through the news media, through its allies in Congress, and presumably directly to FDA that the agency is not moving quickly enough in making substantial equivalence determinations. However, it is critical that FDA not authorize these substantial equivalence claims until and unless the tobacco manufacturers provide the evidence as required by the Tobacco Control Act. If the industry is not meeting the requirements under the law, FDA is correct in determining that these products are substantially equivalent. But the lack of information provided by FDA about substantial equivalence determinations make it difficult to figure out what is actually occurring.

Comments filed with the FDA by public health and medical organizations including the American Lung Association in November of 2011 highlight FDA's legal responsibilities and failings in both areas, which have gone unchanged in 2012. The comments state that, 'it appears that the tobacco industry is carefully using the "substantial equivalence" exception to evade the "new product" requirements and will continue to do so until FDA takes strong action. These concerns deepened when it was revealed that as of earlier in 2012 more than 2,500 substantial equivalence applications had been filed (although it is also not clear whether the manufacturers submitted all of the required information to FDA)—and not a single new product application. This lack of new product applications clearly points to the tobacco industry using the poorly executed substantial equivalence process as a way to ensure their products remain in the marketplace – despite the explicit provisions of the Tobacco Control Act.

In the comments, the organizations also highlight that the lack of "publicly available information about pending substantial equivalence filings or FDA actions taken with regard to such filings does not serve the public interest in ensuring that regulatory policies are transparent."

The American Lung Association is, however, worried that the tobacco industry is introducing new products into the marketplace without prior authorization. In September of 2012, Philip Morris introduced Marlboro NXT, a cigarette with a capsule that, when pressed, will release menthol into the cigarette. Philip Morris and its parent company Altria announced its intent to begin selling this new product without a permit from FDA.

No Action on Recommendations from Scientific Advisory Committee

FDA has also not moved to implement recommendations from its own Tobacco Products Scientific Advisory Committee (TPSAC) regarding menthol cigarettes. In March of 2011, [TPSAC recommended](#) removing menthol cigarettes from the marketplace. FDA proceeded to write its own report and stated the agency would make it available for public comment, which it has failed to do. Approximately 28-34 percent of smokers smoke menthol cigarettes,^{10,11} and the Committee concluded that the availability of menthol cigarettes increases the number of children and African Americans who smoke.

In March, TPSAC issued another report, this time on [dissolvable tobacco](#)

products (DTPs). In its report, TPSAC stated it was “concerned that availability of DTPs with lower risks to health than cigarettes might affect the public perception of all tobacco products, leading to increased use because of reduced concern about health risks of tobacco products generally.” FDA must act so that smokers do not switch to dissolvable tobacco products instead of quitting, and to ensure that children do not use these products as a gateway to other tobacco products, including cigarettes. The American Lung Association has issued a [report](#) on new smokeless tobacco products, including dissolvables.

FDA Has Yet to Put Forth a Tobacco Product Standard

The Tobacco Control Act gives the Center for Tobacco Products sweeping authority to issue tobacco product standards, or new requirements that would impact all tobacco products, including ones that have been sold for decades. One example would be the removal of menthol from all cigarettes, based on the recommendations from the Tobacco Products Scientific Advisory Committee. Many in the public health community view this ability to issue tobacco product standards as the one that could have the greatest impact at reducing the death and disease caused by tobacco use. However, FDA has again failed to put forth any tobacco product standard proposals, nor has it tasked TPSAC to develop a short list for FDA consideration.

Missed Opportunity to Increase Cessation Coverage for Millions of American Smokers

As the federal and state governments work to implement the Patient Protection and Affordable Care Act (Affordable Care Act), there is huge potential to provide millions of more smokers with the help they need to quit. The Affordable Care Act makes major changes to the health insurance market and also puts more focus on prevention in healthcare, which includes tobacco cessation. The law has major implications for states, which are tasked with implementing many of the Affordable Care Act’s most well-known initiatives, including health insurance exchanges and a significant expansion of Medicaid.

However, the Administration has not sufficiently capitalized on new opportunities to help smokers quit. In a [proposed rule released in November 2012](#), the Department of Health and Human Services (HHS) indicated it would allow each state to pick its own benchmark insurance plan, which will then serve as the standard for plans in that state’s health insurance exchange. While preventive services, including tobacco cessation, must be covered in every state’s benchmark plan, HHS missed the opportunity to guarantee that states will offer a comprehensive cessation benefit. The American Lung Association and its partners outlined this incredible missed opportunity in [comments filed with HHS](#) in January of 2012, and in comments filed in December 2012 reiterated this need to specifically define a comprehensive cessation benefit.

Quit Smoking Benefits for Defense Department Appear Stalled

In 2008, Congress required as part of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 that the Department of Defense (DoD) implement a comprehensive smoking cessation program for TRI-

CARE, the healthcare program for members of the military and their families. The Department released a proposed rule to implement this requirement in 2011, but has not finalized the rule yet. In November 2011, the Lung Association both individually and with our partners filed comments urging the Department of Defense to move forward with implementing the comprehensive cessation benefit it proposed for TRICARE members.

While DoD fails to move forward, more of our soldiers become addicted to tobacco. The 2008 Department of Defense Survey of Health Behaviors among Active Duty Personnel found that while smoking rates among active duty personnel have essentially remained steady since 2002, smoking rates among deployed personnel are significantly higher.¹²

Notable Exception to Federal Government Inaction: Tips from Former Smokers Campaign

The major action in 2012 that the Obama Administration is to be commended for is the CDC's [Tips from Former Smokers](#) campaign. The Tips Campaign, which features testimonials from real smokers living with diseases caused by their smoking, is the first federally-funded tobacco cessation advertising campaign. Its evidence-based, hard hitting ads featured the federal government's tobacco cessation resources, 1-800-QUIT-NOW and www.smokefree.gov. During the 12-week campaign, 1-800-QUIT-NOW received 365,194 calls, an increase of 132 percent from the same period in 2011. There were also 629,898 unique visits to www.smokefree.gov, a 428 percent increase from the same period in 2011.¹³

The Tips Campaign invested \$54 million, which is equal to about three days worth of what the tobacco industry spends on marketing cigarettes. Funding for the campaign came from the Prevention and Public Health Fund, which was created by the Affordable Care Act to reduce the death and disease caused by tobacco use and other unhealthy but preventable behaviors.

Tobacco Control Treaty Remains Stalled

For decades, U.S. based tobacco companies have used trade agreements as a gateway to market and sell their deadly products globally. Reports signaled that the Obama Administration's position may be evolving as part of the Trans-Pacific Partnership free trade agreement. In May, the American Lung Association and our partners sent a letter to U.S. Trade Representative Ron Kirk, urging the Administration to propose language in the treaty that would protect the abilities of participating countries to enact measures to reduce tobacco use.

As is reflected in the "D" grade, the Administration has still not sent the Framework Convention on Tobacco Control Treaty to the U.S. Senate for ratification.

Our Commitment

For more than 100 years, the American Lung Association has worked to save lives by preventing lung disease and promoting lung health, including fighting illness and death caused by tobacco use. Unfortunately, lung disease death rates are not decreasing as quickly as the rates of other leading causes

of death, and CDC announced in December 2010 that chronic lower respiratory disease, which includes COPD, is now the third leading cause of death.¹⁴

The American Lung Association was founded in 1904 to combat tuberculosis, decades before antibiotics made it a curable disease. In fighting tuberculosis, we learned that by harnessing political will and using the right advocacy tools, a public health scourge could be tamed. With the same intent, the American Lung Association targeted tobacco use. The Lung Association was one of the first organizations to tell people about the dangers of smoking, even before the landmark Surgeon General's Report on smoking was issued in 1964. The American Lung Association's smoking cessation program for adults, Freedom From Smoking[®], is widely recognized as the gold standard of such programs and is available in a group clinic format, as a self-help manual and online at www.ffsonline.org. The American Lung Association also provides free telephone counseling to help smokers quit at 1-800-LUNGUSA.

From successfully advocating for smokefree air laws to holding the tobacco industry accountable for its wrongdoing, the American Lung Association is a leader in tobacco control advocacy on the national, state and local levels. In addition, the American Lung Association was among the first to offer a proven effective teen smoking-cessation program, Not-On-Tobacco, America's most widely-used teen smoking cessation program that has helped tens of thousands of teen smokers end their addiction to nicotine.

The American Lung Association is also a leader in the battle against air pollution and its devastating impact on public health. More recently, the American Lung Association has taken the lead in responding to the immense burden caused by asthma and chronic obstructive pulmonary disease (COPD). Smoking causes 80 to 90 percent of COPD deaths¹⁵ and both asthma and COPD can be exacerbated by exposure to secondhand smoke. Ninety percent of lung cancer deaths are also caused by smoking¹⁶ and secondhand smoke is a proven cause of lung cancer.¹⁷ The American Lung Association gives support to people with lung cancer, and ultimately through stronger tobacco control policies seeks to reduce the more than 157,000 deaths caused by lung cancer each year.¹⁸

The American Lung Association's commitment to tobacco control is stronger than ever. But there is a crucial difference in this fight: Tobacco, unlike tuberculosis, has a strong lobby supporting it. The American Lung Association's *State of Tobacco Control* is a call to action for national and state elected officials: Enact strong tobacco control laws so lives can be saved by improving lung health and preventing lung disease.

To find out more about the American Lung Association, get help quitting smoking or learn more about lung health issues, call 1-800-LUNGUSA (1-800-586-4872) or log onto www.lung.org.

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Tobacco Prevention and Control Spending Overview

State Name	Tobacco Settlement Funding	Tobacco Tax Funding	Other State Funding	Total State Funding	Federal Funding	Total Funding	CDC Recommended Funding Level	Percentage of CDC Recommended Level	Grade
Alabama	\$275,000	\$0	\$0	\$275,000	\$3,044,925	\$3,319,925	\$56,700,000	5.9%	F
Alaska	\$0	\$0	\$10,873,300	\$10,873,300	\$951,597	\$11,824,897	\$10,700,000	110.5%	A
Arizona	\$0	\$15,200,000	\$0	\$15,200,000	\$2,196,906	\$17,396,906	\$68,100,000	25.5%	F
Arkansas	\$17,802,528	\$0	\$0	\$17,802,528	\$2,190,155	\$19,992,683	\$36,400,000	54.9%	D
California	\$0	\$62,095,000	\$0	\$62,095,000	\$6,532,450	\$68,627,450	\$441,900,000	15.5%	F
Colorado	\$0	\$22,567,704	\$0	\$22,567,704	\$2,288,576	\$24,856,280	\$54,400,000	45.7%	F
Connecticut	\$5,997,000	\$0	\$0	\$5,997,000	\$1,835,179	\$7,832,179	\$43,900,000	17.8%	F
Delaware	\$9,021,800	\$0	\$0	\$9,021,800	\$821,064	\$9,842,864	\$13,900,000	70.8%	B
Florida	\$64,289,944	\$0	\$0	\$64,289,944	\$3,164,145	\$67,454,089	\$210,900,000	32.0%	F
Georgia	\$700,000	\$0	\$0	\$700,000	\$2,254,535	\$2,954,535	\$116,500,000	2.5%	F
Hawaii	\$8,933,769	\$0	\$0	\$8,933,769	\$898,291	\$9,832,060	\$15,200,000	64.7%	C
Idaho	\$2,614,700	\$200,000	\$0	\$2,814,700	\$2,043,020	\$4,857,720	\$16,900,000	28.7%	F
Illinois	\$11,100,000	\$0	\$0	\$11,100,000	\$2,600,641	\$13,700,641	\$157,000,000	8.7%	F
Indiana	\$9,251,037	\$0	\$0	\$9,251,037	\$2,371,788	\$11,622,825	\$78,800,000	14.7%	F
Iowa	\$0	\$0	\$3,653,830	\$3,653,830	\$1,586,023	\$5,239,853	\$36,700,000	14.3%	F
Kansas	\$1,000,000	\$0	\$0	\$1,000,000	\$1,933,751	\$2,933,751	\$32,100,000	9.1%	F
Kentucky	\$2,134,200	\$0	\$0	\$2,134,200	\$1,896,628	\$4,030,828	\$57,200,000	7.0%	F
Louisiana	\$476,000	\$6,694,101	\$0	\$7,170,101	\$2,079,892	\$9,249,993	\$53,500,000	17.3%	F
Maine	\$7,525,630	\$0	\$35,905	\$7,561,535	\$1,762,552	\$9,324,087	\$18,500,000	50.4%	D
Maryland	\$3,600,000	\$0	\$550,000	\$4,150,000	\$2,310,573	\$6,460,573	\$63,300,000	10.2%	F
Massachusetts	\$0	\$0	\$4,151,958	\$4,151,958	\$2,591,344	\$6,743,302	\$90,000,000	7.5%	F
Michigan	\$0	\$1,833,935	\$0	\$1,833,935	\$3,372,944	\$5,206,879	\$121,200,000	4.3%	F
Minnesota	\$16,400,000	\$0	\$3,200,000	\$19,600,000	\$1,807,799	\$21,407,799	\$58,400,000	36.7%	F
Mississippi	\$11,200,000	\$0	\$0	\$11,200,000	\$2,271,455	\$13,471,455	\$39,200,000	34.4%	F
Missouri	\$0	\$0	\$61,785	\$61,785	\$2,275,032	\$2,336,817	\$73,200,000	3.2%	F
Montana	\$4,600,000	\$0	\$0	\$4,600,000	\$1,075,049	\$5,675,049	\$13,900,000	40.8%	F

Tobacco Prevention and Control Spending Overview

State Name	Tobacco Settlement Funding	Tobacco Tax Funding	Other State Funding	Total State Funding	Federal Funding	Total Funding	CDC Recommended Funding Level	Percentage of CDC Recommended Level	Grade
Nebraska	\$2,379,000	\$0	\$0	\$2,379,000	\$1,324,265	\$3,703,265	\$21,500,000	17.2%	F
Nevada	\$150,000	\$0	\$0	\$150,000	\$1,075,049	\$1,225,049	\$32,500,000	3.8%	F
New Hampshire	\$0	\$0	\$0	\$0	\$1,333,586	\$1,333,586	\$19,200,000	6.9%	F
New Jersey	\$0	\$0	\$0	\$0	\$2,601,594	\$2,601,594	\$119,800,000	2.2%	F
New Mexico	\$5,931,300	\$0	\$0	\$5,931,300	\$1,730,538	\$7,661,838	\$23,400,000	32.7%	F
New York	\$0	\$0	\$41,400,000	\$41,400,000	\$3,092,684	\$44,492,684	\$254,300,000	17.5%	F
North Carolina	\$0	\$0	\$0	\$0	\$5,706,444	\$5,706,444	\$106,800,000	5.3%	F
North Dakota	\$8,216,554	\$0	\$0	\$8,216,554	\$1,153,366	\$9,369,920	\$9,300,000	100.8%	A
Ohio	\$0	\$0	\$0	\$0	\$3,319,482	\$3,319,482	\$145,000,000	2.3%	F
Oklahoma	\$16,957,709	\$2,168,810	\$777,366	\$19,903,885	\$2,627,061	\$22,530,946	\$45,000,000	50.1%	D
Oregon	\$0	\$7,534,500	\$0	\$7,534,500	\$1,329,165	\$8,863,665	\$43,000,000	20.6%	F
Pennsylvania	\$14,221,000	\$0	\$0	\$14,221,000	\$2,942,883	\$17,163,883	\$155,500,000	11.0%	F
Rhode Island	\$0	\$0	\$376,437	\$376,437	\$1,847,143	\$2,223,580	\$15,200,000	14.6%	F
South Carolina	\$0	\$5,000,000	\$0	\$5,000,000	\$1,604,767	\$6,604,767	\$62,200,000	10.6%	F
South Dakota	\$0	\$3,999,830	\$0	\$3,999,830	\$963,055	\$4,962,885	\$11,300,000	43.9%	F
Tennessee	\$0	\$0	\$222,267	\$222,267	\$1,936,472	\$2,158,739	\$71,700,000	3.0%	F
Texas	\$5,471,500	\$0	\$978,794	\$6,450,294	\$4,331,461	\$10,781,755	\$266,300,000	4.0%	F
Utah	\$3,887,400	\$3,150,000	\$0	\$7,037,400	\$1,586,549	\$8,623,949	\$23,600,000	36.5%	F
Vermont	\$3,971,713	\$0	\$0	\$3,971,713	\$1,189,143	\$5,160,856	\$10,400,000	50.0%	D
Virginia	\$8,371,777	\$0	\$0	\$8,371,777	\$2,907,480	\$11,279,257	\$103,200,000	10.9%	F
Washington	\$0	\$0	\$2,485,000	\$2,485,000	\$2,568,322	\$5,053,322	\$67,300,000	7.5%	F
West Virginia	\$5,650,000	\$0	\$0	\$5,650,000	\$2,132,328	\$7,782,328	\$27,800,000	28.0%	F
Wisconsin	\$0	\$0	\$5,315,000	\$5,315,000	\$2,064,385	\$7,379,385	\$64,300,000	11.5%	F
Wyoming	\$2,200,000	\$0	\$3,200,000	\$5,400,000	\$535,035	\$5,935,035	\$9,000,000	65.9%	C
District of Columbia	\$0	\$0	\$495,000	\$495,000	\$867,698	\$1,362,698	\$10,500,000	13.0%	F

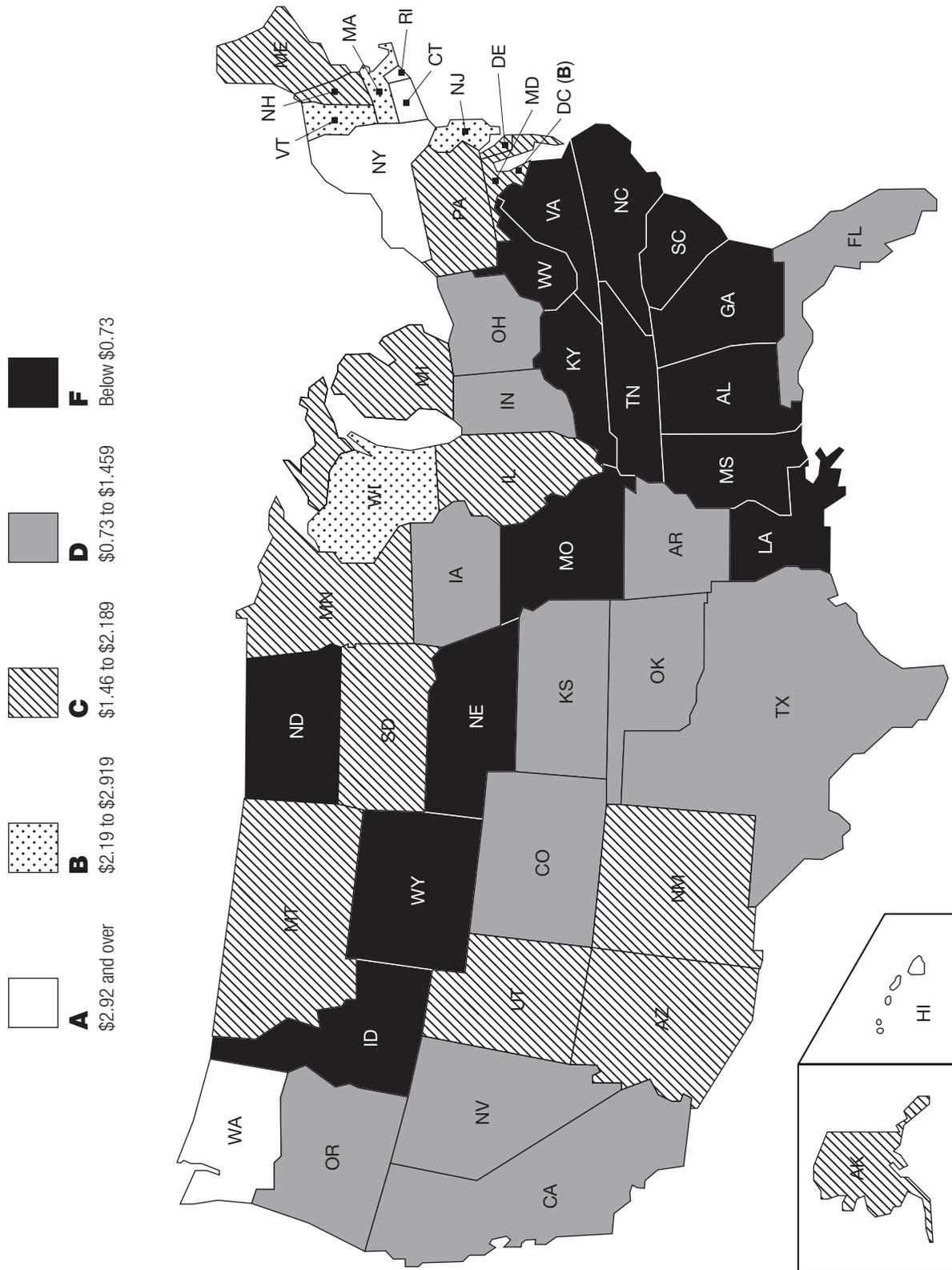
Smokefree Air Grading

State	Government Worksites		Private Worksites		Schools	Childcare Facilities	Restaurants	Bars	Casinos/Gaming Establishments	Retail Stores	Recreational/Cultural Facilities	Penalties	Enforcement	Total Score	Grade
Alabama	2	0	2	2	2	2	0	0	0	2	2	5	4	19	F
Alaska	2	1	3	4	1	0	N/A	1	1	1	1	4	4	21	F
Arizona	4	4	5	4	4	4	4	4	4	4	4	5	4	46	A
Arkansas	4	3	4	4	4	3	1	1	4	4	4	4	4	36	B
California	5	3	4	4	4	3	3	3	3	3	3	5	4	40	A
Colorado	5	3	4	4	4	4	3	4	4	4	4	4	1	40	A
Connecticut	4	2	4	2	4	4	3	4	4	4	4	2	3	36	C
Delaware	4	4	4	4	4	4	5	4	4	4	4	5	4	46	A
District of Columbia	4	4	5	4	4	4	2	N/A	4	4	4	2	4	37	A
Florida	4	4	4	4	4	4	1	4	4	4	4	5	3	41	B
Georgia	4	3	4	4	4	3	1	N/A	3	4	4	2	3	31	C
Hawaii	5	5	4	4	4	4	5	N/A	4	4	4	4	4	43	A
Idaho	4	3	4	4	4	4	0	4	4	4	4	3	2	36	B
Illinois	5	5	4	4	4	4	5	4	4	4	4	5	4	48	A
Indiana	4	4	4	4	4	3	1	0	4	4	4	4	3	35	C
Iowa	4	4	5	4	4	4	4	1	4	4	4	4	4	42	A
Kansas	5	5	4	4	4	4	4	1	4	4	4	5	1	41	A
Kentucky	1	0	1	0	0	0	0	0	0	0	0	1	0	3	F
Louisiana	4	4	4	4	4	4	0	1	4	4	4	5	2	36	B
Maine	5	5	5	4	4	5	4	3	4	4	4	5	3	47	A
Maryland	4	4	4	4	4	4	5	4	4	4	4	3	3	43	A
Massachusetts	4	4	4	4	4	4	3	4	4	4	4	4	3	42	A
Michigan	4	4	4	4	4	4	4	1	4	4	4	5	5	43	B
Minnesota	3	3	4	4	4	4	5	4	4	4	4	3	3	41	A
Mississippi	3	0	4	4	4	0	0	0	0	0	0	2	2	15	F
Missouri	2	1	3	4	4	1	0	0	1	1	1	2	1	16	F

Smokefree Air Grading

State	Government Worksites		Private Worksites		Schools	Childcare Facilities	Restaurants	Bars	Casinos/Gaming Establishments	Retail Stores	Recreational/Cultural Facilities	Penalties	Enforcement	Total Score	Grade
Montana	4	4	4	4	4	4	4	5	4	4	4	3	3	43	A
Montana	4	4	4	4	4	4	4	5	4	4	4	3	3	43	A
Nebraska	4	4	4	4	4	4	4	4	4	4	4	4	4	44	A
Nevada	4	4	4	5	4	4	4	1	1	4	4	3	1	35	C
New Hampshire	2	2	4	4	4	4	2	2	2	2	2	4	4	32	D
New Jersey	4	4	4	5	4	4	4	2	2	4	4	5	3	41	A
New Mexico	5	4	4	4	4	4	4	3	0	4	4	4	4	40	A
New York	4	4	4	5	4	4	4	2	4	4	4	4	4	43	A
North Carolina	2	0	4	4	3	4	4	3	N/A	0	0	3	2	21	F
North Dakota	5	5	4	4	4	4	4	5	4	4	4	4	4	47	A
Ohio	4	4	4	4	4	4	4	5	4	4	4	3	4	44	A
Oklahoma	3	3	4	4	4	4	3	0	3	4	4	2	4	34	D
Oregon	5	5	4	4	4	4	4	3	4	4	4	4	4	45	A
Pennsylvania	4	4	4	4	4	4	2	0	2	4	4	4	4	36	C
Rhode Island	4	4	4	4	4	4	4	3	2	4	4	4	4	41	A
South Carolina	1	0	2	4	4	0	0	0	N/A	0	1	2	0	10	F
South Dakota	4	4	4	4	4	4	4	4	4	4	4	4	0	40	B
Tennessee	4	3	4	4	4	4	3	1	N/A	4	4	3	4	34	C
Texas	0	0	1	4	4	0	0	0	0	0	1	2	1	9	F
Utah	4	4	4	5	4	4	4	5	N/A	4	4	4	3	41	A
Vermont	4	4	4	4	4	4	4	4	N/A	4	4	2	2	36	A
Virginia	1	0	3	3	3	2	2	2	0	1	1	2	1	16	F
Washington	5	5	4	4	4	4	5	4	4	4	4	4	4	47	A
West Virginia	1	0	4	4	1	0	0	0	0	0	0	1	0	7	F
Wisconsin	4	4	4	4	4	4	4	4	4	4	4	3	4	43	A
Wyoming	0	0	0	0	0	0	0	0	0	0	0	0	0	0	F

Cigarette Excise Tax Map



Cigarette Excise Tax Overview

State	Tax Rate (per pk. of 20)	Year of Last Change	Amount of Last Change	Grade
Alabama	\$0.425	2004	\$0.26	F
Alaska	\$2.00	2007	\$0.20	C
Arizona	\$2.00	2006	\$0.82	C
Arkansas	\$1.15	2009	\$0.56	D
California	\$0.87	1999	\$0.50	D
Colorado	\$0.84	2005	\$0.64	D
Connecticut	\$3.40	2011	\$0.40	A
Delaware	\$1.60	2009	\$0.45	C
District of Columbia	\$2.50	2009	\$0.50	B
Florida	\$1.339	2009	\$1.00	D
Georgia	\$0.37	2003	\$0.25	F
Hawaii	\$3.20	2011	\$0.20	A
Idaho	\$0.57	2003	\$0.29	F
Illinois	\$1.98	2012	\$1.00	C
Indiana	\$0.995	2007	\$0.44	D
Iowa	\$1.36	2007	\$1.00	D
Kansas	\$0.79	2003	\$0.09	D
Kentucky	\$0.60	2009	\$0.30	F
Louisiana	\$0.36	2002	\$0.12	F
Maine	\$2.00	2005	\$1.00	C
Maryland	\$2.00	2008	\$1.00	C
Massachusetts	\$2.51	2008	\$1.00	B
Michigan	\$2.00	2004	\$0.75	C
Minnesota	\$1.60	2012	\$0.014	C
Mississippi	\$0.68	2009	\$0.50	F
Missouri	\$0.17	1993	\$0.04	F
Montana	\$1.70	2005	\$1.00	C
Nebraska	\$0.64	2002	\$0.30	F
Nevada	\$0.80	2003	\$0.45	D

Cigarette Excise Tax Overview

State	Tax Rate (per pk. of 20)	Year of Last Change	Amount of Last Change	Grade
New Hampshire	\$1.68	2011	-\$0.10	C
New Jersey	\$2.70	2009	\$0.125	B
New Mexico	\$1.66	2010	\$0.75	C
New York	\$4.35	2010	\$1.60	A
North Carolina	\$0.45	2009	\$0.10	F
North Dakota	\$0.44	1993	\$0.15	F
Ohio	\$1.25	2005	\$0.70	D
Oklahoma	\$1.03	2005	\$0.80	D
Oregon	\$1.18	2004	-\$0.10	D
Pennsylvania	\$1.60	2009	\$0.25	C
Rhode Island	\$3.50	2012	\$0.04	A
South Carolina	\$0.57	2010	\$0.50	F
South Dakota	\$1.53	2006	\$1.00	C
Tennessee	\$0.62	2007	\$0.42	F
Texas	\$1.41	2006	\$1.00	D
Utah	\$1.70	2010	\$1.005	C
Vermont	\$2.62	2011	\$0.38	B
Virginia	\$0.30	2005	\$0.10	F
Washington	\$3.025	2010	\$1.00	A
West Virginia	\$0.55	2003	\$0.38	F
Wisconsin	\$2.52	2009	\$0.75	B
Wyoming	\$0.60	2003	\$0.48	F

State Cigarette Excise Taxes

As of January 1, 2013

State Cigarette Tax Average: \$1.49 per pack

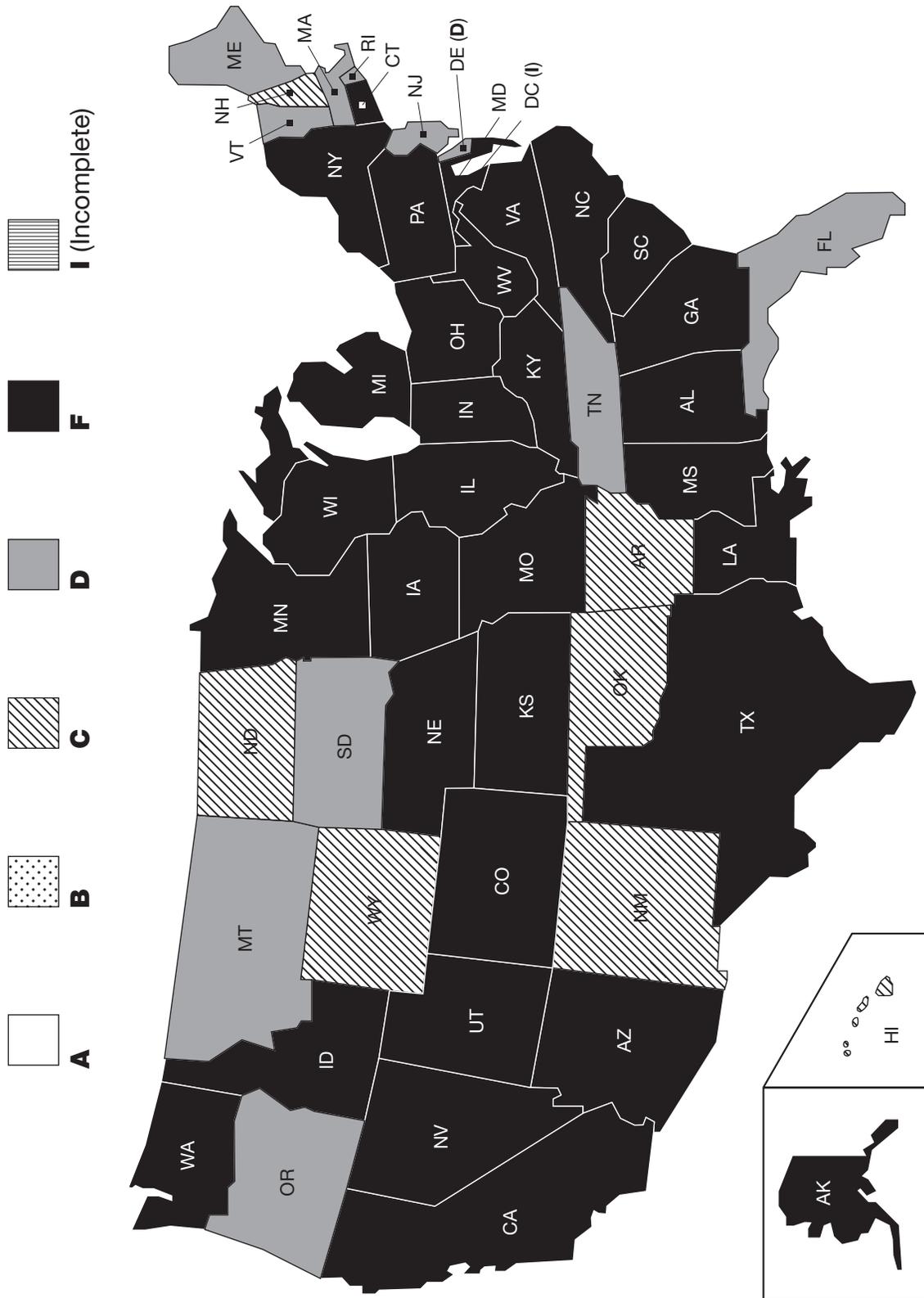
Sorted by Tax Rate From Highest to Lowest

State	Tax Rate (per pack of 20)
New York	\$4.35
Rhode Island	\$3.50
Connecticut	\$3.40
Hawaii	\$3.20
Washington	\$3.025
New Jersey	\$2.70
Vermont	\$2.62
Wisconsin	\$2.52
Massachusetts	\$2.51
District of Columbia	\$2.50
Alaska	\$2.00
Michigan	\$2.00
Maryland	\$2.00
Maine	\$2.00
Arizona	\$2.00
Illinois	\$1.98
Montana	\$1.70
Utah	\$1.70
New Hampshire	\$1.68
New Mexico	\$1.66
Delaware	\$1.60
Minnesota	\$1.60
Pennsylvania	\$1.60
South Dakota	\$1.53
Texas	\$1.41
Iowa	\$1.36
Florida	\$1.339
Ohio	\$1.25
Oregon	\$1.18
Arkansas	\$1.15
Oklahoma	\$1.03
Indiana	\$0.995
California	\$0.87
Colorado	\$0.84
Nevada	\$0.80
Kansas	\$0.79
Mississippi	\$0.68
Nebraska	\$0.64
Tennessee	\$0.62
Wyoming	\$0.60
Kentucky	\$0.60
Idaho	\$0.57
South Carolina	\$0.57
West Virginia	\$0.55
North Carolina	\$0.45
North Dakota	\$0.44
Alabama	\$0.425
Georgia	\$0.37
Louisiana	\$0.36
Virginia	\$0.30
Missouri	\$0.17

Sorted Alphabetically by State Name

State	Tax Rate (per pack of 20)
Alabama	\$0.425
Alaska	\$2.00
Arizona	\$2.00
Arkansas	\$1.15
California	\$0.87
Colorado	\$0.84
Connecticut	\$3.40
Delaware	\$1.60
District of Columbia	\$2.50
Florida	\$1.339
Georgia	\$0.37
Hawaii	\$3.20
Idaho	\$0.57
Illinois	\$1.98
Indiana	\$0.995
Iowa	\$1.36
Kansas	\$0.79
Kentucky	\$0.60
Louisiana	\$0.36
Maine	\$2.00
Maryland	\$2.00
Massachusetts	\$2.51
Michigan	\$2.00
Minnesota	\$1.60
Mississippi	\$0.68
Missouri	\$0.17
Montana	\$1.70
Nebraska	\$0.64
Nevada	\$0.80
New Hampshire	\$1.68
New Jersey	\$2.70
New Mexico	\$1.66
New York	\$4.35
North Carolina	\$0.45
North Dakota	\$0.44
Ohio	\$1.25
Oklahoma	\$1.03
Oregon	\$1.18
Pennsylvania	\$1.60
Rhode Island	\$3.50
South Carolina	\$0.57
South Dakota	\$1.53
Tennessee	\$0.62
Texas	\$1.41
Utah	\$1.70
Vermont	\$2.62
Virginia	\$0.30
Washington	\$3.025
West Virginia	\$0.55
Wisconsin	\$2.52
Wyoming	\$0.60

Cessation Coverage Grading Map



Cessation Coverage Grading

State	State Medicaid Program			State Employee Health Plan			State Quitline		Private Insurance		Total Score	Grade
	Medications	Counseling	Barriers to Coverage	Medications	Counseling	Barriers to Coverage	Investment Per Smoker	Score	Mandate (bonus)	Score		
Alabama	2	1	6	3	4	1	2	19	0	19	F	
Alaska	8	4	3	DNR	DNR	DNR	12	27	0	27	F*	
Arizona	10	0	9	4	2	2	6	33	0	33	F	
Arkansas	8	10	6	3	4	1	14	46	0	46	C	
California	9	3	5	3	2	1	4	27	0	27	F	
Colorado	9	5	5	1	1	1	10	32	2	34	F	
Connecticut	10	4	9	3	1	1	6	34	0	34	F	
Delaware	10	4	4	2	4	1	14	39	0	39	D	
District of Columbia	DNR	DNR	DNR	DNR	DNR	DNR	12	12	0	12	I	
Florida	8	6	5	4	2	1	10	36	0	36	D	
Georgia	2	1	4	3	2	1	2	15	0	15	F	
Hawaii	8	5	6	DNR	DNR	DNR	18	37	0	37	C*	
Idaho	10	0	4	4	2	1	8	29	0	29	F	
Illinois	10	0	9	4	4	1	2	30	1	31	F	
Indiana	10	10	5	4	3	1	2	35	0	35	F	
Iowa	10	7	4	2	0	1	6	30	0	30	F	
Kansas	7	2	8	3	2	1	2	25	0	25	F	
Kentucky	7	4	5	3	3	1	2	25	0	25	F	
Louisiana	9	4	6	2	2	1	2	26	0	26	F	
Maine	2	4	4	4	4	1	20	39	0	39	D	
Maryland	7	7	5	1	3	1	2	26	2	28	F	
Massachusetts	10	10	8	2	2	1	4	37	0	37	D	
Michigan	8	7	5	2	2	1	2	27	0	27	F	
Minnesota	10	7	9	4	2	1	2	35	0	35	F	
Mississippi	10	2	8	4	0	1	4	29	0	29	F	
Missouri	10	4	6	3	3	1	2	29	0	29	F	

* Graded based on 2 out of 3 Cessation categories

I = Incomplete

DNR = Data not reported

Cessation Coverage Grading

State	State Medicaid Program			State Employee Health Plan			State Quitline		Private Insurance		Total Score	Grade
	Medications	Counseling	Barriers to Coverage	Medications	Counseling	Barriers to Coverage	Investment Per Smoker	Score	Mandate (bonus)	Score		
Montana	10	7	5	3	3	0	8	36	0	36	D	
Nebraska	7	4	5	4	2	0	2	24	0	24	F	
Nevada	10	4	6	3	2	1	2	28	0	28	F	
New Hampshire	10	4	9	4	2	1	14	44	0	44	C	
New Jersey	9	0	5	4	1	2	DNR	21	3	24	D*	
New Mexico	10	3	7	4	4	1	12	41	5	46	C	
New York	7	7	7	2	2	1	4	30	0	30	F	
North Carolina	10	7	9	3	3	1	2	35	0	35	F	
North Dakota	10	1	4	4	4	1	20	44	1	45	C	
Ohio	10	0	9	2	2	1	0	24	0	24	F	
Oklahoma	10	7	6	2	2	1	14	42	0	42	C	
Oregon	8	9	7	2	1	1	6	34	2	36	D	
Pennsylvania	10	7	9	1	1	1	2	31	0	31	F	
Rhode Island	10	5	6	4	4	1	2	32	5	37	D	
South Carolina	8	0	5	2	2	1	10	28	0	28	F	
South Dakota	5	1	9	1	2	1	20	39	0	39	D	
Tennessee	10	2	7	4	3	1	DNR	27	0	27	D*	
Texas	7	4	9	1	2	1	2	26	0	26	F	
Utah	8	2	8	1	0	1	8	28	0	28	F	
Vermont	10	2	8	4	3	1	8	36	3	39	D	
Virginia	8	5	5	3	2	1	0	24	0	24	F	
Washington	8	2	5	2	2	1	4	24	0	24	F	
West Virginia	8	2	2	4	2	1	DNR	19	0	19	F*	
Wisconsin	9	5	9	3	2	1	2	31	0	31	F	
Wyoming	8	4	7	DNR	DNR	DNR	20	39	0	39	C*	

* Graded based on 2 out of 3 Cessation categories
 I = Incomplete
 DNR = Data not reported

Smoking Attributable Death Statistics per 100,000 Population

Note: Information can be compared/ranked by state.

State	Smoking Attributable Deaths per 100,000 Population	Smoking Attributable Lung Cancer Deaths per 100,000 Population	Smoking Attributable Respiratory Disease Deaths per 100,000 Population
Alabama	317.5	101.8	81.6
Alaska	270.4	89.4	75.7
Arizona	247.4	73.9	77.0
Arkansas	323.7	110.0	80.5
California	235.0	68.9	70.6
Colorado	237.6	64.1	85.4
Connecticut	238.3	77.6	61.8
Delaware	280.9	96.9	67.7
District of Columbia	249.9	85.6	43.3
Florida	258.8	87.1	64.4
Georgia	299.4	95.8	79.7
Hawaii	167.6	54.0	32.3
Idaho	237.4	68.1	76.6
Illinois	263.1	87.6	63.6
Indiana	308.9	102.2	83.6
Iowa	248.0	80.6	69.6
Kansas	262.7	84.1	76.6
Kentucky	370.6	128.6	96.6
Louisiana	299.8	105.3	66.4
Maine	289.8	97.1	85.6
Maryland	261.9	88.8	64.2
Massachusetts	249.4	84.7	66.2
Michigan	281.9	89.3	71.0
Minnesota	215.1	72.4	59.0
Mississippi	333.6	109.0	80.1
Missouri	307.8	101.2	78.5
Montana	276.0	83.6	93.1
Nebraska	235.8	75.4	70.8
Nevada	343.7	100.1	107.3
New Hampshire	272.4	86.0	76.9
New Jersey	239.5	79.7	54.0

Smoking Attributable Death Statistics per 100,000 Population

Note: Information can be compared/ranked by state.

State	Smoking Attributable Deaths per 100,000 Population	Smoking Attributable Lung Cancer Deaths per 100,000 Population	Smoking Attributable Respiratory Disease Deaths per 100,000 Population
New Mexico	234.0	60.8	77.6
New York	246.1	74.6	57.8
North Carolina	298.4	96.5	78.2
North Dakota	225.6	70.1	60.7
Ohio	299.1	96.4	79.4
Oklahoma	332.1	101.2	89.9
Oregon	263.3	87.8	76.9
Pennsylvania	259.0	84.7	62.1
Rhode Island	266.8	88.9	65.9
South Carolina	293.4	96.3	73.6
South Dakota	239.2	74.9	67.6
Tennessee	325.0	108.6	85.7
Texas	273.1	85.2	72.9
Utah	138.3	34.7	48.9
Vermont	247.5	79.0	74.9
Virginia	267.0	89.6	70.3
Washington	261.0	85.7	75.1
West Virginia	344.3	110.8	96.0
Wisconsin	244.2	76.5	65.1
Wyoming	283.1	75.4	103.6

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable death rates reflect average annual estimates for the period 2000-2004, are calculated for persons aged 35 years and older and are age-adjusted to the 2000 U.S. population. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction.

Methodology

The American Lung Association's *State of Tobacco Control 2013* 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'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* on-line database, available at www.lungusa2.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>.

CALCULATION OF FEDERAL GRADES

Tobacco control and prevention measures at the federal level are graded in four distinct areas: U.S. Food and Drug Administration (FDA) regulation of tobacco products; federal coverage of tobacco cessation treatment; the amount of the federal excise tax on cigarettes; and the ratification of the Framework Convention on Tobacco Control. 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 the U.S. Food and Drug Administration (FDA) the authority to regulate tobacco products in June 2009, the grading system for this category is based on how FDA is implementing its new authority, and whether Congress is providing full funding to FDA.

The American Lung Association has identified three important items in 2012 that FDA was required by the Tobacco Control Act to implement or that FDA indicated they would take action on: 1) a rule asserting authority over tobacco products besides cigarettes and smokeless tobacco; 2) implementation of the recommendations on menthol in tobacco products from FDA's Tobacco Product Scientific Advisory Committee; and 3) submission of the recommendations on dissolvable tobacco products from FDA's Tobacco Product Scientific Advisory Committee. Points were awarded on how FDA implemented these three 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	14 to 16 Total Points
B	13 Total Points
C	11 to 12 Total Points
D	10 Total Points
F	Under 10 Total Points

Proposed Rule to Assert FDA Authority over All Tobacco Products (4 points)

Target is FDA issues proposed rule to assert authority over tobacco products other than cigarettes and smokeless tobacco.

- +4 points: Rule proposed that asserts authority over all tobacco products
- +3 points: Rule proposed that asserts authority over all tobacco products, but some tobacco products not included in deeming
- +2 points: Proposed rule sent to the Office of Management and Budget, but not issued
- +0 points: Rule not proposed

Implementation of the Menthol Report by the Tobacco Products Scientific Advisory Committee (4 points)

Target is FDA takes action to implement recommendations from 2011 report on menthol in tobacco products from the Tobacco Products Scientific Advisory Committee.

- +4 points: FDA implements Committee's recommendations
- +3 points: FDA says publicly that it intends to implement Committee's recommendations
- +2 points: FDA publishes its internal report on menthol for public comment
- +0 points: FDA takes no additional action on the Committee's recommendations

Submission of the Dissolvable Tobacco Products Report by the Tobacco Products Scientific Advisory Committee and Implementation of Recommendations by FDA (4 points)

Target is report on dissolvable tobacco products submitted to FDA by the Tobacco Products Scientific Advisory Committee on time, and the FDA takes some action on those recommendations.

- +4 points: Committee submits report to FDA on time and FDA takes some action on the Committee's recommendations
- +3 points: Report submitted on time; FDA delays action on Committee's recommendations
- +2 points: Submission of report by TPSAC delayed
- +0 points: Submission of report does not occur in 2012

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 previous year's levels
- +0 points: No funding at all provided

Notes Concerning FDA Grading:

Implementation of the graphic cigarette warning labels is also an item that would normally factor into this grading category. However, pending litigation prevented FDA from implementing its proposed rule on graphic warning labels in 2012. Therefore, this item will not be scored or factor into the grade for this year's report.

In the [Federal Overview](#), "State of Tobacco Control 2013" also examines FDA's failure to act on substantial equivalence, namely, ensuring that tobacco companies are not permitted to introduce new products on the market unless FDA has authorized their sale in advance of the product's introduction. Given the very limited publically available data, this area was also not included as part of the evaluation of FDA's 2012 grade.

Cessation Treatment Coverage

The cessation treatment coverage criteria used in the American Lung Association's *State of Tobacco Control 2013* 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 was added in *State of Tobacco Control 2013* to cover federal requirements for tobacco cessation treatment coverage in state health insurance exchanges 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, the U.S. Public Health Service recommends the use of 7 medications and 3 types of counseling as effective for helping tobacco users quit.

The cessation coverage grade breaks down as follows:

<u>Grade</u>	<u>Points Earned</u>
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 Exchanges

Target is all plans in exchanges required to cover a comprehensive tobacco cessation benefit.

- +4 All Guideline-recommended medications and counseling are required to be covered
- +3 At least 4 medications and 1 type of counseling are required to be covered
- +2 At least 2 medications and 1 type of counseling are required to be covered
- +1 At least 1 treatment is required to be covered
- +0 No coverage is required, or regulation is not published

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

Federal Cigarette Excise Tax

Criteria for the federal cigarette excise tax are identical to the state cigarette excise tax. For more information, see the State Cigarette Excise Tax section starting on page 42.

The Excise Tax grades break down as follows:

Grade	Tax
A	\$2.98 and up
B	\$2.236 to \$2.979
C	\$1.49 to \$2.235
D	\$0.745 to \$1.489
F	Under \$0.745

Framework Convention on Tobacco Control

The Framework Convention on Tobacco Control (FCTC) is an international public health treaty created to ensure evidence-based measures are implemented worldwide to control tobacco use and addiction. The full text of the FCTC and its treaty obligations can be found [here](#).

Framework Convention on Tobacco Control: Target is FCTC ratification by the U.S. Senate.

<u>Grade</u>	<u>Criteria</u>
A	Ratification by the U.S. Senate
B	FCTC approved by the Senate Foreign Relations Committee
C	President sends FCTC to Senate for ratification
D	President/Administration sign FCTC
F	No action on FCTC

CALCULATION OF STATE GRADES

State level tobacco control policies are graded in four key areas: tobacco prevention and control funding, smokefree air laws, state cigarette excise taxes and coverage of tobacco cessation treatments and services. The sources for the targets and the basis of the evaluation criteria are described below.

Tobacco Prevention and Control Spending

In October 2007, the Centers for Disease Control and Prevention (CDC) published an updated version of its *Best Practices for Comprehensive Tobacco Control Programs*, first published in 1999. Based on “Best Practices” as determined by evidence-based analysis of state tobacco control programs, the 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, Health Communication Interventions, Cessation Interventions, Surveillance and Evaluation and 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 uninsured. 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 as grants 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.

<u>Grade</u>	<u>Percent of CDC Recommended Level</u>
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, sustainable 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. One 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.

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:

<u>Assigned Grade</u>	<u>No State Casino/ Gaming Establishments</u>	<u>State Casino/ Gaming Establishments Present</u>
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:** State preemption of stricter local ordinances 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 a given state. States with over 90 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.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 was lowered if restriction depended on type of ventilation, location of smoking area and/or number of employees. A bonus point (+1) was available if the laws met the target criteria and required 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 was lowered if restriction depended on type of ventilation, location of smoking area and/or number of employees. A bonus point (+1) was available if the laws met the target criteria and required 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 was lowered if restriction depended on type of school, school hours, type of ventilation and/or location of smoking area. A bonus point (+1) was available if the laws met the target criteria and extended 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 was lowered if restrictions depended 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 was lowered if restriction depended on type of ventilation, location of smoking areas and/or exemptions for some restaurants. A bonus point (+1) was available if the laws met the target criteria and extended 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 was lowered if restriction depended on ventilation standards, location of smoking area and/or if laws only applied to some but not all bars/taverns. A bonus point (+1) was available if the laws met the target criteria and extended 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 was lowered if restriction depended on ventilation standards, location of smoking area and/or if laws only applied 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 was lowered if restriction depended on ventilation standards and/or location of smoking area, and if laws only applied 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 was lowered if restriction depended on ventilation standards, location of smoking area and/or if laws only applied to some but not all recreational/cultural facilities.
- 10) **Penalties** (4 points): Target is “penalties or fines, applicable to smokers and to proprietors or employers, for any violation of clean indoor air legislation.” Score was lowered if penalties included possibilities for delay, exceptions for either smokers or proprietors/employers, or penalties that only applied to some but not all offenses. An intent requirement or affirmative defenses reduced the score by one (1) point. A bonus point (+1) was available if the laws met the target criteria and the penalties or fines were graduated for repeated violations.
- 11) **Enforcement** (4 points): Target is “designate an enforcement authority for clean indoor air and require sign posting.” Score was lowered if there was no requirement for sign posting, enforcement authority only applied to some sites, or an enforcement authority or sign requirement existed,

but not both. A bonus point (+1) was available if the laws met the target criteria and required the enforcement authority to conduct compliance inspections.

State Cigarette Excise Tax

Establishing a basis to grade state cigarette excise taxes begged a question: “What is the appropriate level to tax cigarettes to protect public health?” Research shows that as the price of cigarettes increases, consumption decreases. For each 10 percent price increase, consumption drops by about 7 percent for youth and 4 percent for adults.² The CDC reported that each pack of cigarettes sold in this country costs the economy \$10.47 in direct medical costs and lost productivity.³ So the answer for the cigarette excise tax is simple: The higher the better.

The cigarette tax grades are 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, 2013 was \$1.49 per pack. The range of state excise taxes (\$0.17 to \$4.35 per pack) is divided into quintiles.

The excise tax grades break down as follows:

<u>Grade</u>	<u>Tax</u>
A	\$2.98 and up
B	\$2.236 to \$2.979
C	\$1.49 to \$2.235
D	\$0.745 to \$1.489
F	Under \$0.745

This methodology reflects the dynamic nature of cigarette excise taxes and the need to continue increasing taxes to keep up with inflation and decrease consumption. For instance, in 2004 New Jersey had the highest cigarette tax at \$2.05 per pack, a value that would put them towards the middle of state cigarette tax rates in 2013. As cigarette taxes rise in the future, the average will change and the grades will be adjusted to reflect the new average.

Cessation

The cessation grading system sets targets for states and awards points in three areas – Medicaid coverage of tobacco cessation treatments, State Employee Health Plan coverage of tobacco cessation treatments and 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 were available in a fourth target area, Standards for Private Insurance.

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 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 2007 *Best Practices for Comprehensive Tobacco Control Programs* document, discussed previously under the Tobacco Prevention and Control Spending section above, the CDC establishes benchmarks for quitlines that are funded at the recommended levels. The CDC, in conjunction with the North American Quitline Consortium, determined that to meet these benchmarks, a quitline must spend approximately \$10.53 per smoker in the state.⁴ Grading criteria for quitlines in this section is based on this funding level.

New for *State of Tobacco Control 2013*, coverage for tobacco cessation counseling provided by phone will be incorporated in the scoring for the state Medicaid coverage category. In June 2011, the Centers for Medicare and Medicaid Services (CMS) changed its policy and now allows state Medicaid funds to pay for Medicaid enrollees who use state quitlines. With this change, state Medicaid programs are now able to cover all three types of recommended counseling: individual, group and phone, and states have had a year and a half to implement this new phone counseling coverage. The scoring system for Medicaid coverage of tobacco cessation counseling has been slightly adjusted to reflect this change; see scoring section below for more details.

All data in the Cessation section of *State of Tobacco Control 2013*, including for quitlines, was collected and analyzed by the American Lung Association this year. This grading category replaced youth access laws as a grading category in the *State of Tobacco Control 2008* report.

The cessation grades are based on the maximum number of total points, a score of 60, assigned according to the categories described in detail below. Half of the points (30 points total) under the cessation coverage section are awarded for coverage under a state's Medicaid program. This weighting is due to the much 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. One-third of the points (20 points total) are awarded for the investment per smoker in the state's quitline and one-sixth of the points (10 points total) are awarded for State Employee Health Plan coverage.

The score of 60 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	54 to 60
B	48 to 53
C	42 to 47
D	36 to 41

F 0 to 35

Key to Cessation Coverage Ratings by Category:

Medicaid Coverage (30 points): Target is barrier-free coverage of all Guideline-recommended medications and counseling for the state’s entire Medicaid population.

- 1) States receive up to 10 points for coverage of medications: 1 point for coverage of each of the 7 medications, and 0 to 3 points based on whether coverage is available to all Medicaid members (or just members of certain managed care organizations);
- 2) States receive up to 10 points for coverage of counseling: 1 point for covering any counseling for all members, and 3 points for each type of counseling (individual, group and phone). Deductions were made if coverage is only available to certain Medicaid members (pregnant women or members of certain managed care organizations, for example);
- 3) States receive up to 10 points for providing coverage without barriers: 1 to 2 points are deducted for each barrier to coverage that exists in a state. Deductions vary based on type of barrier and severity.

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): Target is an investment in quitlines per smoker of \$10.53 or more. Points are awarded based on the scale below:

\$\$/smoker \geq 9.5	20 points
\$\$/smoker 8.5 – 9.4	18 points
\$\$/smoker 7.5 – 8.4	16 points
\$\$/smoker 6.5 – 7.4	14 points
\$\$/smoker 5.5 – 6.4	12 points
\$\$/smoker 4.5 – 5.4	10 points
\$\$/smoker 3.5 – 4.4	8 points
\$\$/smoker 2.5 – 3.4	6 points
\$\$/smoker 1.5 – 2.4	4 points
\$\$/smoker .5 – 1.4	2 points
\$\$/smoker $<$.5	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 all private insurance plans within the state.

- 1) 1 point given for the presence of a standard;
- 2) 0 to 2 points given for required coverage of medications;
- 3) 0 to 2 points given for required coverage of counseling.

- 1 Data on local ordinances is obtained from the Americans for Nonsmokers' Rights Foundation, www.no-smoke.org.
- 2 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.
- 3 Centers for Disease Control and Prevention. *Sustaining State Programs for Tobacco Control: Data Highlights 2006*. Available at: http://www.cdc.gov/tobacco/data_statistics/state_data/data_highlights/2006/index.htm.
- 4 See North American Quitline Consortium, Mission and Goals. <http://www.naquitline.org/?page=MissionGoals>.



Federal and State Report Cards

United States Report Card

Food and Drug Administration Regulation of Tobacco Products

F

Rule Asserting Authority over All Tobacco Products: **Not Issued**

TPSAC Menthol Report Implementation: **Not Completed**

TPSAC Submission of Dissolvables Report: **Submitted to FDA**

Funding for FDA Center for Tobacco Products: **Full funding provided with no policy riders**

Cessation

D

Medicaid Coverage: **Partially Required**

Medicare Coverage: **Partially Covered**

TRICARE Coverage: **Partially Covered**

Federal Employee Health Benefits Coverage: **Covered**

State Health Insurance Exchanges: **Partially Required**

Cigarette Tax

D

Tax rate per pack of 20: \$1.01

Framework Convention on Tobacco Control

D

The United States signed the Framework Convention on Tobacco Control, the world's first public health treaty, on May 10, 2004, but failed to submit it to the Senate for ratification.

Federal Highlights:



The lack of federal government action in 2012 was a stark difference from the past few years when the Obama Administration aggressively implemented policies to reduce the burden of tobacco use, the leading cause of preventable death.

The lack of action by the FDA was particularly noteworthy. As a result of the 2009 Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act), FDA was given authority over all tobacco products, but it has failed to assert its jurisdiction and to begin to regulate tobacco products other than cigarettes and smokeless tobacco products, including cigars and e-cigarettes.

In the absence of FDA asserting its authority over other tobacco products, the tobacco industry moved swiftly to capitalize on this void. There has been a proliferation of e-cigarette marketing and sales, as well as claims that the products will help smokers quit. The cigar industry has also capitalized, with the introduction of bills in the House and Senate that would take away future FDA oversight of most cigars. Manufacturers have also released new tobacco products, maneuvering their way around the poorly executed substantial equivalence provision, which is supposed to prohibit manufacturers from introducing new products without FDA’s prior authorization. FDA has even failed to act on the recommendations of the expert Tobacco Products Scientific Advisory Committee, making no effort to remove menthol cigarettes from the market.

The Administration has not taken advantage of opportunities to help smokers quit. In a proposed rule released in November 2012, the Department of Health and Human Services (HHS) indicated it would allow each state to pick its own benchmark insurance plan, which will then serve as the standard for plans in that state’s health insurance exchange. While preventive services, including tobacco cessation, must be covered in every state’s benchmark plan, HHS does not guarantee that states will offer a comprehensive cessation benefit. The Lung Association has called for HHS to specifically define a comprehensive cessation benefit.

In April 2012, the Government Accountability Office issued a report that found “significant market shifts” had occurred as a result of the 2009 federal cigarette tax increase and recommended that Congress equal-

ize tax rates across all tobacco products (i.e. increase the tax on other tobacco products to the level of cigarettes) and consider other measures to reduce tax avoidance. The Lung Association has encouraged Congress to consider tobacco tax increases and parity as part of its negotiations on sequestration.

There is one notable exception to the federal government’s shortcomings of 2012: the “Tips from Former Smokers” mass media campaign. This campaign, which features testimonials from real former smokers living with disease caused by tobacco use, served as an avenue to discourage smoking and encourage quitting, by featuring the federal government’s tobacco cessation resources, 1-800-QUIT-NOW and www.smokefree.gov. Both 1-800-QUIT-NOW and www.smokefree.gov saw a significant increase in callers and visitors during the 12 week campaign. Given the tremendous impact, the Lung Association urges this or similar media campaigns to continue in 2013.

Alabama State Facts	
Economic Costs Due to Smoking:	\$192,775,000,000
Adult Smoking Rates:	19.0%
High School Smoking Rates:	18.1%
Middle School Smoking Rates:	4.3%
Smoking Attributable Death Rates:	392,681
Smoking Attributable Lung Cancer Death Rates:	125,522
Smoking Attributable Respiratory Disease Deaths:	103,338

Adult smoking rate is taken from the 2011 National Health Interview Survey. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2011 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

Alabama Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$275,000
FY2013 Federal Funding for State Tobacco Control Programs:	\$3,044,925*
FY2013 Total Funding for State Tobacco Control Programs:	\$3,319,925
CDC Best Practices State Spending Recommendation:	\$56,700,000
Percentage of CDC Recommended Level:	5.9%

*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
Casinos/Gaming Establishments:	No provision
Bars:	No provision
Retail Stores:	Restricted
Recreational/Cultural Facilities:	Restricted
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	ALA. CODE §§ 22-15A-1 et seq.

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 strong local smokefree ordinances.

Cigarette Tax: **F**

Tax Rate per pack of 20: \$0.425



Thumbs down for Alabama for having the fifth lowest cigarette tax in the country at 42.5 cents per pack.

Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications* for pregnant women only**

Counseling: **Covers individual counseling for pregnant women only**

Barriers to Coverage: **Limits on duration, prior authorization required and counseling required to get medications**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler and NRT Lozenge**

Counseling: **Covers individual, group and phone counseling**

Barriers to Coverage: **Lifetime limit on quit attempts and co-payments required**

STATE QUITLINE:

Investment per Smoker: **\$1.11; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Alabama Tobacco Cessation Coverage page](#) for specific sources.



Thumbs down for Alabama for not providing coverage of any tobacco cessation treatments to all Medicaid enrollees. Coverage is provided for pregnant women as required by federal law.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Alabama State Highlights:



The American Lung Association in Alabama, in partnership with health organizations and coalitions, advocates for tobacco control across the state of Alabama. In 2012, the Lung Association made tremendous progress with tobacco education, prevention, cessation, and advocacy efforts at the state and local level through renewed and new partnerships.

Members of the Alabama Legislature once again failed to pass legislation that would prohibit smoking in all public places and workplaces. The residual lack of support from some veteran members and fairly new legislators set the legislation up for failure almost from the beginning of the 2012 legislative session. The version in the House of Representatives, House Bill 383, was never brought up for discussion in the House Health Committee after it was apparent there were not enough votes to get the bill out of committee. The Senate had two versions, Senate Bill 197 and Senate Bill 198, introduced to committee with the primary difference being that Senate Bill 197 was a constitutional amendment. Senate Bill 198 was ultimately voted out of committee with amendments exempting private clubs, cigar bars, tobacco manufacturing facilities, tobacco retail shops, and outdoor places of employment but received minimal floor time in the Senate before the legislature adjourned.

In addition to smokefree legislation, an increase in the state's tobacco tax was proposed through several bills in the House of Representatives and discussed in committee. Although the state of Alabama was in dire need of additional revenue, none of the bills were voted out of committee due to opposition from many legislators and Governor Bentley who ran on "No New Tax" platforms, apparently even for products that cost the state economy almost \$3.7 billion each year. During the 2012 Special Session, the Alabama Legislature reduced the amount of funding from the Master Settlement Agreement to the Alabama Department of Public Health, thereby eliminating a critical portion of funding to the tobacco prevention and control branch.

Locally, the Smokefree Alabama campaign was successful in encouraging the adoption of comprehensive ordinances in municipalities across the state of Alabama. The cities of Birmingham, Bessemer, and Vestavia Hills passed comprehensive ordinances prohibiting smoking in virtually all public places and

workplaces, including restaurants and bars. The City of Mobile and the City of Warrior passed smokefree ordinances that leave segments of the population, including those most vulnerable, unprotected from the dangers of secondhand smoke.

In 2013, the American Lung Association in Alabama 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. We will also advocate for an increase in the state's tobacco tax, essential tobacco prevention funding and comprehensive cessation coverage for those trying to quit using tobacco products.

Alabama State Facts	
Economic Costs Due to Smoking:	\$3,678,740,000
Adult Smoking Rate:	24.2%
High School Smoking Rate:	22.9%
Middle School Smoking Rate:	7.0%
Smoking Attributable Deaths:	7,584
Smoking Attributable Lung Cancer Deaths:	2,461
Smoking Attributable Respiratory Disease Deaths:	1,927

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2010 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Alabama
 P.O. Box 661465
 Birmingham, AL 35226
 (205) 968-2266
www.lung.org/alabama

Alaska Report Card

Tobacco Prevention and Control Program Funding: **A**

FY2013 State Funding for Tobacco Control Programs:	\$10,873,300
FY2013 Federal Funding for State Tobacco Control Programs:	\$951,597*
FY2013 Total Funding for State Tobacco Control Programs:	\$11,824,897
CDC Best Practices State Spending Recommendation:	\$10,700,000
Percentage of CDC Recommended Level:	110.5%



Thumbs up for Alaska for funding its state tobacco control program at or above the CDC-recommended level, one of only two states to do so this year.

*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:	Restricted
Schools:	Prohibited
Child Care Facilities:	Prohibited
Restaurants:	Restricted
Casinos/Gaming Establishments:	N/A (tribal establishments only)
Bars:	No provision
Retail Stores:	Restricted
Recreational/Cultural Facilities:	Restricted
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	ALASKA STAT. §§ 18.35.300 et seq.
Approximately 47.3% of Alaska's population is covered by a comprehensive smokefree local ordinance. At least 50% of the population must be covered to earn a better grade.	

Cigarette Tax: **C**

Tax Rate per pack of 20:	\$2.00
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Cessation Coverage: **F***

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban)**

Counseling: **Covers Individual Counseling**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, prior authorization required, minimal co-payments required for all medications, use of some medications required before using others and use of counseling required to get medications**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Data not reported**

Counseling: **Data not reported**

Barriers to Coverage: **Data not reported**

STATE QUITLINE:

Investment per Smoker: **\$6.03; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Alaska Tobacco Cessation Coverage page](#) for specific sources.

*Due to current data on tobacco cessation coverage for state employees being unavailable, Alaska was graded based on cessation coverage under Medicaid and quitline investment per smoker only.

Alaska State Highlights



The American Lung Association in Alaska continues its support of efforts to sustain and increase funding for Alaska’s comprehensive tobacco prevention and control program and to increase the number of Alaskans protected from the dangers of secondhand smoke through comprehensive smokefree laws.

Alaska continued its commitment to funding tobacco prevention and control programs in 2012. The American Lung Association in Alaska worked with legislators to maintain funding for the state’s successful program that funds tobacco prevention and control efforts throughout the state. Alaska is one of only two states that is funding its tobacco control program at or above the level recommended by the Centers for Disease Control and Prevention (CDC) in 2012.

Momentum continues around the state for smokefree policies at the local level. In October 2012, voters in Palmer, a community of around 6,000, voted to approve an ordinance prohibiting smoking in almost all public places and workplaces. The ordinance passed overwhelmingly with 61.5 percent of voters supporting the proposal. Palmer’s ordinance took effect January 2, 2013. Palmer will join Anchorage, Juneau, Nome and several other Alaska communities with comprehensive smokefree laws.

As the American Lung Association in Alaska looks forward, work will continue to build capacity to pass a comprehensive statewide smokefree law and we will continue to support funding for tobacco prevention and control programs at CDC-recommended levels.

Alaska State Facts

Economic Costs Due to Smoking:	\$448,937,000
Adult Smoking Rate:	22.8%
High School Smoking Rate:	14.1%
Middle School Smoking Rate:	N/A
Smoking Attributable Deaths:	488
Smoking Attributable Lung Cancer Deaths:	172
Smoking Attributable Respiratory Disease Deaths:	114

Adult smoking rate is taken from CDC’s 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Alaska
 500 West International Airport Road, #A
 Anchorage, AK 99518-1105
 (907) 276-5864
www.lung.org/alaska

Arizona Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$15,200,000
FY2013 Federal Funding for State Tobacco Control Programs:	\$2,196,906*
FY2013 Total Funding for State Tobacco Control Programs:	\$17,396,906
CDC Best Practices State Spending Recommendation:	\$68,100,000
Percentage of CDC Recommended Level:	25.5%

*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
Casinos/Gaming Establishments:	Prohibited (tribal establishments exempt)
Bars:	Prohibited
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation: ARIZ. REV. STAT. § 36-601.01 & AZ ADMIN RULES §§ R9-2-101 to R9-2-112	

Cigarette Tax: **C**

Tax Rate per pack of 20:	\$2.00
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Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications***

Counseling: **No coverage**

Barriers to Coverage: **Limits on duration and annual limits on quit attempts**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers phone counseling**

Barriers to Coverage: **No barriers**

STATE QUITLINE:

Investment per Smoker: **\$2.50; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Arizona Tobacco Cessation Coverage page](#) for specific sources.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Arizona State Highlights:



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.

During the 2012 legislative session, the American Lung Association in Arizona along with partners at the American Heart Association and American Cancer Society-Cancer Action Network worked to pass legislation that would have required all private insurance carriers to cover tobacco cessation medications and counseling as a standard benefit. Although the legislation did not pass our coalition was able to educate legislators about the value of this requirement, which we hope will lead to changes in the future.

Several tobacco control-related bills of interest that did pass in 2012 were a bill that prohibits the possession of or selling to persons under age 18 of any product used to smoke or ingest tobacco, including a hookah or water pipe. Another bill prohibited non-face-to-face sales of most tobacco products except to persons with a license. This includes sales over the Internet. However, the law excludes cigars and pipe tobacco from these requirements.

A diverse coalition made up of partners including the American Heart Association and American Cancer Society-Cancer Action Network have met and formed Arizona Smoke-Free Living. Over the next several months an intense effort will be made to educate property managers of multi-unit housing complexes to go smokefree. Our Goal for 2013 is to persuade and support 10 apartment complexes in Maricopa County, which includes the city of Phoenix, to voluntarily put in place non-smoking policies for their properties.

During the 2013 legislative session, the American Lung Association in Arizona will again work with our partners to ensure that all insurance carriers are required to cover medications and counseling that can help tobacco users quit. We will also continue working diligently to educate our lawmakers on the enormous negative economic impacts that tobacco use has on Arizona, including "harm reduction" proposals being brought forward by the tobacco industry that are mainly about helping them sell their product rather than protecting smokers from harm.

Arizona State Facts

Economic Costs Due to Smoking:	\$3,194,074,000
Adult Smoking Rate:	19.0%
High School Smoking Rate:	17.4%
Middle School Smoking Rate:	4.7%
Smoking Attributable Deaths:	6,861
Smoking Attributable Lung Cancer Deaths:	2,083
Smoking Attributable Respiratory Disease Deaths:	2,129

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2011 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Arizona
 102 West McDowell Road
 Phoenix, AZ 85003-1299
 (602) 258-7505
www.lung.org/arizona

Arkansas Report Card

Tobacco Prevention and Control Program Funding: **D**

FY2013 State Funding for Tobacco Control Programs:	\$17,802,528
FY2013 Federal Funding for State Tobacco Control Programs:	\$2,190,155*
FY2013 Total Funding for State Tobacco Control Programs:	\$19,992,683
CDC Best Practices State Spending Recommendation:	\$36,400,000
Percentage of CDC Recommended Level:	54.9%

*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:	Restricted*
Casinos/Gaming Establishments:	Restricted
Bars:	Restricted*
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	ARK. CODE ANN. §§ 20-27-1801 et seq.

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

Cigarette Tax: **D**

Tax Rate per pack of 20:	\$1.15
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Cessation Coverage: **C**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban)**

Counseling: **Covers individual, group and phone counseling**

Barriers to Coverage: **Limits on duration, prior authorization required and use of counseling required to get medications**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers NRT Patch, NRT Lozenge, NRT Nasal spray, NRT Inhaler, Varenicline (Chantix) and Bupropion (Zyban)**

Counseling: **Covers individual, group, phone and online counseling**

Barriers to Coverage: **Counseling required to receive NRT medications**

STATE QUITLINE:

Investment per Smoker: **\$6.66; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Arkansas Tobacco Cessation Coverage page](#) for specific sources.

Arkansas State Highlights:



For more than 15 years, the American Lung Association in Arkansas has partnered with other health organizations and coalitions to advocate for tobacco control policies in the state of Arkansas. Joining forces with grassroots organizations at the state and local level has strengthened advocacy efforts statewide.

The 2012 legislative session was only a month-long session focused almost entirely on the fiscal year 2013 state budget, so no major legislation was proposed by tobacco control advocates. The good news was that the tobacco prevention and cessation program in Arkansas remained well-funded at over \$17 million in fiscal year 2013. An Initiated Act approved by Arkansas voters in 2000 does dedicate a portion of the annual tobacco Master Settlement Agreement payments to tobacco control programs, which provides relatively steady funding from year to year.

During the 2013 legislative session, the American Lung Association in Arkansas will attempt to re-start activity at the local level to protect people from the dangers of secondhand smoke by strengthening local smokefree air laws. In addition, we will promote tobacco cessation coverage for Medicaid recipients and state employees, and advocate for continued funding of Arkansas' tobacco prevention and cessation program to help reduce Arkansas' high (27%) smoking rate among adults.

Arkansas State Facts	
Economic Costs Due to Smoking:	\$2,271,726,000
Adult Smoking Rate:	26.8%
High School Smoking Rate:	18.2%
Middle School Smoking Rate:	6.9%
Smoking Attributable Deaths:	4,915
Smoking Attributable Lung Cancer Deaths:	1,675
Smoking Attributable Respiratory Disease Deaths:	1,227

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2011 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Arkansas
 217 W. 2nd St., Ste. 105
 Little Rock, AR 72201
 (501) 975-0758
www.lung.org/arkansas

California Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$62,095,000
FY2013 Federal Funding for State Tobacco Control Programs:	\$6,532,450*
FY2013 Total Funding for State Tobacco Control Programs:	\$68,627,450
CDC Best Practices State Spending Recommendation:	\$441,900,000
Percentage of CDC Recommended Level:	15.5%

*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:	Restricted
Schools:	Prohibited (public schools only)
Child Care Facilities:	Prohibited
Restaurants:	Restricted
Casinos/Gaming Establishments:	Restricted (tribal establishments exempt)
Bars:	Restricted
Retail Stores:	Restricted
Recreational/Cultural Facilities:	Restricted
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation: CA LABOR CODE § 6404.5; CA GOVT. CODE §§ 7596 to 7598; CA EDUC. CODE §§ 48900 & 48901; & CA HEALTH & SAFETY CODE § 1596.795	

Cigarette Tax: **D**

Tax Rate per pack of 20:	\$0.87
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Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **All health plans cover NRT Patch, Bupropion (Zyban) and Varenicline (Chantix); coverage of NRT Gum, NRT Lozenge, NRT Nasal Spray and NRT Inhaler varies by health plan**

Counseling: **Coverage of group and individual counseling varies by health plan**

Barriers to Coverage: **Barriers to coverage vary by health plan***

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All plans cover NRT Patch, NRT Nasal Spray, NRT Inhaler, Varenicline (Chantix) and Bupropion (Zyban); coverage of NRT Gum and NRT Lozenge varies by health plan**

Counseling: **Coverage of individual, group, phone and online counseling varies by health plan**

Barriers to Coverage: **All plans have an annual limit on quit attempts and require co-payments; some plans have limits on duration and/or require use of counseling to get medications**

STATE QUITLINE:

Investment per Smoker: **\$2.40; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [California Tobacco Cessation Coverage page](#) for specific sources.

*Barriers could include: Limits on duration, annual or lifetime limits on quit attempts, requiring prior authorization, requiring co-payments, requiring using one or more cessation treatments before using others and/or requiring the use of counseling to receive medications.

California State Highlights:



For more than 20 years, California has been forging new ground in combatting the harmful effects of tobacco use where we live, work and play, with the American Lung Association in California helping to lead the way. In 2012, the Lung Association continued to focus our efforts on two main policy priorities: (1) increasing California's tobacco tax; and (2) eliminating exemptions in the state's smokefree workplace law.

For the first half of 2012, the Lung Association fought hard for the passage of Proposition 29, the California Cancer Research Act, which would have increased the cigarette tax by \$1.00 per pack and directed nearly \$600 million annually to cancer research while tripling the state's funding for tobacco prevention and cessation programs. As a principle co-sponsor of the Yes on Proposition 29 campaign, the Lung Association's staff and volunteers worked tirelessly to engage voters and counter the false and misleading claims spread by the tobacco industry during their \$45 million opposition campaign. This resulted in the closest-ever race for a statewide ballot initiative in California, but ultimately the proposition failed by 0.4 percent (49.8% to 50.2%) on June 5, 2012.

On the legislative front, the American Lung Association in California continued to actively press for the passage of Senate Bill 575, which would have eliminated exemptions in the state's smokefree workplace law such as for warehouses, hotel lobbies and employee break rooms. The bill was held up yet again in the Assembly's Governmental Organization Committee when the committee chair undermined its progress, and ultimately it never made it out of committee. For more updates on tobacco-related bills in California, visit the Lung Association in California's Center for Tobacco Policy and Organizing at www.Center4TobaccoPolicy.org/bills-updates.

On a positive note, the Lung Association saw the success of our local and statewide efforts to make the University of California system completely smokefree. University system President Mark Yudof announced in January 2012 that all ten campuses in the system will prohibit the use of tobacco on all university grounds. The individual universities were given until December 2013 to implement policies on their campuses.

As 2013 begins, so does a new legislative session,

with a new group of legislators, due to term limits. This brings with it the continued opportunity to focus our efforts on achieving expanded comprehensive cessation coverage for the 3.6 million Californians who still smoke. We also remain committed to working at the local level in communities across California to pass strong and effective tobacco control laws. And finally, in a state that was once at the forefront but is now one of only three states in the country that hasn't increased its tax since 1999, we will continue our fight to increase the tobacco tax in an effort to provide ample funding for the California Tobacco Control Program and prevent lung diseases that result from or are exacerbated by smoking.

California State Facts

Economic Costs Due to Smoking:	\$18,135,550,000
Adult Smoking Rate:	13.6%
High School Smoking Rate:	13.8%
Middle School Smoking Rate:	4.8%
Smoking Attributable Deaths:	36,684
Smoking Attributable Lung Cancer Deaths:	10,715
Smoking Attributable Respiratory Disease Deaths:	10,860

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school and middle school smoking rates are taken from the 2010 California Student 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in California

424 Pendleton Way
 Oakland, CA 94621
 (510) 638-5864
www.lung.org/california

Colorado Report Card

Tobacco Prevention and Control Program Funding:

F

FY2013 State Funding for Tobacco Control Programs:	\$22,567,704
FY2013 Federal Funding for State Tobacco Control Programs:	\$2,288,576*
FY2013 Total Funding for State Tobacco Control Programs:	\$24,856,280
CDC Best Practices State Spending Recommendation:	\$54,400,000
Percentage of CDC Recommended Level:	45.7%



Thumbs up to Colorado for increasing the allocation to tobacco prevention and cessation programs by over \$15 million in FY2013.

*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 (non-public workplaces with three or fewer employees exempt)
Schools:	Prohibited
Child Care Facilities:	Prohibited
Restaurants:	Prohibited
Casinos/Gaming Establishments:	Prohibited (tribal establishments exempt)
Bars:	Prohibited (allowed in cigar-tobacco bars)
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	COLO. REV. STAT. ANN. §§ 25-14-201 et seq.

Cigarette Tax:

D

Tax Rate per pack of 20: \$0.84

Cessation Coverage:

F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **All health plans cover Varenicline (Chantix) and Bupropion (Zyban); coverage for NRT Gum, NRT Patch, NRT Nasal spray, NRT Inhaler and NRT Lozenge vary by health plan**

Counseling: **All plans cover phone counseling; Individual and Group counseling covered for pregnant women only**

Barriers to Coverage: **No health plans require lifetime limits on quit attempts; all other barriers to coverage vary by health plan***

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Coverage of NRT Gum and NRT Patch varies by health plan**

Counseling: **Coverage of group, individual and phone counseling varies by health plan**

Barriers to Coverage: **Some plans have limits on duration**

STATE QUITLINE:

Investment per Smoker: **\$4.53; CDC recommends an investment of \$10.53/smoker**

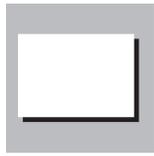
OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Yes**

Citation: See [Colorado Tobacco Cessation Coverage page](#) for specific sources.

*Barriers could include: Limits on duration, annual limits on quit attempts, requiring prior authorization, requiring co-payments, requiring using one or more cessation treatments before using others and/or requiring counseling to get medications.

Colorado State Highlights:



The American Lung Association in Colorado is a member of a statewide advocacy partner group working together to develop strategies and sound tobacco control policies. 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 2012 legislative session there was enough positive revenue growth across the state that the General Assembly did not declare Colorado to be in a state fiscal emergency and as such did not divert funds gathered through the portion of the cigarette tax levied by constitutional amendment to the general fund. Therefore, \$19.2 million of tobacco prevention and control funding was restored to its intended use, to actually prevent and reduce tobacco use. This is a major victory for the state of Colorado.

Additionally, the Colorado Department of Public Health and Environment's Tobacco Review Committee created an eight-year strategic plan to spend down the \$19.2 million this year and tobacco tax allocations in future years, which will address the following areas:

- Cessation services for low income youth and adults
- Exposure to secondhand smoke
- Effective policies and regulations that will reduce youth and adult access to tobacco products
- Healthcare systems that recognize and treat tobacco dependence as a chronic condition
- Tobacco prevalence and initiation among young adults
- Increase the price for tobacco products

The American Lung Association in Colorado will continue to press forward in the area of tobacco control using the new Colorado Tobacco Strategic Plan goals as a critical roadmap. In 2013, the Lung Association and our partners will continue to work to ensure that tobacco prevention and control funding is preserved; work to implement a strong tobacco retail licensing program statewide and to promote tobacco cessation programs around the state of Colorado.

Colorado State Facts

Economic Costs Due to Smoking:	\$2,400,564,000
Adult Smoking Rate:	18.1%
High School Smoking Rate:	15.7%
Middle School Smoking Rate:	3.7%
Smoking Attributable Deaths:	4,390
Smoking Attributable Lung Cancer Deaths:	1,195
Smoking Attributable Respiratory Disease Deaths:	1,529

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2011 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Colorado

5600 Greenwood Plaza Blvd., Suite 100
Greenwood Village, CO 80111
(303) 388-4327
www.lung.org/colorado

Connecticut Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$5,997,000
FY2013 Federal Funding for State Tobacco Control Programs:	\$1,835,179*
FY2013 Total Funding for State Tobacco Control Programs:	\$7,832,179
CDC Best Practices State Spending Recommendation:	\$43,900,000
Percentage of CDC Recommended Level:	17.8%

*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:	Restricted
Restaurants:	Prohibited
Casinos/Gaming Establishments:	Prohibited (tribal establishments exempt)
Bars:	Prohibited (allowed in tobacco bars)
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	Yes
Citation:	CONN. GEN. STAT. §§ 19a-342 & 31-40q; and CT ADMIN CODE §§ 19a-79-7(d)(6) & 19a-87b-9

Cigarette Tax: **A**

Tax Rate per pack of 20:	\$3.40
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Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications:	Covers all 7 recommended cessation medications*
Counseling:	Covers individual counseling
Barriers to Coverage:	Prior authorization required for NRT Nasal spray and NRT Inhaler

STATE EMPLOYEE HEALTH PLAN(S):

Medications:	Covers NRT Patch, NRT Gum, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban)
Counseling:	Coverage of phone counseling varies by health plan
Barriers to Coverage:	Minimal co-payments required

STATE QUITLINE:

Investment per Smoker: **\$3.40; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate:	No provision
Citation:	See Connecticut Tobacco Cessation Coverage page for specific sources.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Connecticut State Highlights:



The American Lung Association in Connecticut along with partner organizations worked hard to advocate for tobacco control and prevention funding from the Tobacco and Health Trust Fund and on communicating to the general public the availability of the new coverage for tobacco cessation for Medicaid recipients.

Tobacco cessation coverage for Medicaid recipients in Connecticut began on January 1, 2012. This allowed access to nicotine replacement therapies, prescription drugs and counseling approved by the U.S. Food and Drug Administration to the over 500,000 individuals currently on Medicaid in the state.

The 2012 legislative session was short and resulted in one tobacco-related bill being introduced, House Bill 5332. This bill would have acted to remove the grandfather clause for tobacco bars and provide an exemption for these establishments in the already existing law in regards to smokefree public buildings. This bill did not make it out of the House Public Health Committee. Efforts also expanded to promote smokefree living in multi-family housing controlled by public housing authorities in the state through voluntary means. The Mobilize Against Tobacco for Connecticut's Health (MATCH) coalition has been instrumental in getting housing authorities to sign on to this initiative.

The Connecticut General Assembly voted in a special session to revise the definition of tobacco manufacturers to include persons and stores that allow for commercial purposes the use of roll-your-own cigarette machines. These stores will now have to pay the \$5,250 cigarette manufacturer's licensing fee. In addition, roll-your-own tobacco will be taxed at the same rate as cigarettes in the state of Connecticut.

The American Lung Association in Connecticut had an opportunity to speak in support of two of U.S. Sen. Richard Blumenthal's federal initiatives in press conferences in 2012. The first was in support of additional funding for the Centers for Disease Control and Prevention's anti-smoking advertising campaign. The second press conference was in support of the Tobacco Tax Equity Act which would close loopholes in the federal tax code for large cigars, smokeless tobacco and pipe tobacco.

In 2013, the American Lung Association in Connecticut, with our partners, will work to maintain the Tobacco Trust Fund, which receives a small portion

of tobacco settlement dollars each year, and prevent it from being raided. We will fight to have Connecticut join the ranks of the existing states with 100 percent smokefree workplaces, and pass legislation to prohibit smoking in home daycare centers. Finally, the Lung Association will work through voluntary efforts on the local level to expand the amount of smokefree multi-unit housing.

Connecticut State Facts

Economic Costs Due to Smoking:	\$2,474,139,000
Adult Smoking Rate:	17.0%
High School Smoking Rate:	15.9%
Middle School Smoking Rate:	2.9%
Smoking Attributable Deaths:	4,786
Smoking Attributable Lung Cancer Deaths:	1,502
Smoking Attributable Respiratory Disease Deaths:	1,270

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2011 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Connecticut

45 Ash Street
 East Hartford, CT 06108-3272
 (860) 289-5401
www.lung.org/connecticut

Delaware Report Card

Tobacco Prevention and Control Program Funding: **B**

FY2013 State Funding for Tobacco Control Programs:	\$9,021,800
FY2013 Federal Funding for State Tobacco Control Programs:	\$821,064*
FY2013 Total Funding for State Tobacco Control Programs:	\$9,842,864
CDC Best Practices State Spending Recommendation:	\$13,900,000
Percentage of CDC Recommended Level:	70.8%

*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
Casinos/Gaming Establishments:	Prohibited
Bars:	Prohibited
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	DEL. CODE ANN. tit. 16, §§ 2901 et seq.

Cigarette Tax: **C**

Tax Rate per pack of 20:	\$1.60
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Cessation Coverage: **D**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers individual counseling**

Barriers to Coverage: **Prior authorization, use of some medications before using others, use of counseling to get medications and minimal copayments required**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers NRT Nasal Spray, NRT Inhaler, Varenicline (Chantix) and Bupropion (Zyban)**

Counseling: **Covers individual, group and phone counseling**

Barriers to Coverage: **Annual limits on treatment and limits on duration**

STATE QUITLINE:

Investment per Smoker: **\$7.30; CDC recommends an investment of \$10.53**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Delaware Tobacco Cessation Coverage page](#) for specific sources.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Delaware State Highlights:



The American Lung Association in Delaware continues its efforts in tobacco prevention and cessation throughout the state. Delaware has been one of several states to provide significant funding for tobacco prevention and cessation programs, when compared to the recommended level by the Centers for Disease Control and Prevention, for a number of years. This continued funding combined with increases in the state cigarette tax and a comprehensive clean indoor air law, have led to consistent declines in adult and youth smoking rates.

This year, the fiscal year 2013 budget maintained funding for tobacco prevention and cessation programs at \$9 million, which will allow for continued progress on smoking rates.

The Delaware Health Fund will receive considerable attention by a workgroup to make recommendations to the Governor for next year's (fiscal year 2014) budget. Legislation originally passed in 1999, dedicated the annual Master Settlement Agreement (MSA) funding to the Delaware Health Fund to be used for specific health-related purposes, tobacco prevention and cessation programming. The tobacco control work has been largely community based prevention and cessation programming with oversight by the Division of Public Health in the Delaware Department of Health & Social Services.

The Lung Association will continue its efforts to advance legislation to make the tax on tobacco products other than cigarettes such as moist snuff, cigars, blunts, and roll-your-own tobacco equivalent to the cigarette tax to discourage smokers from using these products instead of quitting. House Bill 178 was introduced in 2012 and received a hearing before, unfortunately, being tabled in the House Revenue and Finance Committee.

The Lung Association will also work to ensure all Delawareans have access to a comprehensive tobacco cessation benefit through health insurance coverage, whether public or private.

In 2013, the American Lung Association in Delaware will continue to lead the fight to protect people from the dangers of secondhand smoke, prevent youth and young adults from starting to smoke and motivate adults to quit. As Delaware approaches decisions regarding implementation of the Affordable Care Act the Lung Association will advocate for

programs and services that provide patient access to treatment and services for lung-related health conditions, many of which are caused by tobacco use.

Delaware State Facts

Economic Costs Due to Smoking:	\$678,008,000
Adult Smoking Rate:	21.7%
High School Smoking Rate:	18.3%
Middle School Smoking Rate:	6.4%
Smoking Attributable Deaths:	1,196
Smoking Attributable Lung Cancer Deaths:	419
Smoking Attributable Respiratory Disease Deaths:	284

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2010 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Delaware

630 Churchmans Road, Suite 202

Newark, DE 19702

(302) 737-6414

www.lung.org/delaware

District of Columbia Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 City Funding for Tobacco Control Programs:	\$495,000
FY2013 Federal Funding for City Tobacco Control Programs:	\$867,698*
FY2013 Total Funding for City Tobacco Control Programs:	\$1,362,698
CDC Best Practices City Spending Recommendation:	\$10,500,000
Percentage of CDC Recommended Level:	13.0%



Thumbs up to the District of Columbia for allocating \$495,000 in city dollars to tobacco prevention and cessation efforts in FY2013 after allocating zero dollars last year.

*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 CITY SMOKING RESTRICTIONS:

Government Worksites:	Prohibited
Private Worksites:	Prohibited
Schools:	Prohibited
Child Care Facilities:	Prohibited
Restaurants:	Prohibited
Casinos/Gaming Establishments:	N/A
Bars:	Prohibited (allowed in cigar bars and allows for an economic hardship waiver)
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	D.C. CODE ANN. § 7-731, Part B, §§ 4915 to 4921

Cigarette Tax: **B**

Tax Rate per pack of 20:	\$2.50
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Cessation Coverage: **I***

OVERVIEW OF CITY CESSATION COVERAGE:

CITY MEDICAID PROGRAM:

Medications:	Data not reported
Counseling:	Data not reported
Barriers to Coverage:	Data not reported

CITY EMPLOYEE HEALTH PLAN(S):

Medications:	Data not reported
Counseling:	Data not reported
Barriers to Coverage:	Data not reported

CITY QUITLINE:

Investment per Smoker: **\$5.45**; CDC recommends an investment of **\$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate:	No provision
Citation:	See District of Columbia Tobacco Cessation Coverage page for specific sources.

*We were unable to obtain current information on tobacco cessation coverage for Medicaid enrollees or city employees for the District of Columbia, and have therefore awarded them an I for Incomplete in this category.

District of Columbia City Highlights:



The American Lung Association in the District of Columbia remains committed to protecting District residents and visitors from the harmful effects of tobacco use and exposure through advocacy and community education targeted towards the need to strengthen and protect current tobacco control measures. Throughout 2012, the Lung Association worked closely with leading public health partners and advocates to restore and increase the District's investment in tobacco control and to expand awareness of the toll that tobacco takes within the community.

Local tobacco control funding was completely eliminated in the District's Fiscal Year 2012 budget, making it one of only four states failing to contribute any local dollars to fund tobacco prevention. This shortsighted decision put at risk the District's progress in reducing tobacco use amongst its most vulnerable populations, including youth. A 2012 report released by the U.S. Surgeon General, Preventing Tobacco Use Among Youth and Young Adults, made it clear: the failure of states to adequately invest in tobacco control has resulted in three million new youth and young adult smokers. The devastating toll that tobacco use has on the District is no different. In 2011, an estimated 20.5 percent of the District's adult population were smokers and 12.5 percent of high school students still smoked.

Working closely with the American Cancer Society, American Heart Association, Campaign for Tobacco Free Kids, DC Cancer Consortium, and the DC Tobacco Free Coalition (DCTFC), the Lung Association developed a strategic plan to fight back against this loss of funding.

The American Lung Association and public health partners testified at budget hearings and met with key decision makers from the DC Department of Health, the Mayor's office, and the City Council to garner support for investment in tobacco control spending. An advocacy day at the City Council building was also organized to mobilize grassroots support, including members of the Lung Association's Young Professional Council.

Additionally, the Lung Association invested in educating the community, which included:

- Presenting to the DC Youth Tobacco Coalition
- Serving as a keynote speaker at the DC Tobacco

Town Hall meeting

- Meeting with media outlets to secure local coverage on the issue

Through the tireless efforts of the community and key supporters, the City Council voted in favor of investing \$495,000 for tobacco control and prevention funding. This key funding ensured the local Quitline was able to continue assisting the community in their quit attempts.

The American Lung Association in the District of Columbia expressed its gratitude to the City Council for this investment and in 2013 will continue to work to identify additional revenue sources to support this lifesaving funding including addressing the District's local tax on cigarettes and other tobacco products.

District of Columbia Facts	
Economic Costs Due to Smoking:	\$626,555,000
Adult Smoking Rate:	20.5%
High School Smoking Rate:	12.5%
Middle School Smoking Rate:	N/A
Smoking Attributable Deaths:	724
Smoking Attributable Lung Cancer Deaths:	245
Smoking Attributable Respiratory Disease Deaths:	125

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. A current middle school smoking rate is 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in the District of Columbia

1301 Pennsylvania Ave., NW, Suite 800
 Washington, DC 20004
 (202) 785-3355
www.lung.org/districtofcolumbia

Florida Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$64,289,944
FY2013 Federal Funding for State Tobacco Control Programs:	\$3,164,145*
FY2013 Total Funding for State Tobacco Control Programs:	\$67,454,089
CDC Best Practices State Spending Recommendation:	\$210,900,000
Percentage of CDC Recommended Level:	32.0%



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.

*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
Casinos/Gaming Establishments:	Prohibited (tribal establishments exempt)
Bars:	Restricted*
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	Yes**
Citation:	FLA. STAT. ch. 386.201 et seq.

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

**If preemption were repealed Florida's grade would be an "A."

Cigarette Tax: **D**

Tax Rate per pack of 20:	\$1.339
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Cessation Coverage: **D**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Coverage for all 7 recommended cessation medications* varies by health plan**

Counseling: **All health plans cover individual counseling; group counseling coverage varies by plan**

Barriers to Coverage: **Barriers to coverage vary by health plan****

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Coverage for individual and phone counseling varies by health plan**

Barriers to Coverage: **Co-payments required**

STATE QUITLINE:

Investment per Smoker: **\$4.46; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

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



Thumbs up for Florida for expanding and making consistent the tobacco cessation medications available to state employees.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

**Barriers to coverage could include: Limits on duration, annual or lifetime limits on quit attempts, requiring prior authorization, requiring co-payments, requiring using one or more cessation treatments before using others and/or requiring the use of counseling to receive medications.

Florida State Highlights:



Florida has witnessed remarkable success in reducing smoking rates in recent years. In 2012, only 3.3 percent of middle school students and 10.1 percent of high school students

smoked a cigarette at least once during the past 30 days. Since 1998, smoking prevalence has decreased by a remarkable 82.2 percent among middle school students and by 63.1 percent among high school students. Since 2010 alone, the decline has been 32.7 percent among middle school students and 22.9 percent among high school students. The American Lung Association in Florida continues to be at the forefront of this issue and a leader in fighting for policies that address tobacco use by children, smoking in public places and helping those addicted to tobacco quit for good.

During the 2012 Legislative Session, the Lung Association, along with our partners, continued its work maintaining the integrity of a state constitutional amendment requiring the Florida Legislature to allocate at least 15 percent of the state's annual tobacco settlement payments to a tobacco prevention program. The Lung Association successfully safeguarded these funds from allocation to special projects not intended by the state law and ensured certain key programs were maintained.

The state budget included \$64,289,944 for the state-wide Tobacco Education and Use Prevention Program for Fiscal Year 2012-2013, as well as language that permitted the Florida Department of Health to offer nicotine replacements and other treatments approved by the U.S. Food and Drug Administration as part of tobacco dependency interventions. As reported by the Florida Department of Health, annually there are approximately 300 fewer smoking-related deaths among Floridians 35 and older as a result of the program.

The Lung Association is the lead agency of the Florida Tobacco Cessation Alliance, whose goal is to educate employers on the health and economic benefits of providing tobacco cessation coverage for their workforce. In partnership with the Florida Department of Health, the Alliance maintains an educational website and works statewide, as well as with the 67 county tobacco-free partnerships, on this important health initiative.

Florida's Clean Indoor Air Act preempts local governments from enacting laws stronger than the state.

In 2011, it was amended to authorize district school boards to adopt rules prohibiting any person from smoking tobacco on, or in, any district-owned or district-leased facility or property between the hours of 6 a.m. and midnight. As with school districts, there is growing interest by local governments to enact stronger smokefree laws. Many are frustrated that the state law does not allow them to protect children from secondhand smoke in parks and other outdoor venues that children frequent.

During 2013, 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 protect the Clean Indoor Air Act and convince legislators and public officials of the value of providing adequate cessation resources for Medicaid patients and state employees.

Florida State Facts

Economic Costs Due to Smoking:	\$12,879,031,000
Adult Smoking Rate:	19.2%
High School Smoking Rate:	10.1%
Middle School Smoking Rate:	3.3%
Smoking Attributable Deaths:	28,607
Smoking Attributable Lung Cancer Deaths:	9,553
Smoking Attributable Respiratory Disease Deaths:	7,393

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school and middle school smoking rates are taken from the 2012 Florida 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Florida

6852 Belfort Oaks Place
 Jacksonville, FL 32216
 (904) 743-2933
www.lung.org/florida

Georgia Report Card

Tobacco Prevention and Control Program Funding:

F

FY2013 State Funding for Tobacco Control Programs: \$700,000

FY2013 Federal Funding for State Tobacco Control Programs: \$2,254,535*

FY2013 Total Funding for State Tobacco Control Programs: \$2,954,535

CDC Best Practices State Spending Recommendation: \$116,500,000

Percentage of CDC Recommended Level: 2.5%

*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: **Restricted**

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

Bars: **Restricted**

Retail Stores: **Restricted**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

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

Cigarette Tax:

F

Tax Rate per pack of 20: \$0.37



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

Cessation Coverage:

F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications* for pregnant women only**

Counseling: **Covers individual counseling for pregnant women only**

Barriers to Coverage: **Limits on duration, only one quit attempt allowed per pregnancy, use of some medications required before using others and use of counseling required to get medications**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Both health plans cover NRT Patch, NRT Gum, NRT Nasal spray, NRT Inhaler, Bupropion (Zyban) and Varenicline (Chantix); one plan covers NRT Lozenge**

Counseling: **Both health plans cover phone counseling**

Barriers to Coverage: **Duration and annual limits on quit attempts, co-pays for prescription medications required and use of counseling required to get medications**

STATE QUITLINE:

Investment per Smoker: **\$0.89; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Georgia Tobacco Cessation Coverage page](#) for specific sources.



Thumbs down for Georgia for not providing coverage of any tobacco cessation treatments to all Medicaid enrollees. Coverage is provided for pregnant women as required by federal law.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Georgia State Highlights:



The American Lung Association in Georgia has a long history in tobacco control public policy. The Lung Association promoted the first state law in Georgia restricting tobacco

sales to minors and worked to pass the first smoke-free air ordinance in Georgia. With our partners and supporters, we helped establish state tobacco prevention funding, increase tobacco taxes and protect the public from secondhand smoke. We have defeated six tobacco industry attempts to suppress local smokefree air laws, also known as preemption.

Georgia has the lowest tobacco tax of all surrounding states and ranks 48th in the country. Despite the need for more state funds in 2012, the governor and legislature continued to reject consideration of a boost in Georgia's cigarette tax by \$1.00 per pack.

Georgia's state tobacco prevention program runs on minimal funds. The state quit line is funded by Master Settlement Agreement funds, but few dollars are available to promote or improve the service. Georgia is among the bottom tier of states in funding tobacco prevention.

Georgia is one of the few states that provide no funding for any Medicaid recipient seeking help for quitting smoking, despite the well-documented return on investment. The Department of Community Health has complied with the Affordable Care Act requirement to provide smoking cessation coverage to Medicaid recipients who are pregnant. State employees now have coverage for prescription tobacco cessation medications for one quit smoking attempt per year.

Chatham County joined the city of Savannah in passing a comprehensive smokefree air law. Augusta looks to be the next city to pass a similar ordinance. Atlanta became the largest city in the southeast to prohibit smoking in their parks and recreation centers. Georgia K-12 school districts, along with colleges and universities, are prohibiting smoking campus-wide in increasing numbers.

The gap between Georgia and other states continues to widen in public policies to reduce the burden of tobacco use. The Lung Association in Georgia will continue to work to close that gap by supporting passage of a significant cigarette tax increase to prevent kids from starting to smoke and to motivate smokers to quit, by pushing for local smokefree air laws to protect people from the dangers of second-hand smoke, and urging the expansion of tobacco

cessation coverage for all Medicaid recipients.

Georgia State Facts	
Economic Costs Due to Smoking:	\$5,681,925,000
Adult Smoking Rate:	21.1%
High School Smoking Rate:	17.0%
Middle School Smoking Rate:	5.8%
Smoking Attributable Deaths:	10,546
Smoking Attributable Lung Cancer Deaths:	3,437
Smoking Attributable Respiratory Disease Deaths:	2,660

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2011 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Georgia
 2452 Spring Road SE
 Smyrna, GA 30080-3862
 (770) 434-5864
www.lung.org/georgia

Hawaii Report Card

Tobacco Prevention and Control Program Funding: **C**

FY2013 State Funding for Tobacco Control Programs:	\$8,933,769
FY2013 Federal Funding for State Tobacco Control Programs:	\$898,291*
FY2013 Total Funding for State Tobacco Control Programs:	\$9,832,060
CDC Best Practices State Spending Recommendation:	\$15,200,000
Percentage of CDC Recommended Level:	64.7%

*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
Casinos/Gaming Establishments:	N/A
Bars:	Prohibited
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	HAW. REV. STAT. §§ 328J-1 to 328J-15

Cigarette Tax: **A**

Tax Rate per pack of 20:	\$3.20
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Cessation Coverage: **C***

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **All health plans cover NRT Patch and NRT Gum; coverage of NRT Lozenge, NRT Nasal spray, NRT Inhaler, Bupropion (Zyban) and Varenicline (Chantix) varies by health plan**

Counseling: **All health plans required to cover counseling; type of counseling covered varies by plan**

Barriers to Coverage: **Barriers to coverage vary by health plan****

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Data not reported**

Counseling: **Data not reported**

Barriers to Coverage: **Data not reported**

STATE QUITLINE:

Investment per Smoker: **\$9.04; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Hawaii Tobacco Cessation Coverage page](#) for specific sources.

*Due to current data on tobacco cessation coverage for state employees being unavailable, Hawaii was graded based on cessation coverage under Medicaid and quitline investment per smoker only.

**Barriers could include: Limits on duration, annual or lifetime limits on quit attempts, requiring prior authorization, requiring co-payments, requiring using one or more cessation treatments before using others and/or requiring the use of counseling to receive medications.

Hawaii State Highlights:



The American Lung Association in Hawaii continues its leadership role in protecting all the citizens of Hawaii from the deadly health effects of tobacco addiction and the harmful effects of secondhand smoke. The Lung Association continues its collaboration with the Coalition for Tobacco Free Hawaii on bills in the legislature to increase tobacco taxes, increase access to cessation resources and protect Hawaii's comprehensive smokefree law.

During the 2012 legislative session, House Bill 2306 was introduced which would have allowed smoking again in bars and nightclubs. A poll conducted by Qmark found that 87 percent of Hawaii residents surveyed supported the smokefree workplace law. This strong support, along with overwhelming efforts of grassroots advocates contacting legislators resulted in stopping this measure from passing.

The Lung Association continues to advocate for funding for Hawaii's successful tobacco prevention and control programs. Dollars received through the Master Settlement Agreement with the tobacco industry are allocated to the Tobacco Settlement Special Fund. A portion of this fund is used by the Department of Health for health promotion and chronic disease prevention programs, including tobacco control programs. Another portion is deposited into the Tobacco Prevention and Control Trust Fund which provides funding for the Hawaii Quitline, media campaigns and community intervention grants.

Facing continuing budgetary challenges, legislators unfortunately chose to divert money from the Tobacco Prevention and Control Trust Fund to the general revenue budget for two years back in 2011. Due to this diversion, the tobacco program realized a slight decrease in funding this budget year (fiscal year 2013) from last year.

The American Lung Association in Hawaii will continue educational outreach on the vital importance of funding tobacco prevention and cessation programs.

Hawaii State Facts	
Economic Costs Due to Smoking:	\$686,772,000
Adult Smoking Rate:	16.8%
High School Smoking Rate:	8.7%
Middle School Smoking Rate:	3.6%
Smoking Attributable Deaths:	1,163
Smoking Attributable Lung Cancer Deaths:	372
Smoking Attributable Respiratory Disease Deaths:	226

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school and middle school smoking rates are taken from the 2011 Hawaii 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Hawaii

650 Iwilei Road, Suite 208
 Honolulu, HI 96817
 (808) 537-5966
www.lung.org/hawaii

Idaho Report Card

Tobacco Prevention and Control Program Funding:

F

FY2013 State Funding for Tobacco Control Programs: \$2,814,700

FY2013 Federal Funding for State Tobacco Control Programs: \$2,043,020*

FY2013 Total Funding for State Tobacco Control Programs: \$4,857,720

CDC Best Practices State Spending Recommendation: \$16,900,000

Percentage of CDC Recommended Level: 28.7%



Thumbs up for Idaho for increasing its funding for tobacco prevention and cessation initiatives by about \$1.6 million this year.

*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: **Restricted**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

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

Bars: **No provision**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: IDAHO CODE §§ 39-5501 et seq.

Cigarette Tax:

F

Tax Rate per pack of 20: \$0.57

Cessation Coverage:

F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications***

Counseling: **No coverage**

Barriers to Coverage: **Annual limit on quit attempts, prior authorization required, use of counseling required to get medications and dollar limit on benefits**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers NRT Gum, NRT Patch, NRT Lozenge, NRT Nasal spray, NRT Inhaler, Varenicline (Chantix) and Bupropion (Zyban)**

Counseling: **Covers phone counseling**

Barriers to Coverage: **Co-payment required for medications and dollar limit for benefits**

STATE QUITLINE:

Investment per Smoker: **\$3.80; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

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

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Idaho State Highlights:



The American Lung Association in Idaho is a decades-long leader in tobacco prevention and control efforts. Our work with community partners has supported both local and statewide policies to protect Idahoans from second-hand smoke, to prevent youth from initiating tobacco use, and to provide better access to cessation programs and services to those Idahoans who want to quit smoking.

Two city ordinances prohibiting smoking in public places and parks took effect January 2, 2012 after being approved by the Boise City Council in 2011. The ordinances prohibited smoking in bars, workplaces, Boise City parks and the Greenbelt. Boise is both Idaho's largest city and the state capitol, so this is a major victory.

Building on this momentum, the Lung Association and advocates continue working to expand the number of Idahoans protected from exposure to second-hand smoke. Working with partners in Smokefree Idaho, the Lung Association is reinvigorating efforts and joining with grassroots advocates to expand local smokefree workplace laws. The Lung Association is hopeful that current efforts in Garden City, Idaho Falls, Ketchum, Moscow and Pocatello will yield additional smokefree communities in Idaho during 2013.

During the 2012 legislative session, the legislature once again appropriated dollars to the American Lung Association in Idaho to re-start their Teens Against Tobacco Use program which was unfortunately defunded during a difficult budget session in 2011. Funding for this program came from the Millennium Fund, which is the fund where Idaho's annual Master Settlement Agreement payments are deposited. Overall funding for tobacco prevention and cessation activities increased substantially in 2012 from \$1.2 million to over \$2.8 million, which was a welcome development.

The American Lung Association in Idaho will continue working with coalition partners to achieve city-by-city and ultimately statewide, comprehensive smokefree policies. Advocacy efforts will also continue to increase funding for tobacco prevention and cessation programs.

Idaho State Facts

Economic Costs Due to Smoking:	\$685,273,000
Adult Smoking Rate:	17.1%
High School Smoking Rate:	14.3%
Middle School Smoking Rate:	N/A
Smoking Attributable Deaths:	1,509
Smoking Attributable Lung Cancer Deaths:	431
Smoking Attributable Respiratory Disease Deaths:	480

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. A current middle school smoking rate is not available for the 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Idaho

1412 W. Idaho St., Suite 100
 Boise, ID 83702
 (208) 345-5864
www.lung.org/idaho

Illinois Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$11,100,000
FY2013 Federal Funding for State Tobacco Control Programs:	\$2,600,641*
FY2013 Total Funding for State Tobacco Control Programs:	\$13,700,641
CDC Best Practices State Spending Recommendation:	\$157,000,000
Percentage of CDC Recommended Level:	8.7%

*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
Casinos/Gaming Establishments:	Prohibited
Bars:	Prohibited
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	410 ILL. COMP. STAT. 82/1 et seq.

Cigarette Tax: **C**

Tax Rate per pack of 20: \$1.98*



Thumbs up for Illinois for increasing its cigarette tax by \$1.00 per pack.

*On June 24, 2012, the cigarette tax increased from \$0.98 to \$1.98 per pack.

Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications***

Counseling: **No coverage**

Barriers to Coverage: **Co-payments required for prescription medications**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers group, phone and individual counseling**

Barriers to Coverage: **Annual limit on quit attempts, use of counseling required to get medications and dollar limit on benefits**

STATE QUITLINE:

Investment per Smoker: **\$1.23; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Provision requires insurance companies to offer a comprehensive tobacco cessation benefit to purchasers/employers. The purchaser/ employer is not required to buy or otherwise provide the benefit**

Citation: See [Illinois Tobacco Cessation Coverage page](#) for specific sources.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Illinois State Highlights:



The second year of the 97th Illinois General Assembly proved to be extremely successful for the American Lung Association in Illinois as we protected tobacco cessation and prevention funding, passed a \$1.00 per pack cigarette tax increase, and protected the Smoke Free Illinois Act by soundly defeating a bill to sell smoking licenses to bars, private clubs and casinos with 80 No votes to 32 Yes votes.

The 2012 legislative session started with a dismal outlook for tobacco control legislation. The November election loomed, with every legislative seat up for reelection, which only happens once every 10 years. It was highly unlikely that any controversial bill or any tax would pass while every legislator was campaigning for reelection. Early in 2012 the Lung Association focused on a bill to tax roll-your-own cigarettes at the same rate as manufactured cigarettes. Roll-your-own cigarettes avoided most taxes and were available at half the cost of manufactured cigarettes. We knew there were at least 65 roll-your-own stations around the state yielding easily accessible and cheap tobacco products. While we saw this as a parity issue and felt that all cigarettes should be taxed the same, the bill stalled early when some legislators determined it was a tax increase.

The General Assembly was faced with the difficult task of cutting Medicaid services by \$2.7 billion dollars. They successfully made \$1.6 billion in cuts but felt they could go no further and were desperate for a solution. The Lung Association quickly built a statewide coalition to increase the cigarette tax and prevent further devastating cuts to the Medicaid program. Coalition members included the Illinois Hospital Association and over 700 human services and health organizations. A campaign webpage, Facebook page and Twitter account were also created to keep a very broad statewide coalition up to date, activated and informed. The Lung Association and partners were successful and effective June 24, 2012, the state cigarette tax increased by \$1.00 per pack, the tax on other tobacco products doubled, and little cigars and roll-your-own tobacco are now taxed at the same rate as cigarettes as well. It is estimated that 77,000 kids will not start to smoke and 60,000 adults will quit due to the tax increase.

Cook County, Illinois (population of 5.2 million and which includes Chicago) raised its local cigarette tax by another \$1.00 in November 2012—for a total of

\$3.00 per pack. Chicago, with a 68-cent city cigarette tax of its own, now has the second highest combined state and local cigarette tax rate in the country at \$5.66 per pack.

The American Lung Association in Illinois looks forward to welcoming many new legislators to the 98th General Assembly. We will continue to work to create a norm of tobacco free workplaces, educational facilities including college and university campuses, and outdoor recreational areas such as playgrounds and parks.

Illinois State Facts

Economic Costs Due to Smoking:	\$8,317,453,000
Adult Smoking Rate:	20.9%
High School Smoking Rate:	17.5%
Middle School Smoking Rate:	4.8%
Smoking Attributable Deaths:	16,600
Smoking Attributable Lung Cancer Deaths:	5,450
Smoking Attributable Respiratory Disease Deaths:	4,009

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2010 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Illinois Springfield Office:

3000 Kelly Lane
Springfield, IL 62711
(217) 787-5864
www.lung.org/illinois

Chicago Office:

55 W. Wacker Drive, Suite 800
Chicago, IL 60601
(312) 781-1100
www.lung.org/illinois

Indiana Report Card

Tobacco Prevention and Control Program Funding:

F

FY2013 State Funding for Tobacco Control Programs: \$9,251,037

FY2013 Federal Funding for State Tobacco Control Programs: \$2,371,788*

FY2013 Total Funding for State Tobacco Control Programs: \$11,622,825

CDC Best Practices State Spending Recommendation: \$78,800,000

Percentage of CDC Recommended Level: 14.7%

*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**

Casinos/Gaming Establishments: **No provision**

Bars: **Restricted***

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

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

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

Cigarette Tax:

D

Tax Rate per pack of 20: \$0.995

Cessation Coverage:

F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers individual, phone and group counseling**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, minimal co-payments required, use of some medications required before being able to use others and use of counseling required to get medications**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers individual counseling and group counseling with mental health providers**

Barriers to Coverage: **Co-payments required and annual limit on quit attempts**

STATE QUITLINE:

Investment per Smoker: **\$1.14; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Indiana Tobacco Cessation Coverage page](#) for specific sources.



Thumbs up for Indiana for providing comprehensive coverage for all tobacco cessation medications and types of counseling to Medicaid enrollees.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Indiana State Highlights:



In 2012, the American Lung Association in Indiana once again was a key advocate in fighting for effective tobacco control legislation at the Indiana legislature. The Lung Association serves on the Steering Committee for the Indiana Campaign for Smokefree Air and worked with coalition partners to pass a bill that would make Indiana smokefree.

The momentum was strong for a smokefree Indiana going into the legislative session, as the governor noted for the first time his desire for a strong state-wide smokefree law during his State of the State speech. Given the Governor's support along with broad-based community support, a bi-partisan comprehensive smokefree workplace bill was introduced in the General Assembly, House Bill 1149, which would have prohibited smoking in virtually all public places and workplaces, including restaurants and bars. The American Lung Association in Indiana was fully supportive of HB 1149 as introduced.

The bill passed through the House of Representatives, but a number of exemptions were added to the bill, including private clubs, casinos and other gaming establishments. The bill as approved by the House was passed out of Senate Committee and for the first time, was considered by the full Senate. However, an already weak bill was watered down even further, including exemptions for bars and nursing homes. After these further exemptions were added, the American Lung Association in Indiana withdrew its support of HB 1149.

The momentum for the measure proved too strong and HB 1149 became law on July 1, 2012. The law primarily prohibits smoking in workplaces and restaurants, with exemptions for bars, casinos and private membership clubs. Although the Lung Association believes that workers in all public places and workplaces should be protected from secondhand smoke, the state law does provide some protections for many communities across Indiana who had no protections at all in the workplace.

In 2012, the Bowen Research Center at the Indiana University School of Medicine released a study that showed secondhand smoke costs Indiana \$1.3 billion dollars in excess medical expenses and premature loss of life. This breaks down to about \$201 dollars per Hoosier each year. The burden of these expenses is assumed by Indiana businesses, government and

individual citizens.

The 2013 legislative session will be a budget year for Indiana and funding for Indiana's tobacco control program is sure to be under attack once again. The American Lung Association in Indiana will work with its coalition partners to fight for sustaining funding for the program and will look for opportunities to strengthen the smokefree workplace law for Indiana.

Indiana State Facts	
Economic Costs Due to Smoking:	\$4,804,232,000
Adult Smoking Rate:	25.5%
High School Smoking Rate:	18.1%
Middle School Smoking Rate:	4.4%
Smoking Attributable Deaths:	9,728
Smoking Attributable Lung Cancer Deaths:	3,200
Smoking Attributable Respiratory Disease Deaths:	2,623

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2010 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Indiana
 115 W. Washington Street, Suite 1180 South
 Indianapolis, IN 46204
 (317) 819-1181
www.lung.org/indiana

Iowa Report Card

Tobacco Prevention and Control Program Funding:

F

FY2013 State Funding for Tobacco Control Programs: \$3,653,830

FY2013 Federal Funding for State Tobacco Control Programs: \$1,586,023*

FY2013 Total Funding for State Tobacco Control Programs: \$5,239,853

CDC Best Practices State Spending Recommendation: \$36,700,000

Percentage of CDC Recommended Level: 14.3%

*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**

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

Bars: **Prohibited**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: IOWA CODE §§ 142D.1 to 142D.9

Cigarette Tax:

D

Tax Rate per pack of 20: \$1.36

Cessation Coverage:

F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers individual and phone counseling**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, prior authorization required, use of some medications required before using others, minimal co-payments required and use of counseling required to get medications**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers NRT Gum, NRT Patch and NRT Lozenge**

Counseling: **Online counseling covered**

Barriers to Coverage: **Limits on duration and use of counseling required to get medications**

STATE QUITLINE:

Investment per Smoker: **\$3.33; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

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

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Iowa State Highlights:



The American Lung Association in Iowa strongly advocated to maintain funding for the Iowa Department of Public Health’s Division of Tobacco Use Prevention and Control budget.

Together with our partners, we stood firm on the need for tobacco prevention and cessation programming and services in the state.

Unfortunately, funding for the Iowa Department of Public Health’s Division of Tobacco Use Prevention and Control has been cut substantially over the last several years. The Division begins fiscal year 2013 with a very similar budget to fiscal year 2012, making it still about 50 percent less than as recently as fiscal year 2011. The state allocation for tobacco control and prevention work over the last several years breaks down as follows:

- FY 08 – \$12.29 million
- FY 09 – \$11.9 million
- FY 10 – \$9.66 million
- FY 11 – \$7.39 million
- FY 12 – \$3.25 million (\$453,830 for enforcement of tobacco laws)
- FY 13 – \$3.65 million (\$453,830 for enforcement of tobacco laws)

The Health and Human Services budget proposed by the House of Representatives, controlled by Republicans, sought to eliminate the entire tobacco control program, allocating \$0 for tobacco prevention and cessation throughout the session. Gov. Terry Branstad (R) continued to state his support for some funding to reduce tobacco use. The negotiating between the House and Senate on the Health and Human Services budget, which included the highly contentious tobacco control budget, was finalized in May 2012. The negotiated funding level is one of the lowest in Iowa’s history.

As a result, Iowa has limited funds to support a media promotion of the statewide cessation service, Quitline Iowa. The youth prevention program has been crippled by the pressure placed on it for creatively educating youth how tobacco companies target their generation. Surveillance and evaluation will be greatly impacted, and tobacco surveys for youth and adults were eliminated.

The American Lung Association in Iowa will continue to advocate to increase state tobacco control

funding. In the next session, we will also work to close the loophole in the Smokefree Air Act that allows smoking in casinos. The American Lung Association in Iowa staff and our partners will work closely throughout the year with state leadership to determine when the time might be right to consider increasing the tobacco tax.

Iowa State Facts	
Economic Costs Due to Smoking:	\$1,910,667,000
Adult Smoking Rate:	20.3%
High School Smoking Rate:	18.1%
Middle School Smoking Rate:	2.8%
Smoking Attributable Deaths:	4,442
Smoking Attributable Lung Cancer Deaths:	1,380
Smoking Attributable Respiratory Disease Deaths:	1,294

Adult smoking rate is taken from CDC’s 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2009 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Iowa
 2530 73rd Street
 Des Moines, IA 50322
 (515) 309-9507
www.lung.org/iowa

Kansas Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$1,000,000
FY2013 Federal Funding for State Tobacco Control Programs:	\$1,933,751*
FY2013 Total Funding for State Tobacco Control Programs:	\$2,933,751
CDC Best Practices State Spending Recommendation:	\$32,100,000
Percentage of CDC Recommended Level:	9.1%

*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
Casinos/Gaming Establishments:	Restricted (casino floors and tribal establishments exempt)
Bars:	Prohibited
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	KAN. STAT. ANN. §§ 21-4009 to 21-4014

Cigarette Tax: **D**

Tax Rate per pack of 20:	\$0.79
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Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **All health plans cover NRT Patch, Bupropion (Zyban) and Varenicline (Chantix); coverage of NRT Gum and NRT Lozenge vary by health plan**

Counseling: **Individual and group counseling covered for pregnant women only**

Barriers to Coverage: **Some health plans have limits on duration; all plans limit treatment to once per year**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, Varenicline (Chantix) and Bupropion (Zyban)**

Counseling: **Covers phone and online counseling**

Barriers to Coverage: **Co-payments required, dollar limits on benefits and duration limit for NRT medications**

STATE QUITLINE:

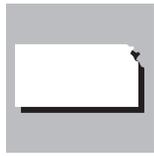
Investment per Smoker: **\$0.82; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Kansas Tobacco Cessation Coverage page](#) for specific sources.

Kansas State Highlights:



The 2012 Kansas Legislative Session was tense with uncertainty and dominated by budget talks and gridlock over the redrawing of legislative districts. There were a variety of bills, some successful and a few close calls on tobacco control issues the American Lung Association in Kansas cared most about.

The Kansas Legislature did successfully pass a bill prohibiting sales of electronic cigarettes to minors. Legislation was introduced which would have strengthened Kansas' smokefree workplace law by removing the exemption for casino floors, but it did not move forward. The Kansas Supreme Court upheld the opening date of January 1, 2009 for Class A/B clubs in the smokefree workplace law. Opponents wanted to change the date so any club could be exempt. A bill to increase tobacco taxes and update tobacco tax language in state law was introduced. A hearing for that bill was held, but no additional action taken.

Kansas' smokefree workplace law was challenged by a bill that would allow smoking again in any business that catered to and hired only adults over 21. While the bill was supported by one group of bars, the unintended effect was that it would include any businesses, not just restaurants and bars. This bill was passed favorably out of committee, but referred back to another committee for consideration where it remained until the end of the legislative session.

The tobacco industry, R.J. Reynolds in particular, attempted to coerce the state of Kansas to conduct and pay for a study of smokeless tobacco products to determine if they produce less harm to users and could be used as strategies to reduce the illnesses and death caused by smoking. Unfortunately, many of the committee members bought into the rhetoric provided by the "experts" brought in by the tobacco lobbyist and passed the bill out of committee. However, no action was taken on the floor and it died at the end of the session.

Kansas also narrowly escaped an effort to reduce the already minimal amount of funding for tobacco prevention and cessation. The House Appropriations Committee passed a fiscal year 2013 budget containing about \$300,000 which was a reduction of almost \$700,000 or 70 percent from fiscal year 2012. This was despite an increase in Master Settlement Agreement funding to the state this year. Luckily, during

end-of-year budget talks, these cuts were restored, so the amount of funding for tobacco prevention programs was restored to the original \$1 million.

During the 2013 Kansas Legislative session, the American Lung Association in Kansas will continue to work with health partners to defend the statewide smokefree law. We will also advocate for essential tobacco prevention funding and comprehensive cessation coverage for those trying to quit using tobacco products.

Kansas State Facts

Economic Costs Due to Smoking:	\$1,700,505,000
Adult Smoking Rate:	21.9%
High School Smoking Rate:	14.4%
Middle School Smoking Rate:	4.3%
Smoking Attributable Deaths:	3,883
Smoking Attributable Lung Cancer Deaths:	1,202
Smoking Attributable Respiratory Disease Deaths:	1,148

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2009 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Kansas

6701 W. 64th Street, Suite 110

Overland Park, KS 66202

(913) 912-7190

www.lung.org/kansas

Kentucky Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$2,134,200
FY2013 Federal Funding for State Tobacco Control Programs:	\$1,896,628*
FY2013 Total Funding for State Tobacco Control Programs:	\$4,030,828
CDC Best Practices State Spending Recommendation:	\$57,200,000
Percentage of CDC Recommended Level:	7.0%

*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: **No provision**
- Restaurants: **No provision**
- Casinos/Gaming Establishments: **No provision**
- Bars: **No provision**
- Retail Stores: **No provision**
- Recreational/Cultural Facilities: **No provision**
- Penalties: **Yes**
- Enforcement: **No**
- Preemption: **No**

Citation: KY REV. STAT. ANN. §§ 61.165, 61.167, 438.050 & EXEC. ORDER 2006-0807

 Thumbs down for Kentucky for failing to pass a law in the 2012 legislative session that would have protected all workers in Kentucky from secondhand smoke.

Note: The Smokefree Air grade only examines state tobacco control law and does not reflect local smokefree ordinances. Kentucky has made great strides at protecting people from secondhand smoke by passing strong local smokefree ordinances.

Cigarette Tax: **F**

Tax Rate per pack of 20: \$0.60

Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **All health plans cover NRT Patch; coverage for other cessation medications* vary by health plan**

Counseling: **Coverage of individual and group counseling varies by health plan**

Barriers to Coverage: **Limits on duration, annual limits, prior authorization requirements and co-payments vary by health plan**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers NRT Gum, NRT Patch, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban)**

Counseling: **Covers group and phone counseling**

Barriers to Coverage: **Limits on duration, annual limits on quit attempts, prior authorization required for some medications, co-payments required and must receive counseling to get certain medications**

STATE QUITLINE:

Investment per Smoker: **\$0.50; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Kentucky Tobacco Cessation Coverage page](#) for specific sources.

*These medications include: NRT Gum, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban)

Kentucky State Highlights:



In recent years the American Lung Association in Kentucky has been focused on making all public places and workplaces in the state of Kentucky smokefree while also supporting the passage of local smokefree workplace laws. Since January 2012, three strong local smokefree ordinances were passed in Manchester, Somerset, and Franklin County. Comprehensive local laws prohibiting smoking in almost all public places and workplaces, including restaurants and bars, protect about 34 percent of Kentucky's population from exposure to secondhand smoke.

In the 2012 legislative session, State Rep. Susan Westrom championed a comprehensive, statewide smokefree law, which will prohibit smoking in virtually all indoor workplaces and public places, including bars and restaurants. Local communities would also continue to be able to pass stronger laws going forward. The legislation passed out of the House Health and Welfare Committee, a major victory in itself, but the legislative session ended before the bill could pass both houses.

Nearly 60 percent of Kentuckians supported protecting workers and patrons from secondhand smoke in public places and workplaces, according to a 2010 public opinion poll conducted by Public Opinion Strategies, a national Republican-aligned polling firm.

With Representative Westrom returning to the legislature in 2013, she will again be introducing comprehensive smokefree legislation at the state level. Public health advocates and grassroots supporters are lining up to support the Smokefree Kentucky Act and the American Lung Association in Kentucky hopes the bill will make it much further through the legislative process in the 2013 session. Thousands of grassroots advocates and hundreds of businesses have endorsed the effort. Passing a smokefree law in Kentucky would help reduce Kentucky's highest smoking rate in the country for adults (28.8%) and high youth smoking rate of 24.1 percent as well. Additionally, a statewide smokefree law would protect Kentuckians from the needless death and disease caused by secondhand smoke exposure at work.

Kentucky State Facts

Economic Costs Due to Smoking:	\$3,767,220,000
Adult Smoking Rate:	28.8%
High School Smoking Rate:	24.1%
Middle School Smoking Rate:	9.0%
Smoking Attributable Deaths:	7,848
Smoking Attributable Lung Cancer Deaths:	2,760
Smoking Attributable Respiratory Disease Deaths:	2,003

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2010 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Kentucky

4100 Churchman Avenue
 Louisville, KY 40215
 (502) 363-2652
www.lung.org/kentucky

Louisiana Report Card

Tobacco Prevention and Control Program Funding:

F

FY2013 State Funding for Tobacco Control Programs:	\$7,170,101
FY2013 Federal Funding for State Tobacco Control Programs:	\$2,079,892*
FY2013 Total Funding for State Tobacco Control Programs:	\$9,249,993
CDC Best Practices State Spending Recommendation:	\$53,500,000
Percentage of CDC Recommended Level:	17.3%

*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
Casinos/Gaming Establishments:	Restricted (tribal establishments exempt)
Bars:	No provision
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	LA REV. STAT. ANN. §§ 40:1300.251 to 1300.263

Cigarette Tax:

F

Tax Rate per pack of 20: \$0.36



Thumbs down for Louisiana for having the third lowest cigarette tax in the country at 36 cents per pack.

Cessation Coverage:

F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, Varenicline (Chantix) and Bupropion (Zyban)**

Counseling: **Covers phone counseling**

Barriers to Coverage: **Minimal co-payments required, use of counseling required to get medications and other barriers that restrict access to medications**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers NRT Patch, NRT Gum, NRT Lozenge**

Counseling: **All health plans cover individual counseling; some plans cover phone counseling**

Barriers to Coverage: **Barriers to coverage vary by health plan***

STATE QUITLINE:

Investment per Smoker: **\$0.51; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Louisiana Tobacco Cessation Coverage page](#) for specific sources.



Thumbs up for Louisiana for adding coverage of tobacco cessation treatments for its state employees.

*Barriers to coverage could include: Limits on duration, annual or lifetime limits on quit attempts, requiring prior authorization, requiring co-payments, requiring using one or more cessation treatments before using others and/or requiring the use of counseling to receive medications.

Louisiana State Highlights:



The American Lung Association in Louisiana works with partners in the Coalition for a Tobacco Free Louisiana to advance policies proven to reduce tobacco use, including passing comprehensive smokefree laws at the local and state level, and increasing Louisiana's tobacco taxes. Unfortunately, Louisiana currently has the third lowest cigarette tax in the country.

During the 2012 legislative session, we saw a variety of tobacco-related bills filed by House and Senate members. A bill was introduced in both houses that would repeal the prohibition of smoking discrimination in the workplace. Other bills were filed that would prohibit outdoor smoking within 25 feet of certain exterior locations of state buildings and also a similar bill was introduced that would prohibit outdoor smoking within 25 feet of certain exterior locations of buildings and other enclosed areas in which smoking is prohibited currently. This bill would have re-opened Louisiana's current law prohibiting smoking in restaurants and most workplaces. A bill was also filed that would prohibit tobacco licensees from accepting food stamps as payment for tobacco products.

All these bills failed to pass during the legislative session. State funding for tobacco prevention and cessation programs in Louisiana comes mostly from tobacco tax revenues with a small amount from annual Master Settlement Agreement payments. The amount was lower this fiscal year (fiscal year 2013) at \$7.2 million than in fiscal year 2012 at \$9 million. However, both amounts are far below what the Centers for Disease Control and Prevention recommends should be spent on tobacco prevention and cessation programs in Louisiana.

In 2013, the American Lung Association in Louisiana alongside our other tobacco control partners, will push for an increase in the state's woefully low tobacco tax as well as strengthening state and local smokefree laws to include bar and casino worker protections from secondhand smoke.

Louisiana State Facts

Economic Costs Due to Smoking:	\$3,512,013,000
Adult Smoking Rate:	25.6%
High School Smoking Rate:	21.8%
Middle School Smoking Rate:	6.3%
Smoking Attributable Deaths:	6,499
Smoking Attributable Lung Cancer Deaths:	2,301
Smoking Attributable Respiratory Disease Deaths:	1,404

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2011 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Louisiana
 2325 Severn Avenue, Suite 8
 Metairie, LA 70001-6918
 (504) 828-5864
www.lung.org/louisiana

Maine Report Card

Tobacco Prevention and Control Program Funding: **D**

FY2013 State Funding for Tobacco Control Programs:	\$7,561,535
FY2013 Federal Funding for State Tobacco Control Programs:	\$1,762,552*
FY2013 Total Funding for State Tobacco Control Programs:	\$9,324,087
CDC Best Practices State Spending Recommendation:	\$18,500,000
Percentage of CDC Recommended Level:	50.4%



Thumbs down for Maine for cutting funding to its successful tobacco prevention and cessation program by over \$1.5 million from last year.

*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
Casinos/Gaming Establishments:	Restricted (tribal establishments exempt)
Bars:	Prohibited
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	ME REV. STAT. ANN. tit. 22, §§ 1541 to 1545, 1547, 1580-A & CODE of ME RULES 10-144, Ch. 249

Cigarette Tax: **C**

Tax Rate per pack of 20:	\$2.00
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Cessation Coverage: **D**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications* for pregnant women only**

Counseling: **Covers Individual counseling**

Barriers to Coverage: **Limits on duration, annual limits on quit attempts, lifetime limit on quit attempts using Varenicline (Chantix), prior authorization required for some medications, minimal co-payments required and use of some treatments before using others required**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers individual and group counseling**

Barriers to Coverage: **Lifetime limit on quit attempts for group counseling, co-payments required and dollar limit for benefits**

STATE QUITLINE:

Investment per Smoker: **\$11.56; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Maine Tobacco Cessation Coverage page](#) for specific sources.



Thumbs down for Maine for eliminating coverage of tobacco cessation medications for all Medicaid enrollees. Coverage is provided to pregnant women as required by federal law.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Maine State Highlights:



The American Lung Association in Maine fought to defend state tobacco prevention and cessation funding from an unprecedented rollback effort during the 2012 legislative session and supported the advancement of smokefree policies in the state. With our partners at the American Heart Association, the American Cancer Society, the Maine Medical Association and the Maine Public Health Association, our coalition was successful in ensuring that annual Master Settlement Agreement (MSA) funds will continue to be used for prevention efforts.

The 2012 legislative session began with the release of a legislative study report on the Allocations of the Fund for a Healthy Maine—Maine’s share of the MSA. The review was supportive of how the fund was being used and its focus on funding primary disease prevention and health promotion efforts. Unfortunately, almost as soon as this report was issued, the governor released a supplemental budget that eliminated the vast majority of these prevention efforts and used the MSA funds for the MaineCare (Medicaid) Program.

Much of the four month legislative session was dedicated to restoring funding for the network of 27 Healthy Maine Partnerships, which conduct population-based tobacco, obesity and chronic disease interventions. Ultimately, our coalition did convince a majority to forego any cuts in Fiscal Year 2012 and to restore a number of prevention efforts, including approximately two-thirds (\$5.0 million) of the funding for the partnerships in Fiscal Year 2013.

During the 2012 legislative session the legislature also approved the governor’s request to eliminate coverage of all tobacco cessation medications from the MaineCare Program (with the exception for pregnant women). Maine will now only cover 3 individual tobacco cessation counseling sessions per year for MaineCare enrollees.

In September 2011, implementation of Maine’s secondhand smoke policy disclosure law began. This new state law requires landlords to inform prospective multi-unit housing tenants whether or not smoking is allowed on the property. All Maine Public Housing Authorities have implemented 100 percent smokefree policies. In addition, the Maine State Housing Authority has adopted a rule that smokefree policies be a requirement for future projects funded with low-income tax credits.

The American Lung Association in Maine and our partner organizations are working to educate policy makers and to build support for a strong tobacco control agenda in 2013. Our goals include building support for a sizeable increase in the cigarette tax, equalizing the other tobacco products tax to the cigarette tax, increasing tobacco control funding to the CDC-recommended level and to restore, and improve, the MaineCare tobacco cessation benefit.

Maine State Facts

Economic Costs Due to Smoking:	\$1,084,231,000
Adult Smoking Rate:	22.6%
High School Smoking Rate:	15.2%
Middle School Smoking Rate:	7.2%
Smoking Attributable Deaths:	2,235
Smoking Attributable Lung Cancer Deaths:	744
Smoking Attributable Respiratory Disease Deaths:	660

Adult smoking rate is taken from CDC’s 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate (7th and 8th grade only) is taken from the 2009 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Maine

122 State Street
 Augusta, ME 04330
 (207) 622-6394
www.lung.org/maine

Maryland Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$4,150,000
FY2013 Federal Funding for State Tobacco Control Programs:	\$2,310,573*
FY2013 Total Funding for State Tobacco Control Programs:	\$6,460,573
CDC Best Practices State Spending Recommendation:	\$63,300,000
Percentage of CDC Recommended Level:	10.2%

*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
Casinos/Gaming Establishments:	Prohibited
Bars:	Prohibited
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	MD. CODE ANN., HEALTH-GEN. §§ 24-501 to 24-511 & MD. CODE ANN., LAB. & EMPLOY. §§ 5-101 & 5-608

Cigarette Tax: **C**

Tax Rate per pack of 20:	\$2.00
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Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **All health plans cover NRT Patch and Bupropion (Zyban); coverage of NRT Gum, NRT Nasal spray, NRT Inhaler, NRT Lozenge and Varenicline (Chantix) vary by health plan**

Counseling: **All health plans cover phone counseling; coverage for Individual and Group counseling varies by plan**

Barriers to Coverage: **Barriers to coverage vary by health plan***

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers Bupropion (Zyban) and Varenicline (Chantix)**

Counseling: **Covers individual and phone counseling**

Barriers to Coverage: **Co-payments required**

STATE QUITLINE:

Investment per Smoker: **\$0.65; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Yes**

Citation: See [Maryland Tobacco Cessation Coverage page](#) for specific sources.

*Barriers could include: Limits on duration, annual limits on quit attempts, requiring prior authorization, requiring co-payments, requiring using one or more cessation treatments before using others and/or requiring the use of counseling to receive medications.

Maryland State Highlights:



The American Lung Association in Maryland continues to remain a key player in the fight to decrease the toll of tobacco use and exposure within the state of Maryland. While Maryland has made significant advances in decreasing the youth smoking rate, the rate at which kids are using other tobacco products has been on the rise since 2000.

The 2012 General Assembly kicked off strong with support from community members and key members of the General Assembly to increase the tax on cigarettes and other tobacco products. This included the O'Malley-Brown Administration's proposal within the Budget Reconciliation and Financing Act to increase the tax on little cigars, smokeless tobacco, and premium cigars to 66 percent of the wholesale price of these products.

The Lung Association worked closely with supporters, including the American Cancer Society, American Heart Association, Campaign for Tobacco Free Kids, Maryland Healthcare for All and MedChi, to develop strategic grassroots advocacy and communications campaigns to grow support and awareness for the importance of this increase. The Lung Association and supporters spoke at the lieutenant governor's tobacco tax press event, testified at key hearings, organized awareness rallies at the State House and met with members of the General Assembly.

Through vast efforts from tobacco control supporters, the Senate and House of Delegates eventually came to an agreement and passed a measure to increase the tax within the budget. The process of reconciliation was tedious, however, and the fight continued for advocates as members of the General Assembly were not able to come to an agreement on the overall budget, requiring a special legislative session to be convened for further review and final passage.

In anticipation, tobacco control advocates continued to contact key members of the General Assembly urging them to pass the tobacco tax increase as outlined by the Senate and House of Delegates. In a final victory, the Budget Reconciliation and Financing Act was passed requiring a tax increase on little cigars from 15 to 70 percent of the wholesale price, and an increase on smokeless tobacco, such as chewing tobacco and snuff, from 15 to 30 percent of the wholesale price. An initial report from the University

of Maryland law school released in October 2012 shows the price of little cigars and smokeless tobacco has increased substantially.

The 2012 General Assembly made it more apparent than ever that there is abundant support for stronger tobacco control measures within Maryland. The American Lung Association in Maryland will continue to work with public health leaders and advocates to further increase the tax on cigarettes and premium cigars, protect the current smokefree law, and advocate for increased funding for tobacco prevention and control programs.

Maryland State Facts	
Economic Costs Due to Smoking:	\$3,658,579,000
Adult Smoking Rate:	19.0%
High School Smoking Rate:	12.5%
Middle School Smoking Rate:	3.5%
Smoking Attributable Deaths:	6,861
Smoking Attributable Lung Cancer Deaths:	2,339
Smoking Attributable Respiratory Disease Deaths:	1,632

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2008 Maryland 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Maryland
 211 East Lombard Street, #260
 Baltimore, MD 21202
 (443) 451-4950
www.lung.org/maryland

Massachusetts Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$4,151,958
FY2013 Federal Funding for State Tobacco Control Programs:	\$2,591,344*
FY2013 Total Funding for State Tobacco Control Programs:	\$6,743,302
CDC Best Practices State Spending Recommendation:	\$90,000,000
Percentage of CDC Recommended Level:	7.5%

*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
Casinos/Gaming Establishments:	Prohibited
Bars:	Prohibited (allowed in smoking bars)
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	MASS. GEN. LAWS ch. 270, § 22

Cigarette Tax: **B**

Tax Rate per pack of 20: \$2.51

Cessation Coverage: **D**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers individual, phone and group counseling**

Barriers to Coverage: **Prior authorization required for some medications and minimal co-payments required**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All health plans cover Varenicline (Chantix); coverage of NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge and Bupropion (Zyban) varies by health plan**

Counseling: **Coverage of individual, group and phone counseling varies by health plan**

Barriers to Coverage: **Barriers to coverage vary by health plan****

STATE QUITLINE:

Investment per Smoker: **\$1.84; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Massachusetts Tobacco Cessation Coverage page](#) for specific sources.



Thumbs up for Massachusetts for providing comprehensive coverage of all tobacco cessation medications and types of counseling to Medicaid enrollees.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

**Barriers could include: Limits on duration, annual limits on quit attempts, requiring prior authorization, requiring co-payments, requiring using one or more cessation treatments before using others and/or requiring the use of counseling to receive medications.

Massachusetts State Highlights:



The American Lung Association in Massachusetts, along with our partners in the Tobacco Free Mass coalition, continued fighting to reduce the burden of tobacco use in Massachusetts. Our 2012 priorities included: closing a tax loophole that taxes some tobacco products at a lower rate than cigarettes, increasing funding for the Massachusetts Department of Public Health’s Tobacco Cessation and Prevention Program, defending our smokefree workplace law, and increasing access to tobacco treatments.

With strong support from Governor Patrick, we fought to include many of our priorities in Massachusetts’ Fiscal Year 2013 budget. While the Tobacco Cessation and Prevention Program did not receive a funding increase, we ensured that they maintained a level budget of \$4.2 million while other state services and programs continued to be cut. The Massachusetts Legislature maintained a general anti-tax sentiment and despite having strong support from House and Senate champions, we were unable to close the tax loophole on flavored, kid-friendly tobacco products like chewing tobacco and new dissolvable tobacco tablets.

Throughout the year, the legislature also debated the next phase in our state’s health reform efforts meant to address increasing health care costs. The Lung Association joined with many voices from the public health community to advocate for the establishment of a Prevention and Wellness Trust Fund. This Trust was included in the final bill, signed into law by Governor Patrick in August 2012, with funding of \$60 million over four years, which will fund prevention and chronic disease management interventions, including tobacco control, across the state.

The Lung Association had other non-legislative advocacy successes, including the expansion of the nationally acclaimed MassHealth (Medicaid) cessation benefit to all state-subsidized Commonwealth Care insurance plans. Also in 2012, the number of municipalities that prohibit the sale of tobacco products in pharmacies has grown rapidly, now covering one third of our state’s population.

Lastly, we had victories in protecting past tobacco control successes. Tobacco Free Mass was vocal during the debate that legalized the construction of three resort-style casinos in Massachusetts. Due to our efforts, all of these casinos will be 100 percent

smokefree, despite efforts to carve out an exemption for these facilities from our 2004 smokefree workplace law. The Lung Association also stopped efforts to eliminate the state’s minimum pricing law, which prevents retailers from dropping tobacco prices below a set level.

In the coming year, the American Lung Association in Massachusetts and Tobacco Free Mass will push again for an increase in the state tobacco tax, closing the tax loophole and dedicating funds to the state’s tobacco control program. We will also track the implementation of both the Prevention and Wellness Trust Fund and the Commonwealth Care cessation benefits to ensure their success.

Massachusetts State Facts	
Economic Costs Due to Smoking:	\$4,998,943,000
Adult Smoking Rate:	18.1%
High School Smoking Rate:	14.0%
Middle School Smoking Rate:	4.2%
Smoking Attributable Deaths:	9,017
Smoking Attributable Lung Cancer Deaths:	2,966
Smoking Attributable Respiratory Disease Deaths:	2,442

Adult smoking rate is taken from CDC’s 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2009 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Massachusetts

460 Totten Pond Road, Suite 400
Waltham, MA 02451
(781) 890-4262
www.lung.org/massachusetts

Michigan Report Card

Tobacco Prevention and Control Program Funding:

F

FY2013 State Funding for Tobacco Control Programs:	\$1,833,935
FY2013 Federal Funding for State Tobacco Control Programs:	\$3,372,944*
FY2013 Total Funding for State Tobacco Control Programs:	\$5,206,879
CDC Best Practices State Spending Recommendation:	\$121,200,000
Percentage of CDC Recommended Level:	4.3%

*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
Casinos/Gaming Establishments:	Restricted (tribal establishments exempt)
Bars:	Prohibited (allowed in cigar bars)
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	Yes (restaurants and bars only)*

Citation: MICH. COMP. LAWS §§ 333.12601 to 333.12615 & 333.12905

*If preemption were repealed, Michigan's grade would be an "A."

Cigarette Tax:

C

Tax Rate per pack of 20: \$2.00

Cessation Coverage:

F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **All health plans cover NRT Patch, NRT Gum, Varenicline (Chantix) and Bupropion (Zyban); coverage of NRT Nasal spray, NRT Inhaler and NRT Lozenge vary by health plan**

Counseling: **All health plans cover individual and phone counseling; coverage for group counseling varies by health plan**

Barriers to Coverage: **Barriers to coverage vary by health plan***

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Coverage of all 7 recommended cessation medications** varies by health plan**

Counseling: **Coverage of individual, group and phone counseling varies by health plan**

Barriers to Coverage: **Barriers to coverage vary by health plan***

STATE QUITLINE:

Investment per Smoker: **\$0.73; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Michigan Tobacco Cessation Coverage page](#) for specific sources.

*Barriers could include: Limits on duration, annual limits on quit attempts, requiring prior authorization, requiring co-payments, requiring using one or more cessation treatments before using others and/or requiring the use of counseling to receive medications.

**The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Michigan State Highlights:



The American Lung Association in Michigan continued to defend Michigan's smokefree workplace law, and push for increased funding for tobacco prevention and cessation

programs to help protect the lung health of all Michigan citizens.

Some legislators again attempted to weaken the Dr. Ron Davis Smoke-Free Air Law. A bill was introduced to carve out an exemption in the law for certain fundraisers involving tobacco products. The Lung Association and partners advocated to keep the law strong and protect everyone's right to breathe clean indoor air, and those efforts were successful. The law remained strong and our coalition will remain vigilant to protect the law from further attacks.

The University of Michigan-Institute for Social Research in coordination with the Michigan Department of Community Health released a study that found no significant negative effect of the Dr. Ron Davis Smoke-Free Air Law on overall bar and restaurant sales and monthly Keno sales. The analysis looked at sales tax collections from Michigan retail eating and drinking establishments as well as from Club Keno sales.

In 2012, the University of Michigan partnered with the U.S. Department of Health and Human Services to launch the Tobacco-Free College Campus Initiative. The Initiative will promote and support the adoption and implementation of tobacco-free policies at universities, colleges, and other institutions of higher learning across the United States. The University of Michigan implemented a smokefree campus policy in July 2011, and was the first school in the Big Ten conference to do so.

In other positive news for Michigan, the Michigan Tobacco Quit Line was able for a limited period of time to offer free nicotine replacement products for people who want to quit smoking or chewing tobacco. The program provided up to an eight-week supply of nicotine patches, gum or lozenges to qualified tobacco users regardless of income or insurance status.

However, legislators unwisely kept funding for tobacco prevention and cessation programs at less than two percent of what the Centers for Disease Control and Prevention recommends they should spend to help reduce current smoking rates and prevent Michigan's children from becoming a new generation

of smokers. Legislators also signed into law a 50-cent cap for the tax on cigars. Capping this tax will lead to increased use of cigars at a time when use of these products is already increasing.

As we look to 2013, the American Lung Association in Michigan will continue to advocate for strategies to increase the price of tobacco products, tobacco cessation treatment coverage, full funding of scientifically-based tobacco prevention and cessation programming, and a strong smokefree public places law to protect our children, save lives and lower healthcare costs.

Michigan State Facts

Economic Costs Due to Smoking:	\$7,259,672,000
Adult Smoking Rate:	23.2%
High School Smoking Rate:	14.0%
Middle School Smoking Rate:	N/A
Smoking Attributable Deaths:	14,522
Smoking Attributable Lung Cancer Deaths:	4,572
Smoking Attributable Respiratory Disease Deaths:	3,633

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. A current middle school smoking rate is not available for the 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Michigan

25900 Greenfield Road, Suite 610

Oak Park, MI 48237

(248) 784-2000

www.lung.org/michigan

Minnesota Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$19,600,000
FY2013 Federal Funding for State Tobacco Control Programs:	\$1,807,799*
FY2013 Total Funding for State Tobacco Control Programs:	\$21,407,799
CDC Best Practices State Spending Recommendation:	\$58,400,000
Percentage of CDC Recommended Level:	36.7%

*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
Casinos/Gaming Establishments:	Prohibited (tribal establishments exempt)
Bars:	Prohibited
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	MINN. STAT. §§ 144.411 to 144.417

Cigarette Tax: **C**

Tax Rate per pack of 20: \$1.60*

*Tax rate changes annually on January 1, increased by 1.4 cents this year.

Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers individual and group counseling**

Barriers to Coverage: **Minimal co-payments required**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers phone counseling**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts and use of counseling required to get medications**

STATE QUITLINE:

Investment per Smoker: **\$1.32; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Minnesota Tobacco Cessation Coverage page](#) for specific sources.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Chantix and Zyban.

Minnesota State Highlights:



The American Lung Association in Minnesota continues the fight to assure that “best practices” in tobacco control are implemented and strategically planned for, including raising cigarette/tobacco taxes, sustained tobacco control program funding, and limiting exposure to second-hand smoke. Minnesota, with a state cigarette tax of \$1.60 per pack, is currently in the middle among all state cigarette taxes, and the tax rate hasn’t been increased since 2005.

Joining with 31 leading health and nonprofit organizations in the Raise it for Health coalition, increasing the tobacco tax was once again the focus of our energies during the 2012 legislative session.

With Republicans in control of both the House of Representatives and Senate in Minnesota, the coalition worked to identify a Republican that would sponsor a bill to increase the tobacco tax, to spark dialogue and continue to keep the conversation around the benefit to all Minnesotans from strong tobacco control policies. A bill was introduced, which was considered a victory for the coalition. Although we were not successful, the education and debate helps to position a tobacco tax increase for a future session.

More than one hundred youth and volunteers represented the American Lung Association in Minnesota at the Day at the Capitol, educating legislators on the need for an increase in the tobacco tax, the continued efforts of the tobacco industry to market to youth, and the environmental impact of cigarette-butt litter to our lakes.

Along with the action around tobacco tax increase, a bill was introduced to protect children in foster care from secondhand smoke. Freedom to Breathe, Minnesota’s smokefree workplace law passed in 2007, did not cover foster care providers, often times who care for some of our most vulnerable youth. A bill was introduced late in the 2012 legislative session, and the Lung Association is once again going to work to support this effort in 2013.

The American Lung Association in Minnesota has led statewide efforts that have resulted in nearly 50 colleges and universities adopting tobacco-free campus policies, and worked with partners to pass smokefree policies in more than 70 public housing authorities across the state.

Raising prices on all tobacco products will encourage current smokers to quit and keep youth from starting to smoke. The American Lung Association in Minnesota will continue to work together as part of the Raise it for Health coalition to press for passage of an increase in tobacco taxes in 2013.

Minnesota State Facts

Economic Costs Due to Smoking:	\$3,207,071,000
Adult Smoking Rate:	19.0%
High School Smoking Rate:	19.2%
Middle School Smoking Rate:	1.6%
Smoking Attributable Deaths:	5,536
Smoking Attributable Lung Cancer Deaths:	1,805
Smoking Attributable Respiratory Disease Deaths:	1,531

Adult smoking rate is taken from CDC’s 2011 Behavioral Risk Factor Surveillance System. High school (12th grade only) and middle school (6th grade only) smoking rates are taken from the 2010 Minnesota Student 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Minnesota

490 Concordia Avenue
St. Paul, MN 55103-2441
(651) 227-8014
www.lung.org/minnesota

Mississippi Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$11,200,000
FY2013 Federal Funding for State Tobacco Control Programs:	\$2,271,455*
FY2013 Total Funding for State Tobacco Control Programs:	\$13,471,455
CDC Best Practices State Spending Recommendation:	\$39,200,000
Percentage of CDC Recommended Level:	34.4%

*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**
- Casinos/Gaming Establishments: **No provision**
- Bars: **No provision**
- Retail Stores: **No provision**
- Recreational/Cultural Facilities: **No provision**
- Penalties: **Yes**
- Enforcement: **Yes**
- Preemption: **No**

Citation: MISS. CODE ANN. §§ 29-5-161, 41-114-1, 97-32-29 & MS ADMIN CODE Tit. 15, Part III, Subpart 55 § 103.02.



Thumbs down for Mississippi for failing to pass a law in the 2012 legislative session that would have protected all workers in Mississippi from secondhand smoke.

Note: The Smokefree Air grade only examines state tobacco control law and does not reflect local smokefree ordinances. Mississippi has made great strides at protecting people from secondhand smoke by passing strong local smokefree ordinances.

Cigarette Tax: **F**

Tax Rate per pack of 20: \$0.68

Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers group and individual counseling for pregnant women only**

Barriers to Coverage: **Minimal co-payments required**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers all 7 recommended cessation medications***

Counseling: **No coverage**

Barriers to Coverage: **Duration limits on medications**

STATE QUITLINE:

Investment per Smoker: **\$2.22; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Mississippi Tobacco Cessation Coverage page](#) for specific sources.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Mississippi State Highlights:



For more than 15 years, the American Lung Association in Mississippi has been a key partner and leader in health organizations and coalitions advocating for tobacco control in the state of Mississippi. Joining forces with grassroots organizations has strengthened the Lung Association's tobacco education, prevention, cessation, and advocacy efforts statewide.

The shift in the political landscape after the November 2011 elections presented barriers that proved insurmountable for several tobacco control efforts in the 2012 Legislature. Approximately 60 new policy makers were sworn into office and needed to be educated on a host of issues. The session's term consisted of four months, and committee appointments and chairmanship announcements were not made until the end of January 2012. Because of this several essential public health policy initiatives were not given attention by the new chairmen of the Public Health and Welfare Committees in the House and Senate. Neither had served on that committee prior to their appointment as Chairman and were reluctant to advance what they deemed "controversial legislation."

During the 2012 session, there were four different smokefree bills introduced. Throughout the session, there were several activities at the state Capitol that the Smokefree Mississippi coalition either led or participated in. One in particular was the release of a statewide public opinion poll showing 68 percent of voters in Mississippi are in favor of a law that would prohibit smoking in virtually all indoor public places and workplaces, including casinos, restaurants and bars.

Support for the smokefree law crossed party lines, with 68 percent of Republicans in favor, as well as 70 percent of Independents and 68 percent of Democrats. Seventy-five percent of Mississippi voters believe that the rights of employees and customers to breathe clean air in casinos, restaurants and bars is more important than the rights of smokers to smoke and owners to allow smoking inside. Unfortunately, legislators turned a deaf ear to the views of their constituents and others across the state as comprehensive smokefree legislation wasn't even brought up for discussion in committee, therefore dying on the first committee deadline.

Mississippi cities continued to make progress adopting smokefree ordinances. As of November 2012, Mississippi has 76 smokefree ordinances; 65 of which are 100 percent comprehensive. However, this still only fully protects less than 25 percent of Mississippi's population from secondhand smoke. We acknowledge the beginning of a smokefree casinos movement in Mississippi with The Palace Casino opening mostly smokefree in June 2011. However, they do have one smoking room with a separate ventilation system attached to the gaming floor.

During the 2013 legislative session, the American Lung Association in Mississippi will continue to work with Smokefree Mississippi partners to support passage of comprehensive statewide smokefree legislation. We will also advocate for essential tobacco prevention funding and comprehensive cessation coverage for those trying to quit using tobacco products.

Mississippi State Facts

Economic Costs Due to Smoking:	\$2,345,142,000
Adult Smoking Rate:	25.9%
High School Smoking Rate:	17.9%
Middle School Smoking Rate:	5.7%
Smoking Attributable Deaths:	4,761
Smoking Attributable Lung Cancer Deaths:	1,564
Smoking Attributable Respiratory Disease Deaths:	1,127

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2010 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Mississippi
P.O. Box 2178
Ridgeland, MS 39158
(601) 206-5810
www.lung.org/mississippi

Missouri Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$61,785
FY2013 Federal Funding for State Tobacco Control Programs:	\$2,275,032*
FY2013 Total Funding for State Tobacco Control Programs:	\$2,336,817
CDC Best Practices State Spending Recommendation:	\$73,200,000
Percentage of CDC Recommended Level:	3.2%

*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:	Restricted
Schools:	Prohibited (public schools only)
Child Care Facilities:	Prohibited
Restaurants:	Restricted
Casinos/Gaming Establishments:	No provision
Bars:	No provision
Retail Stores:	Restricted
Recreational/Cultural Facilities:	Restricted
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	MO. REV. STAT. §§ 191.765 to 191.777

Note: The Smokefree Air grade only examines state tobacco control law and does not reflect local smokefree ordinances. Missouri has made great strides at protecting people from secondhand smoke by passing strong local smokefree ordinances.

Cigarette Tax: **F**

Tax Rate per pack of 20:	\$0.17
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Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers individual counseling**

Barriers to Coverage: **Limits on duration, lifetime limit on quit attempts and prior authorization required**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers NRT Gum, NRT Patch, NRT Lozenge, Bupropion (Zyban) and Varenicline (Chantix)**

Counseling: **Covers individual and phone counseling**

Barriers to Coverage: **Limits on duration**

STATE QUITLINE:

Investment per Smoker: **\$0.62; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Missouri Tobacco Cessation Coverage page](#) for specific sources.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Missouri State Highlights:



The American Lung Association in Missouri continues to be a part of health organizations and coalitions advocating for tobacco control throughout the state of Missouri.

Joining forces with grassroots organizations at the state and local level has strengthened the Lung Association’s tobacco education, prevention, cessation, and advocacy efforts statewide.

Activity on passage and defense of local smokefree ordinances occurred throughout 2012. In April, voters passed a non-binding smokefree ordinance ballot in Hannibal that was then voted and passed by the city council in May. The smokefree ordinance in Springfield, originally passed by voters in April 2011, was voted on again in June 2012, due to a repeal initiative lead by an opposition group. This repeal effort was defeated by an overwhelming margin, although the Springfield city council did vote to amend the current law to exclude private clubs, tobacco retail shops and cigar bars. The exemption for private clubs will expire after two years and only existing tobacco retail shops received an exemption. Despite separate efforts by opponents of a comprehensive smokefree law and the St. Charles City Council, no initiative to limit or prohibit smoking in public places will appear on the November 2012 ballot in St. Charles County.

A diverse group of individuals and health organizations worked to collect signatures to place a 73-cent cigarette tax increase on the November 2012 ballot. Unfortunately, this measure failed narrowly in November 2012 with 49.2 percent of voters in favor and 50.8 percent opposed. This was a sad loss for the health of all Missourians. Revenue from this cigarette tax increase (estimated at \$283 million per year) would have provided much needed funding for tobacco education and cessation efforts across the state. Lung Association staff along with many other health advocates, worked to educate voters about the public health benefits of increasing tobacco taxes. While the results of the initiative did not turn out as the Lung Association hoped, there was increased education and awareness about how an increased tobacco tax can protect public health.

A bill to prevent local communities from including electronic cigarettes in any local smokefree laws was introduced in the House of Representatives this year. However, the discussion quickly shifted toward preventing communities from passing stronger local

smokefree laws at all. This bill began to gain ground, but was ultimately not voted out of committee thanks to pressure from Lung Association advocates and our partner organizations. However, we can expect a similar effort to occur again in 2013, so we must remain vigilant and remember to make our voices heard.

During the 2013 legislative session, the American Lung Association in Missouri will continue to focus on lung health and work with partners to ensure successful passage of a comprehensive statewide smokefree law. We will also advocate for essential tobacco prevention funding and comprehensive cessation coverage for those trying to quit using tobacco products.

Missouri State Facts	
Economic Costs Due to Smoking:	\$4,755,871,000
Adult Smoking Rate:	24.9%
High School Smoking Rate:	18.1%
Middle School Smoking Rate:	5.4%
Smoking Attributable Deaths:	9,584
Smoking Attributable Lung Cancer Deaths:	3,121
Smoking Attributable Respiratory Disease Deaths:	2,454

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school and middle school smoking rates are taken from the 2011 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Missouri
 1118 Hampton Avenue
 St. Louis, MO 63139-3196
 (314) 645-5505
www.lung.org/missouri

Montana Report Card

Tobacco Prevention and Control Program Funding:

F

FY2013 State Funding for Tobacco Control Programs: \$4,600,000

FY2013 Federal Funding for State Tobacco Control Programs: \$1,075,049*

FY2013 Total Funding for State Tobacco Control Programs: \$5,675,049

CDC Best Practices State Spending Recommendation: \$13,900,000

Percentage of CDC Recommended Level: 40.8%



Thumbs down for Montana for cutting state funding for its tobacco control program by over 40 percent from the previous two-year state budget.

*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**

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

Bars: **Prohibited**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: MONT. CODE ANN. §§ 50-40-101 et seq.

Cigarette Tax:

C

Tax Rate per pack of 20: \$1.70

Cessation Coverage:

D

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers individual and phone counseling**

Barriers to Coverage: **Limits on duration, prior authorization required for some medications, co-payments required and must use certain cessation treatments before being able to use others**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers NRT Patch, NRT Gum, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban)**

Counseling: **Covers individual and phone counseling**

Barriers to Coverage: **Limits on duration, annual and lifetime limits on quit attempts, prior authorization, co-payments and use of counseling to receive medications required and dollar limit on benefits**

STATE QUITLINE:

Investment per Smoker: **\$4.23; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Montana Tobacco Cessation Coverage page](#) for specific sources.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Montana State Highlights:



The American Lung Association in Montana works with local and statewide tobacco coalitions to ensure significant change in tobacco prevention and cessation. The Lung Association and its public health partners have secured passage of strong public policies that strengthen tobacco control efforts within the state and help reduce tobacco use.

Montana's legislature only meets once every two years and was not in session during 2012. During the 2011 session, the state tobacco control program faced complete elimination through legislation that would have redirected those funds to the state general overturning Statutory Initiative 146 approved by voters in 2002. Thankfully, this legislation was vetoed by the governor; however, in the two-year state budget that was ultimately approved, state funding was cut to about \$4.6 million each year. The tobacco control program had been funded at about \$8.4 million per year in previous budgets.

Montana's tobacco prevention and cessation program, combined with other public policies to reduce tobacco use, has helped to reduce smoking rates among high school students to a record low of 16.5 percent in 2011 from 28.5 percent in 2001, according to the Centers for Disease Control and Prevention's Youth Risk Behavior Survey. This survey was conducted prior to the cuts to the tobacco control program in the latest two-year budget though, so it remains to be seen if those cuts stall or even reverse the progress Montana has been making.

The American Lung Association in Montana will continue efforts in 2013 to strengthen tobacco control policies to help prevent Montana's youth from ever starting to use tobacco and to help current tobacco users quit. The Lung Association will fight all attempts to weaken Montana's comprehensive clean indoor air law and will look to restore funding for the vital state tobacco prevention and cessation program in the next two-year state budget.

Montana State Facts

Economic Costs Due to Smoking:	\$602,630,000
Adult Smoking Rate:	22.0%
High School Smoking Rate:	16.5%
Middle School Smoking Rate:	8.0%
Smoking Attributable Deaths:	1,418
Smoking Attributable Lung Cancer Deaths:	425
Smoking Attributable Respiratory Disease Deaths:	477

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate (8th grade only) is taken from the 2010 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Montana

3919 Heritage Way
Missoula, MT 59802
(406) 728-0368
www.lung.org/montana

Nebraska Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$2,379,000
FY2013 Federal Funding for State Tobacco Control Programs:	\$1,324,265*
FY2013 Total Funding for State Tobacco Control Programs:	\$3,703,265
CDC Best Practices State Spending Recommendation:	\$21,500,000
Percentage of CDC Recommended Level:	17.2%

*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
Casinos/Gaming Establishments:	Prohibited
Bars:	Prohibited (allowed in cigar bars)
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	Limited
Citation:	NEB. REV. STAT. §§ 71-5716 to 71-5734

Cigarette Tax: **F**

Tax Rate per pack of 20: \$0.64

Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, Varenicline (Chantix) and Bupropion (Zyban)**

Counseling: **Covers individual counseling**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, prior authorization required for medications, minimal co-payments and use of counseling required to get medications**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers phone counseling**

Barriers to Coverage: **Limits on duration, annual and lifetime limits on quit attempts, prior authorization and use of counseling to get medications are required**

STATE QUITLINE:

Investment per Smoker: **\$1.35; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Nebraska Tobacco Cessation Coverage page](#) for specific sources.



Thumbs up for Nebraska for expanding and making consistent the tobacco cessation treatments available to state employees.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Nebraska State Highlights:



For more than 15 years, the American Lung Association in Nebraska and other health partners have successfully advocated for dozens of important pieces of tobacco control legislation.

During the 2012 Unicameral session, the Lung Association continued to work on educating legislators about the benefits of a substantial tobacco tax increase.

A bill that was introduced in 2011 to raise the tax on cigarettes from 64 cents per pack to \$1.99 per pack carried over to the 2012 legislative session. A commensurate increase on other forms of tobacco (except for snuff) was included in the legislation as well, and a portion of the predicted \$72.9 million increase in revenue would be dedicated to comprehensive tobacco control programs.

However, the bill did not move past the committee level, and died when the legislative session ended. Supporters still believe that the additional revenue produced by a substantial tobacco tax increase would resonate most with state senators. On the local level, in October 2012, the Omaha city council did approve a temporary 3 percent tax on tobacco sales in the city with most of the revenue going to build a new campus on the University of Nebraska Medical Center that would combine cancer research and treatment.

Funding from the Master Settlement Agreement (MSA) for comprehensive tobacco control programs remained at \$2.3 million in fiscal year 2013, the same level as fiscal year 2012. This is down slightly from previous years, but the reduction was considered mild compared to the possibility of all MSA funding being diverted to other programs.

There was no visible organized effort to weaken or overturn the Nebraska Clean Indoor Air Act, which prohibits smoking in virtually all public places and workplaces statewide. The strengthened act became effective June 1, 2009. To date, compliance with the law has been exceptional.

The American Lung Association in Nebraska and coalition partners will continue to press for passage of a substantial cigarette tax increase in the 2013 legislative session to prevent kids from starting to smoke and to motivate smokers to quit. We will also continue our work defending our state law that protects all Nebraskans from the dangers of secondhand smoke.

Nebraska State Facts

Economic Costs Due to Smoking:	\$1,091,897,000
Adult Smoking Rate:	19.9%
High School Smoking Rate:	15.0%
Middle School Smoking Rate:	N/A
Smoking Attributable Deaths:	2,274
Smoking Attributable Lung Cancer Deaths:	700
Smoking Attributable Respiratory Disease Deaths:	696

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. A current middle school smoking rate is not available for the 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Nebraska

8990 W. Dodge Road, Suite 226
 Omaha, NE 68114
 (402) 502-4950
www.lung.org/nebraska

Nevada Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$150,000
FY2013 Federal Funding for State Tobacco Control Programs:	\$1,075,049*
FY2013 Total Funding for State Tobacco Control Programs:	\$1,225,049
CDC Best Practices State Spending Recommendation:	\$32,500,000
Percentage of CDC Recommended Level:	3.8%



Thumbs down for Nevada for providing little state money for tobacco prevention and cessation despite smoking costing the state \$1.6 billion in economic costs every year.

*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
Casinos/Gaming Establishments:	Restricted (tribal establishments exempt)*
Bars:	Restricted (smoking allowed in bars or parts of bars if age-restricted)
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	NEV. REV. STAT. § 202.2483

*Smoking is allowed on casinos floors, but prohibited anywhere children are allowed to be.

Cigarette Tax: **D**

Tax Rate per pack of 20: \$0.80

Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Coverage of individual and group counseling provided only under certain conditions**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, prior authorization required for medications and minimal co-payments required**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All health plans cover NRT Patch, NRT Gum, NRT Lozenge, Bupropion (Zyban) and Varenicline (Chantix); coverage of NRT Nasal spray and NRT Inhaler vary by health plan**

Counseling: **Coverage of individual, group and phone counseling varies by health plan**

Barriers to Coverage: **Barriers to coverage vary by health plan****

STATE QUITLINE:

Investment per Smoker: **\$1.00; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

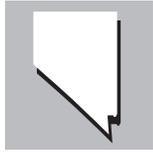
Private Insurance Mandate: **No provision**

Citation: See [Nevada Tobacco Cessation Coverage page](#) for specific sources.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

**Barriers could include: Limits on duration, annual or lifetime limits on quit attempts, requiring prior authorization, requiring co-payments, requiring using one or more cessation treatments before using others and/or requiring the use of counseling to receive medications.

Nevada State Highlights:



The American Lung Association in Nevada has been hard at work on local tobacco control initiatives since the state legislature only meets every other year and was not in session in 2012. Educational outreach on the harmful effects of secondhand smoke was conducted in southern Nevada in Boulder City, Henderson and Mesquite.

The Lung Association hired a team of community educators in all three cities to inform these communities about the harmful effects of secondhand smoke and the benefits of smokefree environments. This included giving presentations to over 22 community groups and attending over 33 community events in the cities, and building coalitions of concerned citizens that cared about the risks of secondhand smoke exposure to workers.

In Northern Nevada, the Lung Association has been focusing on increasing the number of smokefree environments through voluntary policy change. We have been successful in working with one of the largest homeowners associations in Reno to strengthen their policy concerning tobacco use in and around community areas of the association. This new policy took effect on January 1, 2012 after homeowners' association board approval. Additional homeowners associations are being looked at to follow suit.

Partnering with community leaders we have increased the number of smokefree parks in rural communities in Northern Nevada. Along with our statewide tobacco control partners, we held two advocacy forums with over 200 attendees. These forums focused on the legislative process, how to speak to a legislator, and effective ways to use social media.

Looking ahead to the 2013 legislative session, the American Lung Association in Nevada and partners are working on defending the Nevada Clean Indoor Air Act against any further roll back. The law has been weakened twice since it was approved by voters in 2006. The Lung Association believes that all Nevadans deserve protection from exposure to secondhand smoke. In addition, we will advocate for restoring some of the tobacco Master Settlement Agreement dollars to tobacco prevention and control programs.

Nevada State Facts

Economic Costs Due to Smoking:	\$1,611,851,000
Adult Smoking Rate:	22.8%
High School Smoking Rate:	13.6%
Middle School Smoking Rate:	7.1%
Smoking Attributable Deaths:	3,310
Smoking Attributable Lung Cancer Deaths:	1,017
Smoking Attributable Respiratory Disease Deaths:	975

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school and middle school smoking rates are taken from the 2011 Nevada Youth Risk Behavioral 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Nevada Las Vegas Office:

3552 W. Cheyenne Avenue, Suite 130
North Las Vegas NV 89032
(702) 431-6333
www.lung.org/nevada

Reno Office:

10615 Double "R" Blvd., Suite 100
Reno, NV 89521
(775) 829-5864
www.lung.org/nevada

New Hampshire Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$0
FY2013 Federal Funding for State Tobacco Control Programs:	\$1,333,586*
FY2013 Total Funding for State Tobacco Control Programs:	\$1,333,586
CDC Best Practices State Spending Recommendation:	\$19,200,000
Percentage of CDC Recommended Level:	6.9%



Thumbs down for New Hampshire for providing no state dollars for tobacco control programs despite smoking costing the state \$887 million in economic costs every year.

*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:	Restricted
Private Worksites:	Restricted
Schools:	Prohibited (public schools only)
Child Care Facilities:	Prohibited
Restaurants:	Prohibited
Casinos/Gaming Establishments:	Restricted
Bars:	Prohibited (allowed in cigar bars and allows for an economic hardship waiver)
Retail Stores:	Restricted
Recreational/Cultural Facilities:	Restricted
Penalties:	Yes
Enforcement:	Yes
Preemption:	Yes
Citation:	N.H. REV. STAT. ANN. §§ 155:64 to 155:78 & 178:20-a

Cigarette Tax: **C**

Tax Rate per pack of 20:	\$1.68
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Cessation Coverage: **C**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers individual counseling for all enrollees; Covers group counseling for pregnant women only**

Barriers to Coverage: **Minimal co-payments required**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers group counseling**

Barriers to Coverage: **Co-payments required**

STATE QUITLINE:

Investment per Smoker: **\$6.51; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [New Hampshire Tobacco Cessation Coverage page](#) for specific sources.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

New Hampshire State Highlights:



The American Lung Association in New Hampshire fought hard to maintain the progress made in previous years in tobacco prevention and control. With our partners, the American Cancer Society, the American Heart Association, BreatheNH and the New Hampshire Comprehensive Cancer Control Program's Tobacco Workgroup, the Lung Association continued to educate and inform the legislature of the health consequences and the economic costs of tobacco use to the state.

The Lung Association along with our tobacco advocacy partners monitored the impact of the 10 cent tobacco tax rollback that was enacted in July 2011 on a month-to-month basis. And just as a University of New Hampshire study conducted in 2011 predicted, the loss of revenue to the state of New Hampshire was consistent and significant. In late spring 2012, it was reported that revenue was \$17.5 million below the previous years. Emergency legislation to reverse the tobacco tax rollback was sponsored by State Sen. Sylvia Larson. Senator Larson's proposal asked that the rollback be reversed one year ahead of schedule in an effort to address the loss in tax revenue. The staff of the Lung Association, along with other New Hampshire tobacco advocates worked with Senator Larson on the legislation. Unfortunately, the legislation was not approved.

The last two legislative sessions and the legislation that resulted have served as a catalyst to establish a tobacco network for the state of New Hampshire. An assessment was conducted among tobacco advocacy groups and a planning process was completed during 2012. The American Lung Association in New Hampshire will serve as the 'home' and will facilitate the group moving forward. A proposed agenda for the 2013 legislative session was discussed with the members of the network and finalized. The top issues identified were increasing the tobacco tax, increasing funding for tobacco prevention and control and increasing tobacco cessation services.

The American Lung Association in New Hampshire will continue to work tirelessly with our partners to advocate for an increase in the tobacco tax, increased funding for tobacco prevention and control and to close loopholes in the indoor smoking act. A near doubling of smokeless tobacco use among high school students from 4.3 percent in 2003 to 8.4 percent in 2011 also shows the need for the tax on

tobacco products other than cigarettes to be equal to the cigarette tax.

New Hampshire State Facts	
Economic Costs Due to Smoking:	\$887,508,000
Adult Smoking Rate:	19.3%
High School Smoking Rate:	19.8%
Middle School Smoking Rate:	3.6%
Smoking Attributable Deaths:	1,764
Smoking Attributable Lung Cancer Deaths:	556
Smoking Attributable Respiratory Disease Deaths:	490

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2007 New Hampshire 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in New Hampshire

1800 Elm Street
 Manchester, NH 03104
 (603) 410-5108
www.lung.org/newhampshire

New Jersey Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$0
FY2013 Federal Funding for State Tobacco Control Programs:	\$2,601,594*
FY2013 Total Funding for State Tobacco Control Programs:	\$2,601,594
CDC Best Practices State Spending Recommendation:	\$119,800,000
Percentage of CDC Recommended Level:	2.2%



Thumbs down for New Jersey for providing no state funding for tobacco prevention and cessation programs despite smoking costing the state \$5.6 billion in economic costs each year.

*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
Casinos/Gaming Establishments:	Restricted*
Bars:	Prohibited (allowed in cigar bars/lounges)
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	N.J. STAT. ANN. §§ 26:3D-55 to 26:3D-64

*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.

Cigarette Tax: **B**

Tax Rate per pack of 20: \$2.70

Cessation Coverage: **D***

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **All health plans cover NRT Patch and Bupropion (Zyban); coverage for NRT Gum, NRT Lozenge, NRT Inhaler, NRT Nasal spray and Varenicline (Chantix) varies by plan**

Counseling: **No coverage**

Barriers to Coverage: **Barriers to coverage vary by health plan****

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers all 7 recommended cessation medications*****

Counseling: **Some health plans cover phone and/or online counseling**

Barriers to Coverage: **No barriers**

STATE QUITLINE:

Investment per Smoker: **Data not reported; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Yes**

Citation: See [New Jersey Tobacco Cessation Coverage page](#) for specific sources.



Thumbs up for New Jersey for expanding the tobacco cessation medications available to state employees.

*Due to data to calculate a current quitline investment per smoker being unavailable, New Jersey was graded based on tobacco cessation coverage for Medicaid enrollees and state employees only.

**Barriers could include: Limits on duration, annual or lifetime limits on quit attempts, requiring prior authorization, requiring co-payments, requiring using one or more cessation treatments before using others and/or requiring the use of counseling to receive medications.

***The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

New Jersey State Highlights:



The American Lung Association in New Jersey continues its efforts to make tobacco control a public health priority at the state and local level.

Once again the Christie Administration and the legislature failed to include any state funding for New Jersey’s comprehensive tobacco control program in the state budget for fiscal year 2013. This is despite getting hundreds of millions of dollars per year in revenue from tobacco taxes (annual Master Settlement Agreement payments were securitized in 2002). The New Jersey Department of Health and Senior Services has shifted minimal funding in its budget, providing \$600,000 to continue a few tobacco prevention and cessation related program initiatives.

This lack of state funding to combat the leading cause of preventable death in New Jersey severely limits further progress on driving down adult and youth smoking rates. Tobacco-related health care costs and lost productivity take an almost \$5.6 billion toll on New Jersey’s economy each year. The tobacco industry certainly isn’t stopping its efforts despite the state’s inaction either, spending over \$22 million dollars per day in 2010 to market their products nationally.

This lack of funding to help tobacco users quit is also in stark contrast with New Jersey’s high cigarette tax rate of \$2.70 per pack and relatively strong smokefree workplace law. Both of these tobacco control policies would have an even greater impact with a well-funded tobacco prevention and cessation program in place.

In 2013, the American Lung Association in New Jersey will advocate for incremental increases in spending on tobacco prevention and cessation to the CDC-recommended level, to increase the cigarette tax by \$1.00 per pack and to raise the tax on tobacco products other than cigarettes to equal the cigarette tax.

New Jersey State Facts	
Economic Costs Due to Smoking:	\$5,595,317,000
Adult Smoking Rate:	16.7%
High School Smoking Rate:	16.1%
Middle School Smoking Rate:	2.8%
Smoking Attributable Deaths:	11,201
Smoking Attributable Lung Cancer Deaths:	3,679
Smoking Attributable Respiratory Disease Deaths:	2,536

Adult smoking rate is taken from CDC’s 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2008 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in New Jersey

1031 Route 22 West, Suite 203
 Bridgewater, NJ 08807
 (908) 685-8040
www.lung.org/newjersey

New Mexico Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$5,931,300
FY2013 Federal Funding for State Tobacco Control Programs:	\$1,730,538*
FY2013 Total Funding for State Tobacco Control Programs:	\$7,661,838
CDC Best Practices State Spending Recommendation:	\$23,400,000
Percentage of CDC Recommended Level:	32.7%

*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 (non-public workplaces with two or fewer employees exempt)
Schools:	Prohibited
Child Care Facilities:	Prohibited
Restaurants:	Prohibited
Casinos/Gaming Establishments:	No provision
Bars:	Prohibited (allowed in cigar bars)
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	N.M. STAT. ANN. §§ 24-16-1 et seq.

Cigarette Tax: **C**

Tax Rate per pack of 20:	\$1.66
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Cessation Coverage: **C**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications:	Covers all 7 recommended cessation medications*
Counseling:	Coverage of individual, group and phone counseling varies by health plan
Barriers to Coverage:	Some health plans require prior authorization, have limits on duration and/or have annual limits on quit attempts

STATE EMPLOYEE HEALTH PLAN(S):

Medications:	Covers all 7 recommended cessation medications*
Counseling:	Covers individual, group, phone and online counseling
Barriers to Coverage:	Co-payments required

STATE QUITLINE:

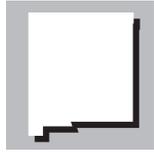
Investment per Smoker: **\$6.05; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate:	Yes
Citation:	See New Mexico Tobacco Cessation Coverage page for specific sources.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

New Mexico State Highlights:



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 use among New Mexicans. Together with our partners, the American Lung Association in New Mexico works to ensure tobacco control and prevention remains a priority for state legislators and local decision makers. In 2012, our focus was to continue to educate legislators, legislative staff and the general public about the importance of providing tobacco cessation programs for adults and youth, and the dangers of secondhand smoke.

During the 2012 legislative session the Lung Association and American Cancer Society Cancer Action Network made a push for taxes on other tobacco products to be equivalent to the tax on cigarettes. Although this effort was unsuccessful we continued the process of educating legislators about the dangers of other tobacco products and the importance of tax parity.

New Mexico has shown leadership in using some dollars received from the Master Settlement Agreement for tobacco prevention and cessation programs, and the program received \$5.9 million in state funding for fiscal year 2013, which is level funding from last year. However, this funding level remains well short of the level recommended by the Centers for Disease Control and Prevention.

The American Lung Association in New Mexico's Smoke-Free at Home program provides education and support to property managers and owners on the economic and health benefits of implementing smokefree policies in multi-unit residences. This voluntary statewide initiative began in 2012 in Albuquerque, Rio Rancho, and Alamogordo and will expand in 2013 to Las Cruces, Anthony, Farmington and Las Vegas. This program has been well received by housing industry leaders and we look forward to helping New Mexicans live free of exposure to secondhand smoke in their homes.

Moving forward in 2013, the American Lung Association in New Mexico will once again work on passing a law that increases taxes on other tobacco products and will continue our efforts towards creating smokefree environments in multi-unit housing. It is our goal to provide New Mexicans with a safe and healthy environment, free from the dangers of

tobacco smoke.

New Mexico State Facts	
Economic Costs Due to Smoking:	\$975,711,000
Adult Smoking Rate:	21.4%
High School Smoking Rate:	19.9%
Middle School Smoking Rate:	6.8%
Smoking Attributable Deaths:	2,104
Smoking Attributable Lung Cancer Deaths:	555
Smoking Attributable Respiratory Disease Deaths:	682

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school and middle school smoking rates are taken from the 2011 and 2009 Youth Risk Behavioral Surveillance System, respectively.

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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in New Mexico
 5911 Jefferson Street NE
 Albuquerque, NM 87109
 (505) 265-0732
www.lung.org/newmexico

New York Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$41,400,000
FY2013 Federal Funding for State Tobacco Control Programs:	\$3,092,684*
FY2013 Total Funding for State Tobacco Control Programs:	\$44,492,684
CDC Best Practices State Spending Recommendation:	\$254,300,000
Percentage of CDC Recommended Level:	17.5%

*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
Casinos/Gaming Establishments:	Prohibited (tribal establishments exempt)
Bars:	Prohibited (allowed in cigar bars and allows for an economic hardship waiver)
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	N.Y. [PUB. HEALTH] LAW §§ 1399-n et seq.

Cigarette Tax: **A**

Tax Rate per pack of 20: \$4.35



Thumbs up for New York for having the highest cigarette tax in the country.

Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **All health plans cover Bupropion (Zyban); coverage of NRT Gum, NRT Patch, NRT Nasal spray, NRT Inhaler, NRT Lozenge and Varenicline (Chantix) varies by health plan**

Counseling: **Covers individual and group counseling**

Barriers to Coverage: **Some health plans have limits on duration, require prior authorization and/or require co-payments**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All health plans cover Bupropion (Zyban); coverage of NRT Gum, NRT Patch, NRT Nasal spray, NRT Inhaler, NRT Lozenge and Varenicline (Chantix) varies by health plan***

Counseling: **Coverage for individual, group, phone and online counseling varies by health plan***

Barriers to Coverage: **Some health plans have limits on duration, annual limits on quit attempts, require use of some medications before using others or require use of counseling to get medications***

STATE QUITLINE:

Investment per Smoker: **\$1.77; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [New York Tobacco Cessation Coverage page](#) for specific sources.

*Data represent information on the 3 largest state employee health plans. Information on other health plans was not available.

New York State Highlights:



During 2012, New York made further progress in its effort to protect its residents from secondhand smoke. Thanks to Governor Cuomo and the legislature, a new law which expanded smokefree areas at public and private preschools, elementary schools and secondary schools took effect at the start of the school year. The law expands smokefree areas by 100 feet, ensuring all our children have the opportunity to learn in a healthier environment.

The Lung Association was a vocal supporter of Governor Cuomo and Parks Commissioner Harvey's decision in April to create new smokefree areas at our state parks; however, we are disappointed the policy has not gone into effect and is caught up in the bureaucratic process. Smokefree areas in our public parks and beaches would go a long way toward protecting adults and children with asthma and lung disease. It would also afford the millions of visitors to our park system each year the opportunity to breathe smokefree air. We will continue to support the implementation of this policy in 2013 and support the growing number of local governments across the state that are taking action on their own to make their local parks smokefree.

While New York made progress with smokefree air, the state missed other opportunities to protect its residents from the burden of tobacco. The state's tobacco control program remains underfunded despite our success in ensuring that the program maintained level funding in the face of proposed cuts. Funded at \$41.4 million, the program is funded significantly lower than recommended by the Centers for Disease Control and Prevention and is funded over \$40 million lower than it was just five years ago.

Similarly, the legislature missed an opportunity to close a tax loophole, which would make the tax on loose tobacco the same as cigarettes. Closing the loophole had been proposed by the Cuomo administration. When tobacco costs more to use, fewer kids start to use it and more adults who have been thinking of quitting are given another reason to stop. Tobacco needs to be taxed uniformly high so that people are not choosing one deadly product over another, but avoiding the substance altogether.

Tobacco use remains the number one preventable cause of death in New York, and lung cancer remains the largest cause of cancer deaths. It is imperative

that New York pushes forward with stronger initiatives that will lead to improved public health and wellness. Toward that end, the Lung Association will continue to advocate for adequate funding of the state tobacco control program and programs which assist New Yorkers who want to quit their deadly addiction. We will also advocate for increasing tobacco cessation coverage by public and private health insurers. The Lung Association will also continue to lead the fight in expansion of state and local smoke-free laws.

New York State Facts

Economic Costs Due to Smoking:	\$14,164,397,000
Adult Smoking Rate:	18.0%
High School Smoking Rate:	12.5%
Middle School Smoking Rate:	3.2%
Smoking Attributable Deaths:	25,432
Smoking Attributable Lung Cancer Deaths:	7,602
Smoking Attributable Respiratory Disease Deaths:	5,984

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2010 New York State 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in New York

155 Washington Ave., Suite 210
Albany, NY 12210
(518) 465-2013
www.lung.org/newyork

North Carolina Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$0
FY2013 Federal Funding for State Tobacco Control Programs:	\$5,706,444*
FY2013 Total Funding for State Tobacco Control Programs:	\$5,706,444
CDC Best Practices State Spending Recommendation:	\$106,800,000
Percentage of CDC Recommended Level:	5.3%



Thumbs Down for North Carolina for eliminating all state funding for tobacco prevention and cessation programs in FY2013.

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration as well as federal substance abuse block grant dollars shifted to tobacco control by North Carolina.

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**
- Casinos/Gaming Establishments: **N/A (tribal casinos only)**
- Bars: **Prohibited (allowed in cigar bars)**
- Retail Stores: **No provision**
- Recreational/Cultural Facilities: **No provision**
- Penalties: **Yes**
- Enforcement: **Yes**
- Preemption: **Yes (private workplaces and other specific venues)**
- Citation: N.C. GEN. STAT. §§ 130A-491 to 130A-498, 115C-407, 131D-4.4 & 131E-114.3

Cigarette Tax: **F**

Tax Rate per pack of 20: \$0.45

Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers individual and phone counseling**

Barriers to Coverage: **Minimal co-payments required**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers NRT Patch, NRT Nasal spray, NRT Inhaler, Varenicline (Chantix) and Bupropion (Zyban)**

Counseling: **Covers individual and phone counseling**

Barriers to Coverage: **Co-payments required**

STATE QUITLINE:

Investment per Smoker: **\$1.20; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [North Carolina Tobacco Cessation Coverage page](#) for specific sources.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

North Carolina State Highlights:



The American Lung Association in North Carolina is committed to advancing tobacco control policies and educating communities on the risks of tobacco use and exposure. As a leader in the community, the Lung Association continues to identify state and local opportunities to partner with tobacco control and public health advocates to advance and protect lifesaving measures to improve quality of life. In 2012, the primary focus remained on protecting state investment in tobacco prevention and control programs.

The Lung Association worked closely with public health partners, including the American Cancer Society, American Heart Association, Campaign for Tobacco Free Kids, and the North Carolina Alliance for Health to urge the governor and general assembly to include a recurring appropriation of at least \$17.3 million in the fiscal year 2013 budget for efforts to reduce tobacco use.

The North Carolina General Assembly moved quickly to pass the budget which required swift action from tobacco control advocates. The governor's proposed fiscal year 2013 budget was released early in the 2012 General Assembly and to the disappointment of tobacco control advocates, included a \$7.3 million cut to tobacco prevention and cessation programs appropriating just \$10 million. Unfortunately, the House and Senate joint budget was far worse and appropriated only \$2.7 million for tobacco prevention and cessation programs, a \$14.6 million reduction. Advocates commended the Governor's decision to veto the House-Senate joint budget, however, the veto was overridden and the state's \$2.7 million non-recurring investment in tobacco control programs was upheld.

The severe cuts to tobacco control spending came as a disappointment to many North Carolinians. In fact, in February 2012 a new poll conducted by Public Opinion Strategies was released which made it clear that nearly three-quarters (74 percent) of North Carolina voters support dedicating at least \$17 million from Master Settlement Agreement funding to programs to prevent kids from starting to smoke and help smokers quit.

The Lung Association is dedicated to protecting and restoring this lifesaving funding. According to a report released by the Campaign for Tobacco Free Kids, the youth impacts from cutting tobacco pre-

vention funding to \$2.7 million will mean:

- A 2.3 percent increase in youth smoking rates
- 12,990 more state kids growing up to become addicted adult smokers
- 4,670 kids growing up to die prematurely from smoking
- A \$227.3 million increase in future healthcare expenditures for the state
- \$24 million increase in the state's Medicaid healthcare spending

In 2013, the American Lung Association in North Carolina will continue to work with public health advocates and key leaders to address the severe cuts the state has seen to its tobacco control funding and will seek to identify new and existing revenue to bolster these lifesaving programs as well as continue to work with communities to protect current tobacco control laws.

North Carolina State Facts	
Economic Costs Due to Smoking:	\$6,281,486,000
Adult Smoking Rate:	21.7%
High School Smoking Rate:	17.7%
Middle School Smoking Rate:	4.2%
Smoking Attributable Deaths:	12,264
Smoking Attributable Lung Cancer Deaths:	4,027
Smoking Attributable Respiratory Disease Deaths:	3,142

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2011 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in North Carolina

514 Daniels Street, #109
 Raleigh, NC 27605
 (919) 719-9960
www.lung.org/northcarolina

North Dakota Report Card

Tobacco Prevention and Control Program Funding: **A**

FY2013 State Funding for Tobacco Control Programs:	\$8,216,554
FY2013 Federal Funding for State Tobacco Control Programs:	\$1,153,366*
FY2013 Total Funding for State Tobacco Control Programs:	\$9,369,920
CDC Best Practices State Spending Recommendation:	\$9,300,000
Percentage of CDC Recommended Level:	100.8%



Thumbs up for North Dakota for funding its state tobacco control program at or above the CDC-recommended level, one of only two states to do so this year.

*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
Casinos/Gaming Establishments:	Prohibited (tribal establishments exempt)
Bars:	Prohibited
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	N.D. CENT. CODE §§ 23-12-9 to 23-12-11



Thumbs up for North Dakota voters for overwhelmingly approving a comprehensive smokefree law in November 2012. The law took effect December 6, 2012.

Cigarette Tax: **F**

Tax Rate per pack of 20: \$0.44

Cessation Coverage: **C**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Individual counseling covered for pregnant women only**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts for some medications, minimal co-payments required, prior authorization required for all medications and use of counseling to get medications required**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers individual, group and phone counseling**

Barriers to Coverage: **Prior authorization required for medications; dollar limits apply to medications and counseling**

STATE QUITLINE:

Investment per Smoker: **\$9.91; CDC recommends an investment of \$10.53/smoker**

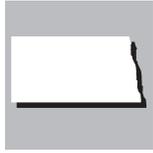
OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Yes**

Citation: See [North Dakota Tobacco Cessation Coverage page](#) for specific sources.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

North Dakota State Highlights:



The American Lung Association in North Dakota has long been a leader and strong partner in the work being done to reduce the harm and destruction from tobacco use in North

Dakota. Our work with partners continues to support policies that prevent youth from starting to smoke, protect people from exposure to secondhand smoke and help people quit.

North Dakota's legislature meets once every two years, and there was no session in 2012. Therefore; the work of the American Lung Association in North Dakota was focused at the local level to build capacity for strong laws to protect all workers from exposure to secondhand smoke. This resulted in four additional communities passing and implementing smokefree policies during 2012 bringing the total number to 11. In the community of Linton, the city council put a question on the ballot to advise them about public opinion on the issue. This resulted in a strong 67 percent of the voters saying they supported adopting a comprehensive smokefree ordinance.

After several years of trying to close the loopholes in North Dakota's current law and protect all workers in North Dakota from secondhand smoke in the state legislature, volunteers and advocates came together across the state to gather the required signatures to place the issue on the November 2012 ballot. The law required 13,452 signatures to qualify; volunteers gathered over 20,000 in a short six week time period and turned them into the Secretary of State ahead of the deadline.

The North Dakota Secretary of State announced in September 2012 that enough valid signatures had been turned in, and the measure, designated Measure 4, would appear on the November ballot. And on November 6th, voters in North Dakota overwhelmingly passed one of the strongest laws in the nation with 66 percent voting "Yes" on Measure 4. The new law prohibits smoking in virtually all public places and workplaces, including the use of e-cigarettes, and keeps smoking 20 feet from entrances. The law received a majority of votes in every county and every precinct in the state.

The American Lung Association in North Dakota will continue to support the new comprehensive statewide smokefree law as it is implemented across the state, along with supporting a significant increase in the tobacco tax. North Dakota ranks as one of the

lowest states in the nation when it comes to the most effective strategy to prevent kids from starting to smoke and motivating smokers to quit.

North Dakota State Facts

Economic Costs Due to Smoking:	\$442,053,000
Adult Smoking Rate:	21.7%
High School Smoking Rate:	19.4%
Middle School Smoking Rate:	5.8%
Smoking Attributable Deaths:	877
Smoking Attributable Lung Cancer Deaths:	259
Smoking Attributable Respiratory Disease Deaths:	245

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2011 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in North Dakota

212 N. 2nd Street
 Bismarck, ND 58501
 (701) 223-5613
www.lung.org/northdakota

Ohio Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$0
FY2013 Federal Funding for State Tobacco Control Programs:	\$3,319,482*
FY2013 Total Funding for State Tobacco Control Programs:	\$3,319,482
CDC Best Practices State Spending Recommendation:	\$145,000,000
Percentage of CDC Recommended Level:	2.3%



Thumbs down for Ohio for spending no state money on tobacco prevention and cessation programs despite smoking costing the state close to \$9.2 billion in economic costs each year.

*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
Casinos/Gaming Establishments:	Prohibited
Bars:	Prohibited
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	OHIO REV. CODE ANN §§ 3794.01 to 3794.09

Cigarette Tax: **D**

Tax Rate per pack of 20:	\$1.25
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Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications***

Counseling: **No coverage**

Barriers to Coverage: **Co-payments required for some medications**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers NRT Gum, NRT Patch, Varenicline (Chantix) and Bupropion (Zyban)**

Counseling: **Covers phone counseling**

Barriers to Coverage: **Annual limit on quit attempts and prior authorization required**

STATE QUITLINE:

Investment per Smoker: **\$0.40; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Ohio Tobacco Cessation Coverage page](#) for specific sources.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Ohio State Highlights:



The American Lung Association in Ohio continued its dedication to reducing the toll of tobacco through policies to reduce exposure to secondhand smoke and fund tobacco prevention and cessation programs.

The Lung Association continued its strong collaboration with numerous health groups, businesses and other organizations in the Investing in Tobacco-Free Youth Coalition. Through a lobby day featuring youth and former professional football players, media advocacy and legislative outreach, we advocated for closing the tax loophole in state tax law now enjoyed by non-cigarette forms of tobacco, to generate sufficient funding for tobacco prevention and cessation programs in the state.

Unfortunately, the same as in previous years, Ohio's legislators chose to cut most funding for tobacco control programs instead. The impact of this choice was seen in Ohio's continuing poor smoking rates. The 2011 smoking rate for the state was 25.2 percent, meaning one out of every four Ohioans over the age of 18 is a smoker.

In 2013, we will continue to emphasize how by simply closing the tax loophole and once again funding tobacco prevention and cessation programs at a reasonable level, we can see our tobacco use rates drop, and positively impact Ohioans' health and healthcare costs in the coming years.

The Lung Association and its partners participated in the five-year rules review of the Smoke-Free Workplace Act, which made all workplaces in Ohio smokefree. We were successful in keeping the rules in place with no weakening, despite strong lobbying by opponents of the law.

Another positive highlight of 2012 was the Ohio Board of Regents' unanimous vote to approve a resolution recommending that all public colleges consider implementing a 100 percent tobacco-free campus policy. More of Ohio's public colleges and universities are likely to adopt such a policy because of this resolution. After the resolution passed, the Lung Association and partners held educational sessions with university staff and health organizations around the state on working with colleges to advocate for, adopt and implement these policies.

The year 2012 also saw four casinos in Ohio open completely smokefree. The Lung Association and its

partners undertook the Celebrate Ohio's Smoke-Free Casinos campaign to generate excitement around Ohio being the first state with an existing smokefree workplace law that had casinos open after the law passed. Our campaign combined media advocacy, social media, stories by casino workers and patrons affected by the policies and advertising all promoting how Ohio benefits from the casinos maintaining a smokefree environment.

As we look to 2013, the American Lung Association in Ohio will continue to advocate for tobacco pricing strategies, tobacco cessation treatment coverage, full funding of scientifically-based tobacco prevention and cessation programming, and a strong smokefree workplace law to protect our children, save lives and lower healthcare costs.

Ohio State Facts

Economic Costs Due to Smoking:	\$9,174,669,000
Adult Smoking Rate:	25.0%
High School Smoking Rate:	21.1%
Middle School Smoking Rate:	4.5%
Smoking Attributable Deaths:	18,590
Smoking Attributable Lung Cancer Deaths:	5,953
Smoking Attributable Respiratory Disease Deaths:	4,953

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2010 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Ohio

1950 Arlingate Lane
Columbus, OH 43228-4102
(614) 279-1700
www.lung.org/ohio

Oklahoma Report Card

Tobacco Prevention and Control Program Funding: **D**

FY2013 State Funding for Tobacco Control Programs:	\$19,903,885
FY2013 Federal Funding for State Tobacco Control Programs:	\$2,627,061*
FY2013 Total Funding for State Tobacco Control Programs:	\$22,530,946
CDC Best Practices State Spending Recommendation:	\$45,000,000
Percentage of CDC Recommended Level:	50.1%



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.

*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:	Restricted
Private Worksites:	Restricted
Schools:	Prohibited
Child Care Facilities:	Prohibited
Restaurants:	Restricted
Casinos/Gaming Establishments:	Restricted (tribal establishments exempt)
Bars:	No provision
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	Yes
Citation:	OKLA. STAT. ANN. tit. 21, § 1247 & tit. 63, §§ 1-1521 et seq.

Cigarette Tax: **D**

Tax Rate per pack of 20: \$1.03

Cessation Coverage: **C**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers individual and phone counseling**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, prior authorization required for 2nd quit attempt, minimal co-payments required and use of counseling to get medications required for 2nd quit attempt**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Coverage of all 7 recommended cessation medications* varies by health plan**

Counseling: **Covers individual and phone counseling; coverage of group counseling varies by health plan**

Barriers to Coverage: **Some health plans have limits on duration, annual limits on quit attempts and/or require co-payments**

STATE QUITLINE:

Investment per Smoker: **\$6.79; CDC recommends an investment of \$10.53/smoker**

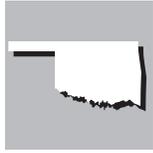
OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Oklahoma Tobacco Cessation Coverage page](#) for specific sources.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Oklahoma State Highlights:



The American Lung Association in Oklahoma continues to support efforts to reduce the burden of tobacco use on all Oklahomans. The Lung Association along with other national and statewide health partners play an important role in the Smoke Free Oklahoma Coalition. Many organizations work tirelessly to make policy changes in order to reduce smoking rates and improve life while defending the health of Oklahomans.

During the 2012 legislative session, a bill supported by the Smoke Free Oklahoma Coalition and Lung Association was introduced in the Oklahoma House of Representatives to restore local rights and control to city government, and allow the passage of local ordinances to completely prohibit smoking in public places and workplaces. The bill was passed in the House Public Health Committee. However, when the bill moved to the House floor, it had two unfavorable amendments added to it, which completely changed what the legislation was meant to do.

The full House then approved the measure with the two amendments intact, which was the first time a bill to restore local control on smokefree laws had made it out of the House of Representatives. As the bill moved to the Senate side, it was refused for a hearing in the assigned Senate Health and Human Services Committee. Ultimately, the bill failed to advance in the Senate and no further action was taken in the 2012 session. The Smoke Free Oklahoma Coalition will continue to offer a bill to restore local control to communities in the 2013 legislative session.

Although lawmakers aren't making progress in implementing the policy changes necessary to protect Oklahoma workers from secondhand smoke, the Oklahoma Tobacco Settlement Endowment Trust (TSET) board of directors and the Oklahoma State Department of Health continue to provide funding for comprehensive tobacco control programs. Program initiatives 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.

In 2013, the American Lung Association in Okla-

homa, along with strong public health partners, will continue to raise public awareness regarding the need for a comprehensive statewide smokefree law and the need for municipalities to have the rights to protect their residents from secondhand smoke.

Oklahoma State Facts

Economic Costs Due to Smoking:	\$2,816,758,000
Adult Smoking Rate:	26.1%
High School Smoking Rate:	22.7%
Middle School Smoking Rate:	3.7%
Smoking Attributable Deaths:	6,212
Smoking Attributable Lung Cancer Deaths:	1,898
Smoking Attributable Respiratory Disease Deaths:	1,677

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2011 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Oklahoma

11212 N. May Avenue, Suite 405
Oklahoma City, OK 73120
(405) 748-4674
www.lung.org/oklahoma

Oregon Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$7,534,500
FY2013 Federal Funding for State Tobacco Control Programs:	\$1,329,165*
FY2013 Total Funding for State Tobacco Control Programs:	\$8,863,665
CDC Best Practices State Spending Recommendation:	\$43,000,000
Percentage of CDC Recommended Level:	20.6%

*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
Casinos/Gaming Establishments:	Prohibited (tribal establishments exempt)
Bars:	Prohibited (allowed in cigar bars)
Retail Stores:	Prohibited (allowed in smoke shops)
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	OR. REV. STAT. §§ 433.835 to 433.990

Cigarette Tax: **D**

Tax Rate per pack of 20: \$1.18

Cessation Coverage: **D**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **All health plans cover NRT Patch, Bupropion (Zyban) and Varenicline (Chantix); coverage for NRT Gum, NRT Lozenge, NRT Inhaler and NRT Nasal spray vary by health plan**

Counseling: **All health plans cover individual counseling; most plans cover group counseling**

Barriers to Coverage: **Some health plans have limits on duration, annual limits on quit attempts, require prior authorization and/or use of counseling to get medications; fee-for-service plan requires a co-payment for Varenicline (Chantix)**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers NRT Gum, NRT Patch, Varenicline (Chantix) and Bupropion (Zyban)**

Counseling: **Covers phone counseling**

Barriers to Coverage: **Use of counseling to get medications required for all health plans; some plans have limits on duration, annual and/or lifetime limits on quit attempts and/or require minimal co-payments**

STATE QUITLINE:

Investment per Smoker: **\$3.13; CDC recommends an investment of \$10.53/smoker**

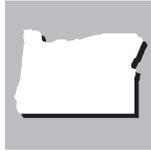
OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Yes**

Citation: See [Oregon Tobacco Cessation Coverage page](#) for specific sources.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Oregon State Highlights:



The American Lung Association in Oregon has long been a leader in Oregon's tobacco control movement. Working with many partners, the Lung Association supports state and local policy efforts that prevent youth from using tobacco products, protect all Oregonians from secondhand smoke and help people who want to quit.

During the short 2012 legislative session (35 days in even-numbered years), the Lung Association's biggest accomplishment was to successfully advocate for House Bill 4172, legislation that again allows enforcement to occur in Oregon's tobacco retailer inspection program. HB 4172 authorizes retired Oregon State Police officers to conduct tobacco retail inspections and issue citations to stores making illegal sales. This bill will help reduce illegal tobacco sales to minors, which could reduce youth tobacco use in Oregon. HB 4172 passed unanimously in both the House and Senate, and was signed by the Governor into law in March 2012.

Despite the Lung Association and our partners' best efforts to protect the Tobacco Prevention and Education Program from cuts, we were disappointed that the legislature approved a disproportionate \$1.5 million cut to the Tobacco Use Reduction Account. This cut was weighed against reductions to programs seen as more urgent in the eyes of some legislators. Moving forward, we will continue to educate legislators and the public that: 1) Tobacco prevention saves lives and money, and 2) the health of the whole community is protected when tobacco use is reduced.

The Lung Association, along with our legislative partners, has been actively preparing for Oregon's 2013 Legislative Session. We are playing a leading role in a comprehensive campaign to use newly available Tobacco Master Settlement Agreement funds for their intended use—tobacco prevention and cessation. We have developed several campaign materials and have conducted outreach meetings with key stakeholders within both the Executive and Legislative branches. Our coalition's budget proposal would bring Oregon's Tobacco Prevention and Education Program closer to the Centers for Disease Control and Prevention's recommended level of funding.

Additionally, Oregon has made great progress with the creation of Coordinated Care Organizations (CCOs), an integrated health care system for Medic-

aid participants. We continue to closely monitor Oregon's health reform process, advocating for proven strategies that will save lives and reduce healthcare costs, including comprehensive tobacco cessation programs.

Lastly, we are making good progress with our educational campaign to encourage parents to keep their cars smokefree. In the past year, we distributed over 4,000 educational materials to parents, teachers and the public. We have also identified a legislative champion for a 2013 public policy campaign. We look forward to attending upcoming community events, specifically selected to reach more families with our message. All of our educational activities are working to build momentum for policy change.

Oregon State Facts

Economic Costs Due to Smoking:	\$2,174,506,000
Adult Smoking Rate:	19.6%
High School Smoking Rate:	11.5%
Middle School Smoking Rate:	6.6%
Smoking Attributable Deaths:	4,981
Smoking Attributable Lung Cancer Deaths:	1,627
Smoking Attributable Respiratory Disease Deaths:	1,454

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school (11th grade only) and middle school (8th grade only) smoking rates are taken from the 2011 Oregon Healthy Teens 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Oregon

7420 SW Bridgeport Road, Suite 200
Tigard, OR 97224-7711
(503) 924-4094
www.lung.org/oregon

Pennsylvania Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$14,221,000
FY2013 Federal Funding for State Tobacco Control Programs:	\$2,942,883*
FY2013 Total Funding for State Tobacco Control Programs:	\$17,163,883
CDC Best Practices State Spending Recommendation:	\$155,500,000
Percentage of CDC Recommended Level:	11.0%

*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
Casinos/Gaming Establishments:	Restricted (tribal establishments exempt)
Bars:	No provision
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	Yes
Citation:	35 PA. STAT §§ 637.1 to 637.11

Cigarette Tax: **C**

Tax Rate per pack of 20:	\$1.60
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Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers individual and group counseling**

Barriers to Coverage: **Minimal co-payments required**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers NRT Gum and NRT Patch**

Counseling: **Covers phone counseling**

Barriers to Coverage: **Use of counseling required to receive medications**

STATE QUITLINE:

Investment per Smoker: **\$0.82; CDC recommends an investment of \$10.53/smoker**

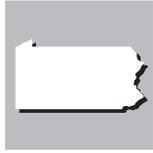
OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Pennsylvania Tobacco Cessation Coverage page](#) for specific sources.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Pennsylvania State Highlights:



The American Lung Association in Pennsylvania continues its tobacco prevention and cessation efforts in the Commonwealth.

Emphasis this past year was placed on funding for Pennsylvania's tobacco prevention and cessation program. Gov. Tom Corbett's Administration designated \$14.2 million for tobacco control in the fiscal year 2013 budget which is slightly higher than the amount allocated in fiscal year 2012. This is considered a major victory since many other public health programs received no funding or damaging cuts.

The money received annually from the Master Settlement Agreement was originally dedicated to be used for uncompensated healthcare, tobacco cessation and prevention, research and healthcare assistance. While 12 percent of the funds coming into Pennsylvania are dedicated to tobacco prevention and cessation in the law, lawmakers have routinely decreased this amount as a result of temporary fiscal code changes. The Lung Association continues to advocate for raising this amount to the level recommended by the Centers for Disease Control and Prevention.

Pennsylvania is the only state without an excise tax on tobacco products other than cigarettes. The Lung Association and its partners focused on education regarding the importance of setting a percentage of wholesale price tax to allow the tax to keep up with inflation and tobacco industry price increases. Governor Corbett, prior to his election, signed a no new tax pledge and therefore indicated he would not push for any new taxes, even on cancer-causing tobacco products. Unfortunately, this means approximately \$100 million in revenue was left on the table in the Commonwealth.

Pennsylvania's clean indoor air law eliminates smoking in many public places and workplaces, including most restaurants, but it has a number of exemptions, including for casinos and some bars. A bill to remove all the exemptions was filed in both the state House of Representatives and Senate in 2012, but was not released from committee. The Lung Association will continue to work on cleaning up the current law to protect all workers in Pennsylvania from secondhand smoke.

A bill was also introduced in the Senate to require comprehensive coverage of tobacco cessation treatments under private health insurance plans issued in

the state. Sadly, the bill did not even get a hearing.

In 2013, the American Lung Association in Pennsylvania will continue to focus on efforts to reduce tobacco use and secondhand smoke that stalled in 2012 and defend Pennsylvania's current level of tobacco prevention and cessation funding.

Pennsylvania State Facts

Economic Costs Due to Smoking:	\$9,423,966,000
Adult Smoking Rate:	22.3%
High School Smoking Rate:	18.6%
Middle School Smoking Rate:	3.4%
Smoking Attributable Deaths:	20,025
Smoking Attributable Lung Cancer Deaths:	6,395
Smoking Attributable Respiratory Disease Deaths:	4,971

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school and middle school smoking rates are taken from the 2010 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Pennsylvania

3001 Old Gettysburg Road
Camp Hill, PA 17011
(717) 541-5864
www.lung.org/pennsylvania

Rhode Island Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$376,437
FY2013 Federal Funding for State Tobacco Control Programs:	\$1,847,143*
FY2013 Total Funding for State Tobacco Control Programs:	\$2,223,580
CDC Best Practices State Spending Recommendation:	\$15,200,000
Percentage of CDC Recommended Level:	14.6%



Thumbs down for Rhode Island for spending little state money on tobacco prevention and cessation programs despite smoking costing the state close to \$870 million in economic costs each year.

*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
Casinos/Gaming Establishments:	Restricted
Bars:	Prohibited (allowed in smoking bars)
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	R.I. GEN. LAWS §§ 23-20.10-1 et seq.

Cigarette Tax: **A**

Tax Rate per pack of 20:	\$3.50*
On July 1, 2012, the cigarette tax increased from \$3.46 to \$3.50 per pack.	

Cessation Coverage: **D**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications***

Counseling: **All health plans cover individual counseling; some plans cover group counseling**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, prior authorization required, use of certain treatments required before using others and use of counseling required to get medications**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers group, individual and phone counseling**

Barriers to Coverage: **Limits on duration, co-payments required and use of counseling required to get medications**

STATE QUITLINE:

Investment per Smoker: **\$0.92; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Yes**

Citation: See Rhode Island Tobacco Cessation Coverage page for specific sources.

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Rhode Island State Highlights:



The American Lung Association in Rhode Island works with more than 50 partner organizations of the Rhode Island Tobacco Control Network to enact and defend strong laws to protect Rhode Islanders from secondhand smoke, to make it more difficult for retailers to sell tobacco to minors and to fight for an effective, well-funded comprehensive state tobacco control program.

In 2012, the Network's policy priorities were to (1) increase the Rhode Island cigarette excise tax by 90 cents, to \$4.36 per pack, matching the highest rate in the nation, (2) increase state funding for the Rhode Island Department of Health's Tobacco Control Program budget to \$3.1 million for Fiscal Year 2013, restoring it to its highest level of funding, (3) reclassify "little cigars" as cigarettes to achieve price equity and protect our youth from being targeted with cheap and sweet tobacco products and (4) improve the tobacco enforcement system to reduce tax evasion and black market sales.

The Lung Association and our Network partners had both successes and challenges this year. Legislation to increase the tobacco tax by 90 cents did not move forward and ultimately, the General Assembly included a four cent tobacco tax increase in the final state budget. That level of increase will have no public health impact.

State funding to the Rhode Island Department of Health's Tobacco Control Program did not increase for Fiscal Year 2013. However, the Network achieved success with legislation that adjusted the definition of cigarettes to capture little cigars. As a result, little cigars weighing up to four pounds per 1,000 will now be taxed at the same rates as cigarettes. Our advocacy efforts also resulted in Governor Chafee including four additional tobacco enforcement agents in his budget proposal, a major move forward from the previous situation of only one enforcement agent for the entire state. The Rhode Island General Assembly agreed with the governor's proposal and kept these positions in the final 2013 budget.

We were also successful in stopping a number of measures that would be counterproductive to reducing tobacco use in Rhode Island. The Rhode Island Tobacco Control Network secured a gubernatorial veto of a tobacco industry effort to divert tobacco control funding to penalize youth caught using

tobacco products. We also successfully rallied against a bill that would have preempted stronger tobacco control laws at the local level and stopped a measure to roll back the state tobacco tax by 10 cents per pack.

In the coming year, the American Lung Association in Rhode Island will continue working to secure needed funding for state tobacco control efforts, increase the price of tobacco products, expand smoke-free environments and further limit the availability of tobacco products in our communities.

Rhode Island State Facts

Economic Costs Due to Smoking:	\$869,938,000
Adult Smoking Rate:	19.9%
High School Smoking Rate:	11.4%
Middle School Smoking Rate:	5.0%
Smoking Attributable Deaths:	1,696
Smoking Attributable Lung Cancer Deaths:	540
Smoking Attributable Respiratory Disease Deaths:	435

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school and middle school smoking rates are taken from the 2011 and 2009 Youth Risk Behavioral Surveillance System, respectively.

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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Rhode Island

260 West Exchange Street, Suite 102-B
Providence, RI 02903
(401) 421-6487
www.lung.org/rhodeisland

South Carolina Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs: \$5,000,000

FY2013 Federal Funding for State Tobacco Control Programs: \$1,604,767*

FY2013 Total Funding for State Tobacco Control Programs: \$6,604,767

CDC Best Practices State Spending Recommendation: \$62,200,000

Percentage of CDC Recommended Level: 10.6%

*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**

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

Bars: **No provision**

Retail Stores: **No provision**

Recreational/Cultural Facilities: **Restricted**

Penalties: **Yes**

Enforcement: **No**

Preemption: **No**

Citation: S.C. CODE ANN. §§ 44-95-10 et seq.

Note: The Smokefree Air grade only examines state law and does not reflect local smokefree ordinances. South Carolina has made great strides at protecting people from secondhand smoke by passing strong local smokefree ordinances.

Cigarette Tax: **F**

Tax Rate per pack of 20: \$0.57

Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **All health plans cover NRT Patch; coverage for NRT Gum, NRT Inhaler, NRT Nasal spray, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban) varies by health plan**

Counseling: **No coverage**

Barriers to Coverage: **All health plans have limits on duration; some plans have annual limits on quit attempts and/or require prior authorization, minimal co-payments, use of certain treatments before using others or use of counseling to get medications**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All health plans cover NRT Gum and NRT Patch; some plans cover NRT Lozenge, Bupropion (Zyban) and Varenicline (Chantix)**

Counseling: **All health plans cover phone counseling**

Barriers to Coverage: **Annual limit on quit attempts, co-payments required for some medications and use of counseling required to get medications**

STATE QUITLINE:

Investment per Smoker: **\$4.91; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See South Carolina Tobacco Cessation Coverage page for specific sources.

South Carolina State Highlights:



The American Lung Association in South Carolina continues to support public policy as a means to reduce the death and disease from tobacco use. With the South Carolina Tobacco-

Free Collaborative and our partners and supporters, we have supported state tobacco prevention funding, increased cigarette taxes and comprehensive smoke free air ordinances at the local level.

South Carolina continues to pass strong, comprehensive local smokefree air laws. Nearly all of the largest cities have laws in place. While the majority of South Carolinians do not yet have protection from second-hand smoke in public places and workplaces, over 30 percent do. This is a major victory for a traditional tobacco-growing state. South Carolina serves as a model for other states on this front.

The five million dollars earmarked for tobacco prevention and cessation funding during passage of the 2010 cigarette tax increase survived the 2012 legislative session intact. State budget leaders in the House of Representatives sought to divert much of the funding to other health issues during the budget process. Fortunately, Senate leaders continued to favor maintaining the funding and their wishes ultimately prevailed. The funds support promotion of the tobacco quit line and programs to deter our youth from beginning to smoke.

The American Lung Association in South Carolina continues to work for more local smokefree air ordinances. We support improvements in quit smoking benefits for workers and will fight to maintain the \$5 million in state tobacco prevention funding.

South Carolina State Facts

Economic Costs Due to Smoking:	\$3,275,713,000
Adult Smoking Rate:	23.0%
High School Smoking Rate:	19.1%
Middle School Smoking Rate:	5.9%
Smoking Attributable Deaths:	6,129
Smoking Attributable Lung Cancer Deaths:	2,046
Smoking Attributable Respiratory Disease Deaths:	1,490

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2011 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in South Carolina

44-A Markfield Drive
Charleston, SC 29407
(843) 556-8451
www.lung.org/southcarolina

South Dakota Report Card

Tobacco Prevention and Control Program Funding:

F

FY2013 State Funding for Tobacco Control Programs: \$3,999,830

FY2013 Federal Funding for State Tobacco Control Programs: \$963,055*

FY2013 Total Funding for State Tobacco Control Programs: \$4,962,885

CDC Best Practices State Spending Recommendation: \$11,300,000

Percentage of CDC Recommended Level: 43.9%

*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**

Casinos/Gaming Establishments: **Prohibited**

Bars: **Prohibited (smoking of certain tobacco products allowed in certain bars)**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **No provision**

Preemption: **Yes***

Citation: S.D. CODIFIED LAWS §§ 34-46-13 to 34-46-19

*If preemption were repealed, South Dakota's grade would be an "A."

Cigarette Tax:

C

Tax Rate per pack of 20: \$1.53

Cessation Coverage:

D

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers Varenicline (Chantix) and Bupropion (Zyban)**

Counseling: **Individual counseling covered for pregnant women only**

Barriers to Coverage: **Minimal co-payments required**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers Bupropion (Zyban) and Varenicline (Chantix)**

Counseling: **Covers phone counseling**

Barriers to Coverage: **Lifetime limit on quit attempts and co-payments required**

STATE QUITLINE:

Investment per Smoker: **\$13.28; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

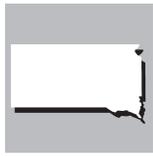
Private Insurance Mandate: **No provision**

Citation: See [South Dakota Tobacco Cessation Coverage page](#) for specific sources.



Thumbs up for South Dakota for exceeding the CDC-recommended investment per smoker for its state quitline.

South Dakota State Highlights:



The American Lung Association in South Dakota, as a founding member of the South Dakota Tobacco Free Kids Network, worked together with network partners in 2012 to assure the smokefree law stayed strong, monitoring any attempts to weaken the law as rumors of possible exemptions for Deadwood casinos and gaming establishments were prevalent leading up to the legislative session.

In early January, those rumors were put to rest as State Sen. Nelson confirmed that he would not be bringing forward a bill and Governor Dugaard indicated that he would veto any attempt by the Senator to add the exemption. The strong and sustained support for the smokefree law, the improved state budget outlook, and the power of the coalition helped in forming this decision. This was a very positive way to begin the 2012 legislative session.

Governor Dugaard, in his State of the State address, announced his plans to expand the education and resources dedicated to address tobacco use during pregnancy. This proposal was in response to an Infant Mortality Task Force led by the First Lady. While the Governor highlighted this need, there was no change in the level of resources to the tobacco control program. The priority of smoking during pregnancy will be addressed utilizing these current dollars. Pregnant women are the only group of people that have not seen a decline in tobacco use in South Dakota.

Legislation was introduced to classify persons and stores that allowed the use of roll-your-own cigarette machines for commercial purposes as tobacco product manufacturers under state law. This required these “Roll-your-own” shops to collect sales tax on cigarettes, comply with the Master Settlement Agreement and use paper designed to help prevent cigarette-caused fires. The roll-your-own businesses came into being after the 2006 \$1.00 cigarette tax increase approved by voters, with the specific purpose of avoiding that cigarette tax increase as stated in their advertising and legislative testimony. House Bill 1273 easily passed the legislature and was signed into law. The only part of the bill that doesn’t take effect until 2014 is the requirement to use paper that reduces fire in the making of these cigarettes.

In 2013, the American Lung Association in South Dakota, together with partners in the South Dakota Tobacco Free Kids Network, will advocate for tobac-

co prevention and control funding to be increased to the Centers for Disease Control’s recommended level along with ensuring that our comprehensive smoke-free workplace law stays strong and defend against any attempts to weaken it.

South Dakota State Facts

Economic Costs Due to Smoking:	\$509,230,000
Adult Smoking Rate:	22.9%
High School Smoking Rate:	23.1%
Middle School Smoking Rate:	6.1%
Smoking Attributable Deaths:	1,068
Smoking Attributable Lung Cancer Deaths:	321
Smoking Attributable Respiratory Disease Deaths:	312

Adult smoking rate is taken from CDC’s 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2009 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in South Dakota

108 E. 38th Street, Suite 600
Sioux Falls, SD 57105
(605) 336-7222
www.lung.org/southdakota

Tennessee Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$222,267
FY2013 Federal Funding for State Tobacco Control Programs:	\$1,936,472*
FY2013 Total Funding for State Tobacco Control Programs:	\$2,158,739
CDC Best Practices State Spending Recommendation:	\$71,700,000
Percentage of CDC Recommended Level:	3.0%

*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*
Casinos/Gaming Establishments:	N/A
Bars:	Restricted*
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	Yes
Citation:	TENN. CODE ANN. §§ 39-17-1801 to 39-17-1810

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

Cigarette Tax: **F**

Tax Rate per pack of 20:	\$0.62
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Cessation Coverage: **D***

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications****

Counseling: **Covers Individual and Group counseling for pregnant women only**

Barriers to Coverage: **Prior authorization required and limits on duration**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers all 7 recommended cessation medications****

Counseling: **Covers individual and phone counseling**

Barriers to Coverage: **Limits on duration, annual and lifetime limits on quit attempts and co-payments required for medications**

STATE QUITLINE:

Investment per Smoker: **Data not reported; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

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



Thumbs Up for Tennessee for allocating funding and providing coverage for tobacco cessation treatments for all Medicaid enrollees; previously no coverage was provided to all enrollees.

*Due to data to calculate a current quitline investment per smoker being unavailable, Tennessee was graded based on tobacco cessation coverage for Medicaid enrollees and state employees only.

**The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Tennessee State Highlights:



The American Lung Association in Tennessee continued to work with its public health partners in 2012 to ensure that the current law prohibiting smoking in many public places

and workplaces was not weakened, despite previous threats from members of the legislature to do so.

Workers in bars and small workplaces with three or fewer employees are still exposed to secondhand smoke under Tennessee's current law. Local communities are also prohibited from passing stronger local laws. The Lung Association supports comprehensive smokefree laws that cover all workplaces and public places, including bars, and giving local communities the freedom to protect their citizens from second-hand smoke.

Unfortunately, the climate was not right to attempt to strengthen the smokefree law in 2012, but the Lung Association did work with lawmakers to promote the successes of the law at providing safer workplaces for many Tennessee workers.

The Lung Association focused its efforts on asthma awareness during the legislative session and continually educates the Tennessee Legislature about the negative effects that tobacco smoke has on people with asthma. Tennessee has high asthma rates so secondhand smoke in the workplace is particularly threatening to them.

Moving forward in 2013, the American Lung Association in Tennessee will continue to defend the Nonsmoker's Protection Act and look for opportunities to strengthen the law. The Lung Association will explore working with new partners to address additional tobacco control issues such as smokefree multi-unit housing, increasing the cigarette tax and improving tobacco prevention and cessation program funding. Tennessee's smoking rate stands at 23 percent, above the national average, so effective tobacco prevention and cessation policies need to be put in place to protect future generations from a lifetime of tobacco addiction.

Tennessee State Facts

Economic Costs Due to Smoking:	\$5,135,105,000
Adult Smoking Rate:	23.0%
High School Smoking Rate:	21.6%
Middle School Smoking Rate:	N/A
Smoking Attributable Deaths:	9,709
Smoking Attributable Lung Cancer Deaths:	3,285
Smoking Attributable Respiratory Disease Deaths:	2,505

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. A current middle school smoking rate is not available for the 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Tennessee

One Vantage Way, Suite D-220
Nashville, TN 37228
(615) 329-1151
www.lung.org/tennessee

Texas Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$6,450,294
FY2013 Federal Funding for State Tobacco Control Programs:	\$4,331,461*
FY2013 Total Funding for State Tobacco Control Programs:	\$10,781,755
CDC Best Practices State Spending Recommendation:	\$266,300,000
Percentage of CDC Recommended Level:	4.0%

*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:	No provision
Private Worksites:	No provision
Schools:	Restricted
Child Care Facilities:	Prohibited
Restaurants:	No provision
Casinos/Gaming Establishments:	No provision
Bars:	No provision
Retail Stores:	No provision
Recreational/Cultural Facilities:	Restricted
Penalties:	Yes
Enforcement:	Yes
Preemption:	No

Citation: TEX. PENAL CODE ANN. § 48.01; TX EDUC. CODE § 21.927; and TX ADMIN. CODE tit. 40, Part 19, Subchapter S, Div. 1 §§ 746.3703(d) & 747.3503(d)

Note: The Smokefree Air grade only examines state tobacco control law and does not reflect local smokefree ordinances. Texas has made great strides at protecting people from secondhand smoke by passing strong local smokefree ordinances.

Cigarette Tax: **D**

Tax Rate per pack of 20:	\$1.41
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Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, Varenicline (Chantix) and Bupropion (Zyban)**

Counseling: **Coverage of individual and group counseling varies by health plan**

Barriers to Coverage: **Minimal co-payments required for medications; co-payments for counseling vary by health plan**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers Bupropion (Zyban) and Varenicline (Chantix)**

Counseling: **Some health plans cover group and phone counseling**

Barriers to Coverage: **Co-payments required**

STATE QUITLINE:

Investment per Smoker: **\$0.84; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Texas Tobacco Cessation Coverage page](#) for specific sources.

Texas State Highlights:



The American Lung Association in Texas has continued to fight for air by advocating for stronger tobacco control policies and comprehensive statewide smokefree legislation to reduce exposure to secondhand smoke in all workplaces. Due to the lack of a statewide comprehensive smokefree workplace law, millions of Texans remain exposed to secondhand smoke.

Since the 2011 legislative session, there have been significant changes in the composition of both the state House of Representatives and Senate. The Texas Senate has more members that are skeptical of public health legislation than in recent years, and both the House and Senate have a large number of newly elected members. Due to the unusually high turnover rate in House membership, after the 2012 election cycles, concerted efforts were made to educate the incoming members on the importance of a smokefree workplace law.

The Lung Association has continued its work as a partner in the Smoke-Free Texas coalition. In 2012, the coalition worked towards educating and building support among grassroots supporters and businesses for comprehensive smokefree policies that protect the public and workers from secondhand smoke. Tens of thousands of Texans support the coalition's effort to pass a statewide smoke-free workplace law, including, as of November 2012, more than 65,000 Facebook supporters, more than 3,400 Twitter followers and more than 27,000 Texans in our grassroots database, as well as numerous organizations, business groups, musicians, faith leaders and everyday Texans from across the political spectrum.

There are now 36 cities across Texas with comprehensive local ordinances in place that protect more than 45 percent of the population from the harmful effects of secondhand smoke. In a 2011 study, 90% of Texans polled would go out to bars and restaurants more often, or as often, as they do now if a statewide smokefree law was passed in Texas. Another joint study found that a statewide smoke-free workplace law in Texas would save the Texas economy \$404 million in reduced health care costs and productivity savings every two years.

At the local level in 2012, Lewisville expanded their smokefree ordinance to cover restaurants, bars and bowling alleys. Brownsville considered proposals to extend their existing non-comprehensive ordinance

to bars and bingo halls, but has yet to vote on the ordinance. Stafford also heard public testimony on a possible smokefree ordinance, but the council has yet to move the ordinance forward.

The American Lung Association in Texas, along with our health advocacy partners, is devoted to reducing tobacco use across all demographics, including adults, teens, and youth as well as within minority groups. We will also advocate for sustained funding for tobacco prevention, cessation and control programs. The Smoke-Free Texas coalition is well positioned to once again push for a statewide smoke-free workplace law in Texas in the 2013 legislative session.

Texas State Facts	
Economic Costs Due to Smoking:	\$13,044,600,000
Adult Smoking Rate:	19.1%
High School Smoking Rate:	17.4%
Middle School Smoking Rate:	5.7%
Smoking Attributable Deaths:	24,570
Smoking Attributable Lung Cancer Deaths:	7,770
Smoking Attributable Respiratory Disease Deaths:	6,324

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate (8th grader only) is taken from the 2008 Texas School Survey of Substance Use among Students: Grades 7-12.

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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Texas

5926 Balcones Drive, Suite 100

Austin, TX 78753

(512) 467-6753

www.lung.org/texas

Utah Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$7,037,400
FY2013 Federal Funding for State Tobacco Control Programs:	\$1,586,549*
FY2013 Total Funding for State Tobacco Control Programs:	\$8,623,949
CDC Best Practices State Spending Recommendation:	\$23,600,000
Percentage of CDC Recommended Level:	36.5%

*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
Casinos/Gaming Establishments:	N/A
Bars:	Prohibited
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	Yes
Citation:	UTAH CODE ANN. §§ 26-38-1 et seq.

Cigarette Tax: **C**

Tax Rate per pack of 20:	\$1.70
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Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers Varenicline (Chantix) and Bupropion (Zyban); other medications covered only for certain types of Medicaid**

Counseling: **Covers group and individual counseling for pregnant women only**

Barriers to Coverage: **Prior authorization required for some medications and minimal co-payments required**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers Varenicline (Chantix) and Bupropion (Zyban)**

Counseling: **No coverage**

Barriers to Coverage: **Annual limit on quit attempts, prior authorization required for some medications and minimal co-payments required**

STATE QUITLINE:

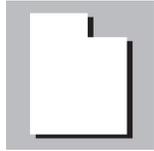
Investment per Smoker: **\$4.36; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Utah Tobacco Cessation Coverage page](#) for specific sources.

Utah State Highlights:



The American Lung Association in Utah continued fighting for air in 2012 by pursuing the passage of a law that would include hookahs and e-cigarettes in Utah’s smokefree workplace law. Although the bill passed, the legislature did include unwarranted exemptions for five years (through July 2017) to some businesses that already permitted the use of hookahs and e-cigarettes. The Lung Association feels it would have been better to leave the otherwise comprehensive Utah Clean Indoor Air Act alone rather than creating additional exemptions.

House Bill 95, a bill sponsored by Rep. Paul Ray was passed and requires retailers that sell predominantly tobacco or smoking paraphernalia to obtain a tobacco specialty business license. The bill also sets proximity restrictions on smoke shops to prevent them from locating near schools, parks, youth facilities and other community areas.

State funding for tobacco prevention and cessation programs in Utah comes from both annual Master Settlement Agreement payments and cigarette tax revenues, and remained at about \$7 million in fiscal year 2013. Although only funded at about one third of the level recommended by the Centers for Disease Control and Prevention, the program along with other tobacco control policies such as the \$1.00 increase in the cigarette tax in 2010, have reduced high school smoking rates by 50 percent since 1999 to only 5.9 percent, according to the CDC’s 2011 Youth Risk Behavioral Surveillance System.

In 2013, the American Lung Association in Utah will again work to pass a bill prohibiting smoking in vehicles with a minor younger than 15 years old. We will continue working with our partners on educating elected officials about the dangers of tobacco products and secondhand smoke. We will also be vigilant in rebutting any of the tobacco industry “harm reduction” claims about other tobacco products.

Utah State Facts	
Economic Costs Due to Smoking:	\$662,595,000
Adult Smoking Rate:	11.8%
High School Smoking Rate:	5.9%
Middle School Smoking Rate:	2.3%
Smoking Attributable Deaths:	1,156
Smoking Attributable Lung Cancer Deaths:	291
Smoking Attributable Respiratory Disease Deaths:	400

Adult smoking rate is taken from CDC’s 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2007 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Utah
 1930 South 1100 East
 Salt Lake City, UT 84106-2317
 (801) 484-4456
www.lung.org/utah

Vermont Report Card

Tobacco Prevention and Control Program Funding: **D**

FY2013 State Funding for Tobacco Control Programs:	\$3,971,713
FY2013 Federal Funding for State Tobacco Control Programs:	\$1,189,143*
FY2013 Total Funding for State Tobacco Control Programs:	\$5,160,856
CDC Best Practices State Spending Recommendation:	\$10,400,000
Percentage of CDC Recommended Level:	50.0%



Thumbs Up for Vermont for increasing funding for its tobacco prevention and cessation program by over \$500,000 in FY2013.

*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
Casinos/Gaming Establishments:	N/A
Bars:	Prohibited
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	No
Citation:	VT STAT. ANN. tit. 18, §§ 28-1421 to 28-1428 & 37-1741 et seq.

Cigarette Tax: **B**

Tax Rate per pack of 20: \$2.62

Cessation Coverage: **D**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Individual and group counseling covered for pregnant women only**

Barriers to Coverage: **Limits on duration, minimal co-payments required and prior authorization required for certain medications and instances**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers all 7 recommended cessation medications***

Counseling: **Covers individual and phone counseling**

Barriers to Coverage: **Co-payments required**

STATE QUITLINE:

Investment per Smoker: **\$3.62; CDC recommends an investment of \$10.53/smoker**

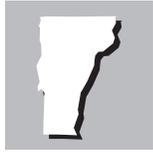
OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **Yes**

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

*The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

Vermont State Highlights:



For more than a decade, the American Lung Association in Vermont, the American Cancer Society, the American Heart Association and other partners in the Coalition for a Tobacco Free Vermont have advocated successfully to pass state and local laws to reduce the burden of tobacco use. During the 2012 legislative session, we worked to increase funding for the Tobacco Control Program, protect the Tobacco Trust Fund, and eliminate a loophole in the tobacco tax.

Since Fiscal Year 2008, appropriations to the Tobacco Control Program have been cut by more than one third. This year was different. Thanks to champions on the House Committee on Appropriations, the program received an increase of \$500,000 for fiscal year 2013. This increase brings the program total to \$3.9 million, a far cry from its first appropriation in fiscal year 2001 of \$6.4 million, but a step in the right direction.

Each year, the legislature, making budget decisions based on anticipated Master Settlement Agreement (MSA) revenue, has appropriated more MSA money than the state received, with the majority directed to Medicaid. Due to this oversubscription, the Tobacco Trust Fund, created for future tobacco control efforts, has been used to close the gap. For fiscal year 2013, the administration and the legislature made a concerted effort to step down the Medicaid appropriation from MSA funds to reduce the gap and keep the trust fund solvent. Although good news, the trust fund's balance is \$4.3 million compared to over \$30 million when the fund began. Fortunately, the legislature included language in the budget bill that requires the Department of Health, the Tobacco Evaluation and Review Board and the Blueprint for Health to develop a sustainability plan through fiscal year 2016, and present this to the legislature in January 2013.

We pushed hard for passage of House Bill 747, an omnibus tobacco prevention bill that included our third priority: increasing the price of certain little cigars. Although the bill faced challenges in the Senate, it passed in the last few days of the session thanks to vigilant members of the House Committee on Human Services. The language addressing the cigar tax expands the weight definition of little cigars so that slightly heavier cigars are taxed at a higher rate, equal to a pack of cigarettes. The sale of electronic cigarettes is now prohibited to minors as well.

Finally, commercial roll-your-own cigarette machines were prohibited.

The American Lung Association in Vermont and its partners in the Coalition for a Tobacco Free Vermont will continue to work hard to ensure that MSA and trust fund dollars are used for tobacco control and prevention. In addition, the Lung Association will work with partners to review the tobacco products' tax structure and work to ensure price equity.

Vermont State Facts

Economic Costs Due to Smoking:	\$434,237,000
Adult Smoking Rate:	19.0%
High School Smoking Rate:	13.0%
Middle School Smoking Rate:	3.0%
Smoking Attributable Deaths:	830
Smoking Attributable Lung Cancer Deaths:	264
Smoking Attributable Respiratory Disease Deaths:	248

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school and middle school smoking rates (rounded to nearest whole number) are taken from the 2011 Youth Risk Behavioral 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Vermont

372 Hurricane Lane, Suite 101

Williston, VT 05495

(802) 876-6500

www.lung.org/vermont

Virginia Report Card

Tobacco Prevention and Control Program Funding:

F

FY2013 State Funding for Tobacco Control Programs:	\$8,371,777
FY2013 Federal Funding for State Tobacco Control Programs:	\$2,907,480*
FY2013 Total Funding for State Tobacco Control Programs:	\$11,279,257
CDC Best Practices State Spending Recommendation:	\$103,200,000
Percentage of CDC Recommended Level:	10.9%

*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
Casinos/Gaming Establishments:	No provision
Bars:	Restricted
Retail Stores:	Restricted
Recreational/Cultural Facilities:	Restricted
Penalties:	Yes
Enforcement:	Yes
Preemption:	Yes
Citation:	VA. CODE ANN. §§ 15.2-2820 to 15.2-2828

Cigarette Tax:

F

Tax Rate per pack of 20: \$0.30



Thumbs down for Virginia for having the second lowest cigarette tax in the country at 30 cents per pack.

Cessation Coverage:

F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **All health plans cover NRT Patch and Bupropion (Zyban); coverage for NRT Gum, NRT Nasal spray, NRT Inhaler, NRT Lozenge and Varenicline (Chantix) varies by plan**

Counseling: **All health plans cover individual counseling; coverage for group counseling varies by plan**

Barriers to Coverage: **Barriers to coverage vary by health plan***

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers NRT Gum, NRT Patch, NRT Inhaler, Varenicline (Chantix) and Bupropion (Zyban)**

Counseling: **Covers phone counseling**

Barriers to Coverage: **Limits on duration, co-payments required for some medications, prior authorization required in some instances and use of counseling required to get medications**

STATE QUITLINE:

Investment per Smoker: **\$0.42; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [Virginia Tobacco Cessation Coverage page](#) for specific sources.

*Barriers could include: Limits on duration, annual or lifetime limits on quit attempts, requiring prior authorization, requiring co-payments, requiring using one or more cessation treatments before using others and/or requiring the use of counseling to receive medications.

Virginia State Highlights:



Increasing awareness and support for advanced tobacco control measures remains a top priority for the American Lung Association in Virginia.

Identifying state and local opportunities, the Lung Association continues to work with key public health leaders to advocate for stronger tobacco control measures that would mitigate the severe health consequences of tobacco exposure and improve public health for both individuals and communities. In 2012, the Lung Association sought to expand awareness of the benefits of increased tobacco taxes, the negative effects of secondhand smoke exposure, and the need for adequate funding for tobacco control programs.

During the 2012 legislative session, a bill that would increase the state's tobacco tax was once again introduced. House Bill 160 would have increased the cigarette tax rate from 30 cents per pack to \$1.45 per pack while also increasing the excise tax on roll-your-own and certain other tobacco products.

House Bill 160 would not only have increased the tax on tobacco products reducing youth consumption but the additional revenue from the tax increase would have been distributed to key state programs:

- Four percent to the Virginia state tobacco Quit-line
- Four percent to the Virginia Foundation for Healthy Youth to fund tobacco prevention and cessation programs
- 92 percent to increase appropriations to localities for car tax relief

The Lung Association worked with key partners, including the American Cancer Society, American Heart Association and Campaign for Tobacco Free Kids to bolster community support and led efforts to establish the new Tobacco Free Alliance of Virginia (TFAV). The official kick-off event for the alliance was held in conjunction with a press conference announcing the introduction of HB 160 and a lobby day to provide the opportunity to build further support within the General Assembly.

Despite the efforts of key leaders, members of the public health community, and a strengthened tobacco coalition, the legislation was unable to gain traction and lacked the support needed to advance out of committee.

The Lung Association's efforts did not end there. In addition to advocating at the General Assembly, the Lung Association began to work on a local project to educate about the benefits of and increase access to tobacco-free public school environments, including all school property and off-campus school sponsored events, in select communities in Southwest Virginia, a region that has some of the highest rates of tobacco use and tobacco-related disease in the entire state. This work is ongoing through 2013.

Dedicated to reducing the toll that tobacco use and exposure has on the Commonwealth, the American Lung Association in Virginia will continue to focus on creating awareness for the deadly impacts of tobacco and providing solutions to the community in order to achieve a healthier population.

Virginia State Facts

Economic Costs Due to Smoking:	\$4,737,271,000
Adult Smoking Rate:	20.8%
High School Smoking Rate:	15.0%
Middle School Smoking Rate:	3.6%
Smoking Attributable Deaths:	9,241
Smoking Attributable Lung Cancer Deaths:	3,136
Smoking Attributable Respiratory Disease Deaths:	2,348

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2009 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Virginia

9702 Gayton Road, #110
 Richmond, VA 23238
 (804) 955-4910
www.lung.org/virginia

Washington Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$2,485,000
FY2013 Federal Funding for State Tobacco Control Programs:	\$2,568,322*
FY2013 Total Funding for State Tobacco Control Programs:	\$5,053,322
CDC Best Practices State Spending Recommendation:	\$67,300,000
Percentage of CDC Recommended Level:	7.5%

*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
Casinos/Gaming Establishments:	Prohibited (tribal establishments exempt)
Bars:	Prohibited
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	Yes
Citation:	WASH. REV. CODE §§ 70.160.010 et seq.

Cigarette Tax: **A**

Tax Rate per pack of 20:	\$3.025
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Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **All health plans cover Varenicline (Chantix); coverage for other medications* varies by plan**

Counseling: **Fee-for-service Medicaid plan covers individual counseling; some health plans cover phone counseling**

Barriers to Coverage: **Barriers to coverage vary by health plan****

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All health plans cover NRT Gum, NRT Patch and Varenicline (Chantix); coverage for NRT Nasal spray, NRT Inhaler, NRT Lozenge and Bupropion (Zyban) vary by health plan**

Counseling: **Some health plans cover group and/or phone counseling**

Barriers to Coverage: **Use of counseling to get medications required for all health plans; some plans have annual limits on quit attempts, require prior authorization and/or require co-payments**

STATE QUITLINE:

Investment per Smoker: **\$2.34; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

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

*Other medications are: NRT Gum, NRT Patch, NRT Nasal spray, NRT Inhaler, NRT Lozenge and Bupropion (Zyban).

**Barriers could include: Limits on duration, annual or lifetime limits on quit attempts, requiring prior authorization, requiring co-payments, requiring using one or more cessation treatments before using others and/or requiring the use of counseling to receive medications.

Washington State Highlights:



The American Lung Association in Washington has an established history of successfully working with partners, stakeholders and grassroots advocates in fighting for and supporting public policies that protect Washingtonians from tobacco's deadly health effects. The Lung Association remains vigilant in defending the state's comprehensive smokefree law, working on laws addressing tobacco use by youth and supporting policies that help those addicted to tobacco to quit.

The Lung Association once again worked to fight off attempts to weaken Washington's clean indoor air law. Legislation introduced in 2011 was brought to life again during the 2012 legislative session. The bill would have established special license endorsements for cigar lounges and retail tobacconist shops, opening up the possibility of smoking in workplaces in over six hundred businesses.

Polling was done just prior to the beginning of the 2012 legislative session. Poll results showed that 71 percent of Washington voters opposed the rule that would allow cigar smoking in bars and restaurants.

Armed with evidence of strong public support, the Lung Association and advocates were able to thwart attempts to once again allow smoking in public places in the state, exposing workers and the public to secondhand smoke.

A struggling economy and weak revenue forecasts continued in 2012, dashing hopes of re-establishing Washington's once successful tobacco prevention and control program. The program was victim to regular cuts and was completely eliminated at the end of the 2011 legislative session leaving Washington as one of the only states without quitline services available for residents throughout the state. The Lung Association and its public health partners worked to secure some funding and were successful in getting \$1.7 million from state funds to re-open and operate the quitline. The Department of Health worked to secure additional funding to promote the quitline to ensure residents knew the quitline was once again open and available to provide tobacco cessation services.

Funding was also maintained to provide smoking cessation benefits for persons enrolled in Washington's Medicaid program.

The American Lung Association in Washington will

continue working to re-instate the tobacco prevention and control program. This will continue to be a priority for partners and stakeholders. Work will continue to protect Washington's youth and disparate populations from the deadly impacts of tobacco use.

Washington State Facts

Economic Costs Due to Smoking:	\$3,763,962,000
Adult Smoking Rate:	17.4%
High School Smoking Rate:	14.4%
Middle School Smoking Rate:	7.3%
Smoking Attributable Deaths:	7,619
Smoking Attributable Lung Cancer Deaths:	2,472
Smoking Attributable Respiratory Disease Deaths:	2,164

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school (10th grade only) and middle school (8th grade only) smoking rates are taken from the 2008 Washington State Healthy Youth 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Washington

822 John Street
Seattle, WA 98109
(206) 441-5100
www.lung.org/washington

West Virginia Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$5,650,000
FY2013 Federal Funding for State Tobacco Control Programs:	\$2,132,328*
FY2013 Total Funding for State Tobacco Control Programs:	\$7,782,328
CDC Best Practices State Spending Recommendation:	\$27,800,000
Percentage of CDC Recommended Level:	28.0%

*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:	Restricted
Restaurants:	No provision
Casinos/Gaming Establishments:	No provision
Bars:	No provision
Retail Stores:	No provision
Recreational/Cultural Facilities:	No provision
Penalties:	Yes
Enforcement:	No
Preemption:	No

Citation: W. VA. CODE §§ 16-9A-4 & 31-20-5b; WV Div. of Personnel Policy, Smoking Restrictions in the Workplace; WV CSR §§ 64-21-10, 64-21-20 & 126-66-1 et seq.

Note: The Smokefree Air grade only examines state tobacco control law and does not reflect local smokefree ordinances. All 49 local boards of health and several communities in West Virginia have policies or regulations of varying strength regulating secondhand smoke exposure.

Cigarette Tax: **F**

Tax Rate per pack of 20:	\$0.55
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Cessation Coverage: **F***

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Coverage for NRT Gum, NRT Patch, NRT Nasal spray, NRT Inhaler, NRT Lozenge and Bupropion (Zyban) covered for members enrolled in enhanced benefits package**

Counseling: **Coverage for group counseling varies by health plan**

Barriers to Coverage: **Limits on duration and annual limits on quit attempts; prior authorization, co-payments, use of some treatments before using others and use of counseling to get medications required**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers all 7 recommended cessation medications****

Counseling: **Covers individual counseling**

Barriers to Coverage: **Lifetime limit on quit attempts and co-payments required for some medications**

STATE QUITLINE:

Investment per Smoker: **Data not reported; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Citation: See [West Virginia Tobacco Cessation Coverage page](#) for specific sources.

*Due to data to calculate a current quitline investment per smoker being unavailable, West Virginia was graded based on tobacco cessation coverage for Medicaid enrollees and state employees only.

**The 7 recommended cessation medications are: NRT Gum, NRT Patch, NRT Nasal spray, NRT Inhaler, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban).

West Virginia State Highlights:



The American Lung Association in West Virginia continues to fight for an increase in the excise tax on cigarettes and smokefree workplace laws at the local level.

Efforts continued during the 2012 legislative session to increase the excise tax on cigarettes. A bill was introduced in the West Virginia State Senate to increase West Virginia's excise tax on tobacco by \$1.00 per pack with half of the revenue directed to help fund a tobacco control and prevention program at the level recommended by the Centers for Disease Control and Prevention. Unfortunately, the bill never made it out of committee.

With our local and statewide coalitions, the Lung Association has been making steady progress through the enactment of county-level clean indoor air Board of Health regulations that prohibit smoking in some or all public places and workplaces. All 49 county boards of health and several municipalities in West Virginia have laws or regulations restricting smoking of varying strength, and a number of them prohibit smoking in virtually all public places and workplaces. In 2012, both Monongalia and Greenbrier counties joined the list of counties with comprehensive smokefree regulations.

Although the West Virginia legislature securitized Master Settlement Agreement funds back in 2007, the Lung Association has worked hard to maintain a \$5.65 million budget for tobacco cessation and education programming. And we were once again successful, as the program ended up being funded at the same amount in fiscal year 2013.

Although not funded at an adequate level, West Virginia's tobacco control program has made some smart investments with its limited resources. The West Virginia tobacco quitline is open and free of charge to all West Virginia residents, and offers multiple telephone counseling sessions and medications to help tobacco users quit.

Other bills introduced included a bill to prohibit flavored tobacco products, including cigars, smokeless tobacco and hookah tobacco although menthol and mint flavors were excluded. Bills were also introduced in the House and Senate to make persons or stores that allow the use of roll-your-own cigarette machines for commercial purposes tobacco product manufacturers. This would mean taxes on cigarettes apply to the cigarettes produced by the machines,

and would subject these persons to a number of additional regulations. However, none of these bills ended up being approved by the legislature.

In 2013, the American Lung Association in West Virginia will continue to lead the fight to raise West Virginia's low cigarette excise tax. West Virginia has the 2nd highest smoking rate in the country for adults at 28.5 percent, so action is clearly needed to motivate adults to quit and prevent kids from starting to smoke in the first place.

West Virginia State Facts	
Economic Costs Due to Smoking:	\$1,727,637,000
Adult Smoking Rate:	28.5%
High School Smoking Rate:	19.1%
Middle School Smoking Rate:	8.3%
Smoking Attributable Deaths:	3,821
Smoking Attributable Lung Cancer Deaths:	1,238
Smoking Attributable Respiratory Disease Deaths:	1,068

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school smoking rate is taken from the 2011 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2011 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in West Virginia

P.O. Box 3980
 Charleston, WV 25339-3980
 (304) 342-6600
www.lung.org/westvirginia

Wisconsin Report Card

Tobacco Prevention and Control Program Funding: **F**

FY2013 State Funding for Tobacco Control Programs:	\$5,315,000
FY2013 Federal Funding for State Tobacco Control Programs:	\$2,064,385*
FY2013 Total Funding for State Tobacco Control Programs:	\$7,379,385
CDC Best Practices State Spending Recommendation:	\$64,300,000
Percentage of CDC Recommended Level:	11.5%

*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
Casinos/Gaming Establishments:	Prohibited (tribal establishments exempt)
Bars:	Prohibited (allowed in existing tobacco bars)
Retail Stores:	Prohibited
Recreational/Cultural Facilities:	Prohibited
Penalties:	Yes
Enforcement:	Yes
Preemption:	Limited
Citation:	WI STAT. ANN. § 101.123

Cigarette Tax: **B**

Tax Rate per pack of 20:	\$2.52
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Cessation Coverage: **F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal Spray, NRT Inhaler, Varenicline (Chantix) and Bupropion (Zyban)**

Counseling: **All health plans cover individual counseling; some plans cover group counseling**

Barriers to Coverage: **Minimal co-payments required**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Covers NRT Patch, NRT Inhaler, NRT Nasal spray, Varenicline (Chantix) and Bupropion (Zyban)**

Counseling: **Covers individual counseling**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts and co-payments required**

STATE QUITLINE:

Investment per Smoker: **\$1.21; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

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

Wisconsin State Highlights:



The American Lung Association in Wisconsin is the state's oldest voluntary health agency and a leader in the fight against tobacco use. Along with our partners in the Smoke Free

Wisconsin coalition, we have scored major victories in reducing smoking, particularly among youth, through increasing the cigarette tax to \$2.52 per pack, passing a statewide smokefree air law, and protecting the state tobacco prevention and control program.

2012 was a year of political turmoil for the state with recall efforts aimed at the Governor and several state senators. The Governor successfully fought back the challenge but several Republicans in the state Senate were recalled giving Democrats a one seat majority in the state Senate briefly. However, power shifted back to the Republicans after the November 2012 elections, once again giving them full control of the Senate, Assembly and Governor's office.

2012 also was a non-budget year so funding for the Tobacco Prevention and Control Program remained stable, although at its lowest level (\$5.3 million per year) in its 10 plus year history. Efforts to restore at least a small part of the cuts made in 2011 will be a part of the 2013 legislative agenda.

The Lung Association also continues in its efforts to curtail the further spread of candy and fruit flavored tobacco products, including the newest smokeless varieties, snus, sticks and orbs, as well as little cigars. Our efforts will be directed to creating tax parity between cigarettes and other tobacco products, eliminating the price advantage these products now enjoy.

Finally, the American Lung Association in Wisconsin remains on the alert for weakening amendments to Wisconsin's comprehensive smokefree workplace law, and will continue to monitor legal developments affecting stores that allow the use of roll-your-own cigarette machines for commercial purposes. The federal transportation bill designating these roll-your-own shops as "manufacturers" was a major blow to the industry, but attempts to regroup and find other loopholes to allow these stores to operate are still underway. In all likelihood, our tax parity proposal in 2013 will include RYO products, taxing them equally with packaged cigarettes and thus eliminating their price advantage too.

Wisconsin State Facts

Economic Costs Due to Smoking:	\$3,657,509,000
Adult Smoking Rate:	20.8%
High School Smoking Rate:	13.1%
Middle School Smoking Rate:	2.5%
Smoking Attributable Deaths:	7,240
Smoking Attributable Lung Cancer Deaths:	2,212
Smoking Attributable Respiratory Disease Deaths:	1,955

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school and middle school smoking rates are taken from the 2012 Wisconsin 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Wisconsin

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 Brookfield, WI 53005-2508
 (262) 703-4200
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Wyoming Report Card

Tobacco Prevention and Control Program Funding: **C**

FY2013 State Funding for Tobacco Control Programs:	\$5,400,000
FY2013 Federal Funding for State Tobacco Control Programs:	\$535,035*
FY2013 Total Funding for State Tobacco Control Programs:	\$5,935,035
CDC Best Practices State Spending Recommendation:	\$9,000,000
Percentage of CDC Recommended Level:	65.9%

*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
Casinos/Gaming Establishments:	No provision
Bars:	No provision
Retail Stores:	No provision
Recreational/Cultural Facilities:	No provision
Penalties:	No
Enforcement:	No
Preemption:	No
Citation:	Wyoming State Govt. Non-Smoking Policy

Cigarette Tax: **F**

Tax Rate per pack of 20:	\$0.60
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Cessation Coverage: **C***

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Lozenge, Varenicline (Chantix) and Bupropion (Zyban)**

Counseling: **Covers individual counseling**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts and minimal co-payments required**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **Data not reported**

Counseling: **Data not reported**

Barriers to Coverage: **Data not reported**

STATE QUITLINE:

Investment per Smoker: **\$11.21; CDC recommends an investment of \$10.53/smoker**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

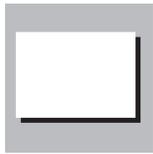
Citation: See [Wyoming Tobacco Cessation Coverage page](#) for specific sources.



Thumbs up for Wyoming for exceeding the CDC-recommended investment per smoker for its state quitline

*Due to current data on tobacco cessation coverage for state employees being unavailable, Wyoming was graded based on cessation coverage under Medicaid and quitline investment per smoker only.

Wyoming State Highlights:



The American Lung Association in Wyoming works through local and statewide tobacco coalitions to bring about public policy changes to benefit the health of the people of Wyoming.

Ongoing partnerships share the mission of decreasing tobacco use through evidence based practices such as increasing tobacco taxes, promoting smoke-free policies at the local level and funding comprehensive tobacco prevention programs.

Wyoming remained committed to funding tobacco prevention and cessation programs in 2012. During Wyoming's short 2012 legislative session focused almost exclusively on the two-year state budget, funding levels were maintained by the state legislature at about \$5.4 million per year.

In June, the Casper City Council passed a comprehensive smokefree ordinance by a 6 to 2 vote. The ordinance makes all public places, including bars, restaurants and private clubs smokefree. Unhappy with this outcome, opponents of the ordinance threatened to bring this decision to the voters on the November 2012 ballot and began collecting signatures soon after the ordinance was approved by city council. Notably, opponents were unable to even gather enough signatures to place the ordinance before voters, which then took effect as scheduled on September 1.

Casper is Wyoming's second largest city in population with about 56,000 people and they join several other cities in Wyoming, including Burlington, Cheyenne, Evanston, Laramie and Mountain View in providing healthy smokefree public places for their citizens.

The American Lung Association in Wyoming will continue working to protect people from the dangers of secondhand smoke by strengthening local smoke-free air laws in 2013 with future efforts to include pursuing a statewide smokefree law.

Wyoming State Facts

Economic Costs Due to Smoking:	\$315,154,000
Adult Smoking Rate:	22.9%
High School Smoking Rate:	22.0%
Middle School Smoking Rate:	5.3%
Smoking Attributable Deaths:	700
Smoking Attributable Lung Cancer Deaths:	190
Smoking Attributable Respiratory Disease Deaths:	250

Adult smoking rate is taken from CDC's 2011 Behavioral Risk Factor Surveillance System. High school and middle school smoking rates are taken from the 2011 Youth Risk Behavioral 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 2000-2004 and are calculated for persons aged 35 years and older. They do not take into account deaths from burns or secondhand smoke. Respiratory diseases include pneumonia, influenza, bronchitis, emphysema and chronic airway obstruction. The estimated economic impact of smoking is based on smoking-attributable health care expenditures in 2004 and the average annual productivity losses for the period 2000-2004.

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

American Lung Association in Wyoming

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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

Now in its second century, the American Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease. With your generous support, the American Lung Association is "Fighting for Air" through research, education and advocacy. 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.

