



Additional Materials

1. Tobacco's Toll in the USA
2. FDA Regulation: A Common-Sense Plan to Protect Kids From Tobacco
3. Large Public Health Benefits, Cost Savings and New Revenues From Substantial Federal Tobacco Tax Rate Increases
4. Quitlines Help Smokers Quit
5. Medicaid and Medicare Should Provide Access to comprehensive Tobacco Cessation Treatments
6. Tobacco Control Programs Save Money
7. State and Community-Based Tobacco Control Programs effectively reduce Tobacco Use



TOLL OF TOBACCO IN THE UNITED STATES OF AMERICA

Tobacco Use in the USA

- High school students who are current (past month) smokers: 20.0% or 3.5 million [Boys: 21.3% Girls: 18.7%]
- High school males who currently use smokeless tobacco: 13.4% [Girls: 2.3%]
- Kids (under 18) who try smoking for the first time each day: 3,500+
- Kids (under 18) who become new regular, daily smokers each day: 1,000+
- Kids exposed to secondhand smoke at home: 15.5 million
- Workplaces that have smoke-free policies: 68.6%
- Packs of cigarettes consumed by kids each year: 800 million (roughly \$2.0 billion per year in sales revenue)
- Adults in the USA who smoke: 19.8% or more than 45 million [Men: 22.3% Women: 17.4%]

Deaths & Disease in the USA from Tobacco Use

- People who die each year from their own cigarette smoking: approx. 400,000
- Adult nonsmokers who die each year from exposure to secondhand smoke: approx. 50,000
- Kids under 18 alive today who will ultimately die from smoking (unless smoking rates decline): 6,000,000+
- People in the USA who currently suffer from smoking-caused illness: 8.6 million

Smoking kills more people than alcohol, AIDS, car accidents, illegal drugs, murders, and suicides combined, with thousands more dying from spit tobacco use. Of the roughly 400,000 kids who become new regular, daily smokers each year, almost a third will ultimately die from it. In addition, smokers lose an average of 13 to 14 years of life because of their smoking.

Tobacco-Related Monetary Costs in the USA

Total annual public and private *health care* expenditures caused by smoking: \$96 billion

- Annual Federal and state government smoking-caused Medicaid payments: \$30.9 billion [Federal share: \$17.6 billion per year. States' share: \$13.3 billion]
- Federal government smoking-caused Medicare expenditures each year: \$27.4 billion
- Other federal government tobacco-caused health care costs (e.g. through VA health care): \$9.6 billion

- Annual health care expenditures solely from secondhand smoke exposure: \$4.98 billion

Additional smoking-caused health costs caused by tobacco use include annual expenditures for health and developmental problems of infants and children caused by mothers smoking or being exposed to second-hand smoke during pregnancy or by kids being exposed to parents smoking after birth (at least \$1.4 to \$4.0 billion). Also not included above are costs from smokeless or spit tobacco use, adult secondhand smoke exposure, or pipe/cigar smoking.

Productivity losses caused by smoking each year: \$97 billion

[Only includes costs from productive work lives shortened by smoking-caused death. Not included: costs from smoking-caused disability during work lives, smoking-caused sick days, or smoking-caused productivity declines when on the job.]

Annual expenditures through Social Security Survivors Insurance for the more than 300,000 kids who have lost at least one parent from a smoking-caused death: \$2.6 billion

Other non-healthcare costs from tobacco use include residential and commercial property losses from smoking-caused fires (about half a billion dollars per year) and tobacco-related cleaning & maintenance (\$3 billion).

- Taxpayers yearly fed/state tax burden from smoking-caused gov't spending: \$70.7 billion (\$630 per household)
- Smoking-caused health costs and productivity losses per pack sold in USA (low estimate): \$10.28 per pack
- Average retail price per pack in the USA (including sales tax): \$4.20

Tobacco Industry Advertising & Political Influence

- Annual tobacco industry spending on marketing its products nationwide: \$13.4 billion (\$36+ million each day)

Research studies have found that kids are three times as sensitive to tobacco advertising than adults and are more likely to be influenced to smoke by cigarette marketing than by peer pressure; and that a third of underage experimentation with smoking is attributable to tobacco company advertising and promotion.

- Annual tobacco industry contributions to federal candidates, political parties, and PACS: Over \$3 million
- Annual tobacco industry expenditures lobbying Congress: Over \$20 million

Tobacco companies also spend enormous amounts to influence state and local politics; and, when threatened by the federal McCain tobacco control bill in 1998, spent more than \$125 million in direct and grassroots lobbying to defeat it. Since 1998, Altria (Philip Morris) has spent more on lobbying Congress than any other business.



Youth tobacco use. 2001 National Youth Risk Behavior Survey (YRBS). The 2006 National Youth Tobacco Survey (YTS), with a different methodology than the YTS, found that 19.7% of U.S. high school kids smoke and 13.4% of high school males use spit tobacco, but the results from the YRBS and YTS cannot be compared because they use different methodologies. Current smoker defined as having smoked in the past month. YRBS is done in odd-numbered years, YTS in even. See, also, Inst. for Social Research, Univ. of Mich., *Monitoring the Future Studies*, <http://monitoringthefuture.org/new.html>.

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FDA REGULATION:

A Common-Sense Plan To Protect Kids From Tobacco S. 625 / H.R. 1108

Background

Bipartisan legislation (S.625/H.R. 1108) has been introduced in the House by Representatives Henry Waxman and Tom Davis and in the Senate by Senators Kennedy and Cornyn that would grant the U.S. Food and Drug Administration (FDA) authority to regulate tobacco products. H.R. 1108 passed the House on July 30th by an overwhelming and bipartisan vote of 326 to 102. S.625 has passed the Senate Committee on Health, Education, Labor and Pensions and currently has 60 sponsors/cosponsors.

Why This Bill Is Needed

Tobacco use is the leading preventable cause of death in the United States, killing more than 400,000 Americans every year and resulting in \$96 billion in health care costs every year. Every day, approximately 3,500 kids will try a cigarette for the first time, and another 1,000 will become new, regular daily smokers. One-third of these kids will eventually die prematurely as a result of their addiction.

Despite tobacco's huge societal costs, tobacco products are the most unregulated consumer products on the market today; they are exempt from important and basic consumer protections, such as ingredient disclosure, product testing and restrictions on marketing to children.

What This Bill Will Do

H.R. 1108/S.625, the "Family Smoking Prevention and Tobacco Control Act," amends the Federal Food, Drug, and Cosmetic Act (FFDCA) to grant the Food and Drug Administration (FDA) the authority to regulate the advertising, marketing and manufacturing of tobacco products.

The bill adds a new chapter to the FFDCA to regulate tobacco products. Tobacco products would not be regulated under the "safe and effective" standard currently used for other products under the agency's purview, but under a new standard -- "appropriate for the protection of the public health."

The key features of H.R. 1108/S.625 are outlined below:

1. Reinstate FDA's 1996 Rule -- This legislation would require that the FDA's 1996 Rule, which restricted tobacco marketing and sales to youth, take effect within one year of enactment of the legislation. These regulations:

- Ban all outdoor tobacco advertising within 1,000 feet of schools and playgrounds,



- Ban all remaining tobacco-brand sponsorships of sports and entertainment events,
- Ban free giveaways of any non-tobacco items with the purchase of a tobacco product or in exchange for coupons or proof of purchase,
- Limit advertising in publications with significant teen readership as well as outdoor and point-of-sale advertising, except in adults-only facilities, to black-and-white text only,
- Restrict vending machines and self-service displays to adult-only facilities, and
- Require retailers to verify age for all over-the-counter sales and provide for federal enforcement and penalties against retailers who sell to minors.

2. Grant FDA specific authority to restrict tobacco marketing -- The Secretary of Health and Human Services (HHS) would be given authority to develop regulations that impose restrictions on the advertising and promotion of a tobacco product consistent with and to the full extent permitted by the first amendment to the Constitution. These regulations would be based on whether they would be appropriate for the protection of the public health as a whole.

3. Require detailed disclosure of ingredients, nicotine and harmful smoke constituents -- Tobacco companies would be required to give the FDA the information the agency needs to require changes to tobacco products to reduce the harm they cause and to better educate the public about the health effects of tobacco use and the dozens of carcinogens in tobacco products. For example, tobacco companies would be required to disclose to the FDA the ingredients in each existing tobacco product by brand and by quantity in each brand, including all smoke constituents. They must also inform the FDA of any changes to the product.

4. Allow FDA to require changes to tobacco products to protect the public health -- FDA would be granted authority to require changes in current and future tobacco products to protect public health, such as the reduction or elimination of harmful ingredients, additives and constituents. FDA would be granted authority to change nicotine yields; only Congress could ban nicotine from the product.

5. Strictly regulate “reduced harm” products -- This legislation would prohibit the use of descriptors, such as “light”, “mild” and “low” to characterize a product on labels or in advertising. In addition, a manufacturer must first file an application and receive an order before they market any tobacco product as presenting a “modified risk.” FDA would have authority to review the marketing of such products and determine if the applicant demonstrates that the product, as actually used by consumers, will significantly reduce harm and the risk of tobacco-related disease to individual tobacco users and benefit the health of the population as a whole – taking into account both users of tobacco products and persons who do not currently use tobacco products.

6. Require bigger, better health warnings -- This legislation would require stronger, more specific health warnings. H.R. 1108 would require health warnings to cover the top 30% of the front and rear panels of the package and would give FDA the authority to require graphic warning labels that cover 50% of the front and rear panels of the package. S. 625 would require warning labels to cover the top 50% of the front and rear panels of the package. Under the legislation, warnings must bear the word “warning” in capital letters and 17-point type, the FDA would be empowered to revise labeling requirements including text and format size, and the same warning labels would be required in advertising and must comprise at least 20% of the advertisement’s area.

7. Fund FDA activity through a user fee on manufacturers of cigarettes, cigarette tobacco and smokeless tobacco, allocated by market share -- The legislation allocates payment of all tobacco product-related FDA costs among the manufacturers of cigarettes,



cigarette tobacco and smokeless tobacco products sold in the United States, based on the manufacturers' respective shares of the entire U.S. tobacco product market.

Who Supports S.625/H.R. 1108

Public health organizations, including the American Cancer Society Cancer Action Network, American Heart Association, American Lung Association and the Campaign for Tobacco-Free Kids, have endorsed this legislation. This legislation also has the support of almost 700 public health, faith and other organizations from around the country. Recent surveys have indicated that 70 percent of voters support this common-sense legislation.



LARGE PUBLIC HEALTH BENEFITS, COST SAVINGS AND NEW REVENUES FROM SUBSTANTIAL FEDERAL TOBACCO TAX RATE INCREASES

Increasing the Federal tobacco tax is a win-win-win solution: a public health win that reduces smoking and saves lives, a financial win that raises much-needed revenue and reduces smoking-caused health care costs, and a political win because tobacco taxes have the strong support among the public, including likely voters.

Numerous economic studies, Surgeon General Reports, the 2007 Institute of Medicine report on tobacco control, and the 2007 report of the President's Cancer Panel have all confirmed the power of tobacco tax rate increases to sharply reduce tobacco use and related harms and costs, especially among youth, pregnant women, and persons with lower incomes. Larger tobacco tax rate increases will, of course, produce much larger amounts of revenue, public health benefits and future health care and other cost savings than smaller increases.

Some of the Public Health Benefits from Increasing the Federal Cigarette Tax Rate

Tax Increase Per Pack	Youth Smoker Decline	Fewer Future Youth Smokers	Fewer Adult Smokers	Smoking Caused Deaths Avoided	5-Year Smoking Harmed Births Avoided	5-Year Heart & Stroke Savings (Millions)	5-Year Smoking-Births Savings (Millions)	Overall Long-Term Health Savings (Billions)	Medicaid Share of Health Savings (Billions)	Medicare Share of Health Savings (Billions)
\$0.50	8.2%	259,400	832,700	738,100	202,900	\$402.3	\$344.9	\$36.3	\$6.1	\$7.0
\$0.61	10.0%	317,200	1,016,100	900,700	247,700	\$490.8	\$421.1	\$44.3	\$7.4	\$8.6
\$0.75	12.3%	390,400	1,249,700	1,108,300	304,550	\$603.4	\$517.7	\$54.5	\$9.1	\$10.6
\$1.00	16.3%	521,200	1,667,900	1,479,300	406,000	\$804.6	\$690.2	\$72.7	\$12.2	\$14.1

The current federal cigarette tax rate is only 39 cents per pack, and has fallen well behind inflation and cigarette company price and profit increases since it was last raised. Additional federal healthcare savings would be secured by military hospitals and VA healthcare services.

Raising Other Tobacco Product Tax Rates Will Expand Benefits and Revenues. Raising the federal tax rates on other tobacco products to match the increased cigarette tax rate would not only promote tax equity, but would also maximize related state revenues, public health benefits and cost savings. In fact, recent sales of smokeless tobacco products, cigars and roll-your-own tobacco have been increasing sharply while cigarette sales have declined, fueled in large part by lower federal and state tax rates on other tobacco products compared to the rates on cigarettes.

Small or Multi-Year Tobacco Tax Increases Are Weak and Ineffectual. Tax increases of less than 10% of the average pack price (currently about \$4.10 nationwide) do not produce significant public health benefits or cost savings because the cigarette companies can readily offset the beneficial impact of such small increases with temporary price cuts, coupons, and other retail-based promotions and discounts. Splitting a tax rate increase into separate, smaller increases over multiple years will similarly diminish if not eliminate the otherwise large public health benefits and related cost savings (and will also reduce revenues).

Voters and the General Public Strongly Support Tobacco Tax Increases. National and state polls across the country show overwhelming public support for tobacco tax increases. In a recent survey, for example, more than two-thirds of likely voters supported a 75-cent federal cigarette tax increase to fund the S-CHIP program. This support extends across party lines, from smokers and non-smokers alike, throughout all regions. Public and voter support is highest when a significant portion of the new tobacco tax revenues are used to prevent and reduce tobacco use and for other public health purposes.

Sources & Explanations: These projections are based on consensus research findings that a 10% cigarette price increase reduces youth smoking rates by 6.5% or more, adult rates by 2%, and total consumption by 4%, adjusted down to be conservative. All savings are in 2004 dollars in order to parallel the available CDC estimates, in 2004 dollars, that smoking annually causes \$96 billion in healthcare costs in the United States and more than \$97 billion in lost productivity. For citations to the data and research underlying the projections presented in the table and additional explanation, please see <http://www.tobaccofreekids.org/research/factsheets/pdf/0338.pdf>.



QUITLINES HELP SMOKERS QUIT

An increase in the federal cigarette excise tax to pay for SCHIP will motivate millions of smokers to try to quit smoking while still raising hundreds of millions of dollars to fund health care for uninsured children and families. Unfortunately, because of the addictive power of nicotine, most smokers fail when they try to quit smoking on their own, and many do not have access to proven interventions that would greatly enhance their chances of success.

That is why it is critical that at least a nickel's worth of new revenues from a tobacco tax increase be used to provide and promote quitlines and other services for those smokers who want to quit. Studies show that only 3-5 percent of smokers are able to quit without any quitting assistance.¹ Quitlines greatly increase the chances that a smoker will quit successfully. The U.S. Public Health Service's recently updated clinical practice guideline found that quitline counseling can more than double a smoker's chances of quitting and quitline counseling combined with medication (such as nicotine replacement therapy) can more than triple the chances of quitting.² Quitlines are a cost-effective and efficient way to reach a large number of smokers and dramatically increase success rates in quitting. It is only fair that smokers who are paying the tax get something in return – some help if they want to quit.

While all states now provide some level of quitline services, these services are nowhere near the level that the Centers for Disease Control and Prevention (CDC) recommends and are therefore simply not available to the vast majority of smokers. With additional funding from a federal tobacco tax, we can reach many more smokers and save many more lives.

Quitlines Work to Reduce Smoking

There is more evidence than ever before that quitlines are effective in helping tobacco users quit. In 2007, the Centers for Disease Control and Prevention (CDC) issued a guidance document, *Best Practices for Comprehensive Tobacco Control Programs*, in which CDC recommends that a key component of any effort to reduce the toll of tobacco include action to sustain, expand and promote quitline services.³

Quitlines can serve the following important purposes:

- Reach a large number of tobacco users in a cost-effective way by reaching racial and ethnic communities as well as uninsured and underserved populations
- Reduce access-related barriers to treatment by providing a free telephone number that is flexible to the caller's schedule
- Serve as a gateway to other cessation resources (e.g. medications), and in some cases link tobacco users to broader health-related information and resources (e.g., care for diabetes or hypertension)
- Provide local health providers with a place to refer a smoker for help with quitting
- Offer a treatment service that is appealing to a broad spectrum of people regardless of race/ethnicity, education level or area of residence (urban vs. rural)

Telephone counseling services have proven effective in helping people quit using tobacco and remain abstinent.⁴ An exhaustive review of the research literature in the U.S. Public Health Service's updated *Treating Tobacco Use and Dependence: 2008 Update—Clinical Practice Guideline* (PHS Guideline) found strong evidence to support the use of quitline counseling to help people quit.⁵

- An analysis of quitlines published in 2006 found that quitlines significantly increase quit rates compared to minimal or no counseling interventions and the addition of quitline counseling to medication significantly improves quit rates compared to medication alone.⁶



- A 2006 study published in the *Archives of Internal Medicine* found that smokers who received counseling and medications through a quitline were more than three times as likely to remain abstinent after quitting compared to smokers who received self-help materials through the mail and had access to brief advice from a primary care physician.⁷
- A 2005 analysis of Maine's HelpLine found that the program, which consisted of telephone counseling and free NRT, reached uninsured smokers who may have had limited access to health care. Forty-seven percent of smokers calling the HelpLine were either Medicaid beneficiaries or those without health insurance.⁸
- A 2000 study of the California quitline program, which was implemented in 1992, found that the quit rate for people who called the quitline was twice that of people who attempted to quit on their own. This difference could be attributed to the higher concurrent use of counseling and cessation medications.⁹
- Proactive counseling, in particular, helps smokers quit. Research suggests that one or two brief calls are less likely to provide a measurable benefit, while three or more calls increase the odds of quitting compared to brief advice, self-help materials or pharmacotherapy alone.¹⁰
- A 2007 study found that quitlines are an effective way to reach young adults, particularly those who smoke daily.¹¹
- Quitlines are most effective when they offer connections to other treatment resources, especially medications.¹² For example, when Minnesota's QUITPLAN helpline offered free nicotine replacement therapy to callers, the volume of calls to quitlines increased dramatically. Likewise, the quit rate also increased because of easier access to medications and counseling services.¹³
- Research indicates that state quitlines are well-received and effective among callers regardless of their race/ethnicity, education level, gender or area of residence (rural vs. urban).¹⁴

How Do Quitlines Work?

Quitlines are a telephone-based tobacco cessation counseling service that offer a variety of services to help tobacco users quit. Quitlines in each state offer different forms of assistance in varying degrees but are often constrained by budget issues. States determine what to offer based on the best evidence of what works, the needs of their population and budget constraints. The typical quitline model is a telephone counseling system where callers may speak directly with a counselor or callers are offered options from which they can select the services they need (e.g., self-help materials, counseling, medications, referral). Quitlines offer single or multi-session counseling to tobacco users. Multi-session counseling can be either proactive (the quitline proactively calls the smoker back for follow-up sessions) or reactive (the smoker has to initiate calls including any follow-up calls).

Quitlines are essential elements in the treatment process because they are free, flexible, can be tailored to the caller's needs and enable easy access for anyone who needs their services. A large majority of quitlines are open every day of the week, with a few offering 24-hour help, which increases convenience and accessibility.¹⁵ Most smokers prefer telephone services,¹⁶ and, by providing somewhat-anonymous services, people who would be intimidated in face-to-face settings can get the help they need.¹⁷ Eligibility criteria, length of counseling sessions and the number of sessions allowed vary across states.

To accommodate the range of needs from the variety of callers, quitlines provide services in many languages and tailor information to specific populations (i.e., pregnant women, smokeless tobacco users, different age groups). These services include:¹⁸



- Information mailed to the caller, including self-help materials
- Single-session counseling
- Multiple-session counseling with proactive follow-up to the caller
- Treatment aids, including medication, either free or at a discount
- Referrals to local services, including group programs or professional services
- Fax referrals from healthcare providers or other counselors that request quitline call smoker proactively
- Materials for non-smokers to provide to their healthcare providers and people they want to help quit
- Web-based information and services, including chat rooms, interactive counseling services, and emailing services with counselors

As noted previously, funding for state tobacco control programs varies widely across states and impacts the types and intensity of programs and services that are available. However, despite differences in current quitline funding, every state will benefit from the ability to offer enhanced quitline services. For example, with additional funding, states could choose from a number of potential enhancements:

- Extend the hours of operation
- Offer additional proactive counseling sessions
- Expand eligibility criteria so more population groups have access to the most intensive treatment
- Fully cover or discount the cost of FDA-approved cessation medications
- Offer counseling services in additional languages
- Promote the quitline more widely so more smokers know about it, and more are motivated to call

Current Quitline Efforts and the Need for Additional Resources

In 2004, the U.S. Department of Health and Human Services (HHS) established a toll-free, national telephone quitline network, 1-800-QUIT-NOW, to provide treatment support for people who wish to quit using tobacco.¹⁹ As of June 2006, all states including Washington, DC, have their own quitlines, which are accessible through HHS's telephone number,²⁰ however the level and quality of services available vary greatly depending on funding. Current funding for quitlines comes from a range of sources, including Master Settlement Agreement funds, tobacco tax revenues, federal or state governments, and private sources (i.e., foundations, insurance companies, grants).²¹

Since the 1-800-QUIT-NOW network was implemented, more than 750,000 calls have been received and re-routed to states. Call volume grew by 54 percent between 2005 and 2006 and by another 49 percent between 2006 and 2007.²² This volume, however, represents only one or two percent of all tobacco users. CDC has concluded that state quitlines could actually reach about ten percent of a state's tobacco users if the quitline is sufficiently promoted and nicotine replacement therapy is made more readily available.

Quitlines are a cost-effective way for states to provide a wide range of services for smokers who want to quit, particularly in light of the high cost of tobacco use to our health care system. Smokers, on average, have lifetime healthcare costs that are an estimated \$17,500 higher (in 2004 dollars) than those who do not smoke, despite smokers, on average, living shorter lives.²³ Tobacco use costs the nation nearly \$100 billion a year in health care bills, including more than \$30 billion in federal and state government Medicaid program costs. Studies indicate that for every smoker who quits in response to tobacco control measures, such as through a quitline, their total healthcare costs over the next five years would drop, on average, by approximately \$2,400.²⁴

Unfortunately, despite all the evidence regarding quitlines and broader tobacco prevention and cessation efforts, the states in total are only spending about 20 percent of what the CDC recommends for these life-saving programs. The quitline component, like the broader programs, are severely under-funded.

Cigarette Tax Hikes Increase Demand for Quitline Services



An increase in the federal excise tax will produce more calls to the state quitlines. It is therefore critical that the states have the resources to meet the new demand that will be generated. Quitlines have been a crucial tool for smokers who wish to quit following a state cigarette tax increase. State evidence shows that cigarette tax increases have prompted many smokers to seek help in quitting. For example, after the most recent cigarette tax increases in Michigan (from \$1.25 to \$2.00 per pack) and Montana (\$0.70 to \$1.70), smoker calls to the state smoking quitlines skyrocketed. In the six months after the tax increase, the Michigan quitline received 3,100 calls, compared to only 550 in the previous six months; and in Montana more than 2,000 people called in the first 20 days after the tax increase, compared to only 380 calls per month previously.²⁵ Likewise, in Texas and Iowa, the numbers of calls to their state quitlines have been much higher after each increased their cigarette taxes by \$1.00 in 2007, compared to the previous year.²⁶ Probably the most dramatic example is from Wisconsin, which received a record-breaking 20,000 calls to its state quitline in the first *two months* after its \$1.00 cigarette tax increase went into effect on January 1, 2008 – compared to typically 9,000 calls per year prior to the tax increase.²⁷ The evidence from the states is clear – when states increase their tobacco tax, the demand for assistance in quitting increases, and in many cases, increases dramatically. Given current economic conditions we would expect that the demand for quitline services would be even greater.

The network of quitlines requires additional funding and resources to reach the largest number of smokers and to have the greatest impact on tobacco use in the U.S. Inadequate funding limits quitlines' reach and effectiveness, and hinders access to the highest quality care possible, particularly for uninsured and underserved populations. If properly funded, designed, and implemented, however, quitlines could greatly reduce the number of smokers in the U.S.

Quitline Services Must Be Promoted

To reach its full potential in reducing smoking, a quitline must be widely promoted. It is not enough just to have the service. Smokers must not only be informed of the service but also motivated to call and understand enough about the quitline to be comfortable calling it. Promotions include a variety of activities to raise awareness about the service and increase call volume, such as mass media campaigns, promotion through community-based programs, education of healthcare providers to make referrals, and collaboration with other state agencies or programs to disseminate educational materials that include the quitline number. Promotions should strive to reach all populations who need quitline services, particularly those groups who are at high risk for smoking or are underserved. Of course, any promotion plan must include a plan to respond to an increase in demand for quitline services.

Several state examples demonstrate the importance of promotion to generate call volume:

- During 2005-2006, the Colorado tobacco control program targeted cessation interventions by employing different spokespersons in its televised promotions for the quitline. The number of African-Americans calling the state's quitline nearly doubled when the campaign featured an African-American sports celebrity.²⁸
- The Ohio Tobacco quitline informed smokers about the quitline through a mass media campaign and broad outreach to a diverse set of partners which resulted in the quitline receiving more than 100,000 calls between 2004 and 2007.²⁹
- California reached out to physicians and other tobacco cessation and prevention organizations to encourage them to refer patients or clients to the Helpline.³⁰
- The DC Quitline received a record number of calls in July and August of 2007, after TV public service announcements advertising the quitline started airing in June.³¹
- After the West Virginia Tobacco Cessation Program launched its Save Face-Stop Spit Tobacco Program, which included a TV commercial, calls to the state quitline increased by 41 percent.³²

As the evidence shows, quitlines are effective tools to aid tobacco users in the quitting process. The resources to which they connect callers and the services that they provide can significantly contribute in states' efforts to improve the public health of their citizens. Quitlines are not meant to replace existing treatment programs supported by health care delivery systems, but rather make successful connections and work with them to help tobacco users quit. They are far-reaching and enable people all over the



country to receive the support and services they need to quit. Because of the limited reach and resources of individual programs or health care providers, providing a central place where people can call in and receive all of the services or referrals to services that they need is cost-effective and efficient.

Campaign for Tobacco-Free Kids, October 23, 2008 /Meg Riordan & Ann Boonn

Related Campaign Factsheets (available at www.tobaccofreekids.org)

- *Benefits from Tobacco Use Cessation*
- *Key Elements of a Model Tobacco Use Treatment Benefit*
- *Tobacco Cessation Works: An Overview of Best Practices and State Experiences*
- *Resources for Quitting Smoking*

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MEDICAID AND MEDICARE SHOULD PROVIDE ACCESS TO COMPREHENSIVE TOBACCO CESSATION TREATMENTS

Despite reductions in smoking prevalence achieved since the first Surgeon General's report on the consequences of smoking in 1964, more than 43 million Americans continue to smoke.¹ 70 percent of smokers would like to quit, but because of the addictive power of nicotine, most smokers fail when they try to quit smoking on their own, and many do not have access to proven interventions that would greatly enhance their chances of success. Smoking accounts for over 400,000 deaths in the United States each year and costs the nation almost \$100 billion in health care costs annually.

The ultimate goal of cessation assistance is to help addicted users eliminate their dependence on tobacco products and completely stop their tobacco use. Tobacco users who attempt to quit typically require multiple attempts before achieving long-term abstinence. With effective cessation assistance, however, smokers can increase their chances of quitting for good. Moreover, with effective cessation assistance, those who relapse can prolong their time being tobacco-free and can more constructively handle their relapse, more quickly begin trying to quit again, and will quit for good sooner than those without access to cessation assistance.

Medicaid coverage for tobacco cessation treatments varies widely from state to state. According to a recent survey by the American Lung Association, only seven states offer comprehensive cessation benefits, including all FDA-approved cessation medications and group and individual counseling, to all Medicaid beneficiaries. Forty-two states provide coverage for at least one FDA-approved medication and twenty-seven states provide some form of cessation counseling.² However, every state that provides Medicaid coverage has at least one barrier to accessing coverage such as required co-payments which dissuade Medicaid clients from seeking assistance in helping them to quit smoking.

Since January 2006, Medicare has provided tobacco cessation and treatment coverage for beneficiaries, including intermediate and intensive cessation counseling and prescription medications (covered under Part D, but over-the-counter medications are not covered). However, this benefit is available only to smokers who have a disease or an adverse health effect linked to tobacco use, or who are taking a therapeutic agent whose metabolism or dosing is affected by tobacco use.³

Medicaid and Medicare programs should provide the range of tobacco cessation treatment services recommended in the May 2008 update of the U.S. Public Health Service (PHS), *Treating Tobacco Use and Dependence: 2008 Update - Clinical Practice Guideline*.⁴ Among the many recommendations, the Guideline finds evidence to support the availability of both counseling and drug treatment for all tobacco users to improve their chances of success (i.e., long-term abstinence). While quitting tobacco use is a difficult process that requires persistence, the Guideline concludes that tobacco users can greatly increase their chances of ultimately succeeding if they and their health care professionals apply the cessation measures that have been proven most effective. Furthermore, the Guideline strongly recommends full coverage of cessation treatment based on finding that “[p]roviding tobacco dependence treatments (both medication and counseling) as a paid or covered benefit by health insurance plans has been shown to increase the proportion of smokers who use cessation treatment, attempt to quit, and successfully quit.”

Campaign for Tobacco Free Kids, December 1, 2008 / Meg Riordan

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TOBACCO CONTROL PROGRAMS SAVE MONEY

It is well established that comprehensive statewide tobacco-prevention programs prompt sharp reductions in smoking levels among both adults and kids by both increasing the numbers who quit or cutback and reducing the numbers who start or relapse.* As shown by the experience of those states that already have comprehensive tobacco-prevention programs, these smoking reductions save thousands of people from suffering from the wide range of smoking-caused illnesses and other health problems, thereby producing enormous declines in state health care costs and other smoking-caused expenditures.

Immediate Savings

Substantial cost savings from getting adult smokers to quit begin to appear as soon as the smoking declines occur. While most of the healthcare savings from getting kids to quit smoking or never start do not appear until many years later, some savings from reducing youth smoking also appear immediately. Most notably, reducing smoking among pregnant women (including pregnant teens, who have especially high smoking rates) produce immediate reductions in smoking-caused pregnancy and birth complications and related healthcare costs. Research studies estimate that the direct additional healthcare costs in the United States associated just with the birth complications caused by pregnant women smoking or being exposed to secondhand smoke could be as high as \$2 billion per year or more, with the costs linked to each smoking-affected birth averaging \$1,142 to \$1,358.¹ And state Medicaid programs cover well over half of all births in the United States.²

Not surprisingly, program officials have announced that the Massachusetts comprehensive tobacco-prevention program, which began in 1993, quickly began paying for itself just through the declines in smoking among pregnant women in the state.³ In addition, research in California shows that its program, which began in 1989, reduced state healthcare costs by more than \$100 million in its first seven years just by reducing the number of smoking-caused low-birthweight babies, with more than \$11 million of those savings in the first two years.⁴ Subsequent research indicates that California's overall cost savings from reducing all smoking-affected births and birth complications during its first two years totaled roughly \$20 million.⁵

Similarly, smoking declines among parents (including teen parents) rapidly produce healthcare cost savings by immediately reducing smoking-triggered asthma and respiratory illness and other secondhand-smoke health problems among their children. Parental smoking has been estimated to cause direct medical expenditures of more than \$2.5 billion per year to care for smoking-caused problems of exposed newborns, infants, and children.⁶ And these estimates do not even include the enormous costs associated with the physical, developmental, and behavioral problems of smoking-affected offspring that not only occur during infancy but can extend throughout their entire lives.⁷

By quickly reducing the number of cigarettes smoked by adults and kids in the state each year, statewide tobacco-control programs also reduce other health problems, and related costs, caused by secondhand smoke. Adults and children with emphysema, asthma or other respiratory illnesses, for example, can suffer immediate distress from being exposed to cigarette smoke, which can even lead to hospitalization in some cases.⁸

Sharp drops in the major smoking-caused diseases (such as strokes, heart disease, and lung and other cancers), with large related savings, do not appear for several years after state adult smoking levels decline. But some small declines in these smoking-caused diseases do begin to occur immediately, with significant cost savings. In California, for example, the state tobacco control program's reductions to adult smoking in its first

* For extensive examples of real-world adult and youth smoking declines in states that have already initiated statewide tobacco-prevention programs, see TFK Factsheet, *Comprehensive Statewide Tobacco Prevention Programs Effectively Reduce Tobacco Use*, <http://www.tobaccofreekids.org/research/factsheets/pdf/0045.pdf>, and other related Factsheets at www.tobaccofreekids.org/research/factsheets/index6.shtml. For information on the structure of effective state programs, see TFK Factsheet, *Essential Elements of a Comprehensive State Tobacco Prevention Program*, <http://www.tobaccofreekids.org/research/factsheets/pdf/0015.pdf>, and the others at www.tobaccofreekids.org/research/factsheets/index7.shtml.



seven years produced healthcare costs savings of \$390 million just through the related declines in smoking-caused heart attacks and strokes, with more than \$25 million of those savings appearing in the first two years.⁹

Annual Cost Savings From An Established State Tobacco-Prevention Program

As noted, California's tobacco-control program secured substantial savings over the first seven years of its operation just from reducing smoking-affected births and smoking-caused heart attacks and strokes. Taken together, these savings more than covered the entire cost of the state's program over that time period, by themselves, and produced even larger savings in the following years.¹⁰ For every single dollar the state has been spending on the California program it has been reducing statewide healthcare costs by more than \$3.60 -- with reductions in other smoking-caused costs saving another six dollars or more.¹¹ Between 1990 and 1998 the California Tobacco Control Program saved an estimated \$8.4 billion in overall smoking-caused costs and more than \$3.0 billion in smoking-caused healthcare costs.¹² In addition, these savings estimates for California do not even reflect the fact that since 1988 (the year before the California tobacco-prevention began), the rates of lung and bronchus cancer in California have declined more than five times as fast as they have in a sample of other areas of the U.S. (-14.0% vs. -2.7%). This decline is not only saving thousands of lives but also saving the state millions of dollars in medical costs with projected future savings in the billions.¹³

Because it started later, and is a smaller state (which faces higher per-capita costs to implement some key tobacco-control elements), the Massachusetts program has not yet enjoyed as large per-capita savings as the California tobacco prevention program. But a report by an economist at the Massachusetts Institute of Technology in 2000 found that the state's program was already reducing statewide healthcare costs by \$85 million per year -- which means the state was annually reducing smoking-caused health care costs by at least two dollars for every single dollar it invested in its comprehensive tobacco-prevention efforts.¹⁴

More recent research has added to these findings to show that state programs secure even larger returns on investment for sustained funding of tobacco prevention at adequate levels over ten or more years. Most notably, a more recent study of California's tobacco prevention program found that for every dollar the state spent on its tobacco control program from 1989 to 2004, the state received tens of dollars in savings in the form of sharp reductions to total healthcare costs in the state.¹⁵ This study confirms that the cost-saving benefits from sustained state investments in effective tobacco control programs quickly grow over time to dwarf the state expenditures, producing massive gains for the state not only in terms of both improved public health and increased worker productivity but in reduced government, business, and household costs.

Similarly, an August 2008 Australian study found that for every dollar spent on a strong tobacco control program there (consisting primarily of aggressive anti-smoking television ads along with telephone quitlines and other support services to help smokers quit) the program reduced future healthcare costs by \$70 over the lifetimes of the persons the program prompted to quit. This savings estimate was based on the study's finding that for every 10,000 who quit because of the tobacco control program, more than 500 were saved from lung cancer, more than 600 escaped having heart attacks, at least 130 avoid suffering from a stroke, and more than 1700 were prevented from suffering from chronic obstructive pulmonary disease (COPD).¹⁶

Even Larger Future Savings From Early Tobacco-Program Smoking Declines

While impressive, the estimates of current savings compared to current costs overlook a critically important component of the cost savings from state tobacco-control. By prompting current adult and youth smokers to quit, helping former smokers from relapsing, and getting thousands of kids to never start smoking, state tobacco-prevention programs lock in enormous savings over the lifetimes of each person stopped from smoking. Put simply, the lifetime healthcare costs of smokers total at least \$16,000 more than nonsmokers, on average, despite the fact that smokers do not live as long, with a somewhat smaller difference between smokers and former smokers.¹⁷ That means that for every thousand kids kept from smoking by a state program, future healthcare costs in the state decline by roughly \$16 million (in current dollars), and for every thousand adults prompted to quit future health costs drop by roughly \$8.5 million.

These savings-per-thousand figures are significant, but it is important to note that in an average-sized state a one percentage point decline in adult smoking means that more than 30,000 adults have quit smoking, which translates into savings over their lifetimes of more than a quarter of a billion dollars in reduced smoking-caused healthcare costs. And maintaining a single one-percentage-point reduction in youth smoking in an average-



sized state will keep 16,000 kids alive today from ever becoming smokers, producing healthcare savings over their lifetimes of more than one quarter of a billion dollars, as well.¹⁸ Moreover, an adequately funded, comprehensive statewide tobacco-prevention program in any state should be able to reduce adult and youth smoking by much more than a single percentage point over just its first few years of operation. California, for example, reduced adult smoking rates by roughly one percentage point per year, above and beyond national adult smoking declines, during each of its first seven years.¹⁹ In the first three years of its youth-directed tobacco control program, Florida reduced high-school and middle-school smoking by almost three percentage points per year.²⁰ By reducing adult and youth smoking rates by five percentage points, an average-sized state would reduce future state smoking-caused healthcare costs by more than \$2.5 billion.

Along the same lines, the findings of a 2004 study show that if every state funded its tobacco prevention efforts at the minimum amount recommended by the U.S. Centers for Disease Control and Prevention (CDC), just the related declines in youth smoking would lock in future reductions in smoking-caused healthcare costs of more than \$31 billion.²¹ The related declines in adult smoking and in secondhand smoke exposure from the states making these CDC investments in tobacco prevention would lock in tens of billions of dollars in additional smoking-caused cost savings.

State Tobacco-Prevention Efforts and State Medicaid Program Savings

The long-term savings from state tobacco-prevention programs -- as well as the immediate and short-term savings outlined above -- also directly reduce state Medicaid program expenditures. For the average state, more than 17% of all smoking-caused healthcare expenditures within its borders are paid for by the state's Medicaid program (with actual state rates ranging from a low of slightly more than 10% for North Dakota and Delaware to more than 27% for Maine, New Hampshire and New York, and a high of 36% for Louisiana).²² Other state healthcare programs and the state's health insurance programs for government employees also accrue significant cost savings from the smoking declines prompted by state tobacco-prevention programs.

Can Other States Do As Well As California and Massachusetts?

States that establish comprehensive statewide tobacco-prevention programs should do at least as well, in terms of cost savings, as California and Massachusetts have in the past, and could do even better. By taking advantage of the knowledge and experience gained from the efforts in California, Massachusetts, and elsewhere, other states can design and initiate programs that are even more effective than those states' early efforts and can get up to full speed more quickly. Other states can also simply make larger investments in tobacco prevention. Massachusetts and California tobacco-control expenditures have only roughly matched or even fallen below the minimum funding recommendations of the U.S. Centers for Disease Control and Prevention (CDC). By matching or exceeding the CDC guidelines, and maintaining those funding levels over time, other states should secure even larger per-capita savings.

Campaign for Tobacco-Free Kids, October 7, 2008 / Eric Lindblom

Related Campaign Fact Sheets (available at <http://www.tobaccofreekids.org/research/factsheets>)

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STATE AND COMMUNITY-BASED TOBACCO CONTROL PROGRAMS EFFECTIVELY REDUCE TOBACCO USE

State and community-based tobacco control programs prevent kids from starting to smoking and help adult smokers quit. By reducing tobacco use, they play a crucial role in the prevention of many chronic conditions such as cancer, heart disease, and respiratory illness, thereby saving lives and healthcare dollars.

Recommendations for state tobacco prevention and cessation programs are clearly delineated in the Center for Disease Control and Prevention's *Best Practices for Comprehensive Tobacco Control Programs*. CDC recommends that states establish tobacco control programs that are comprehensive, sustainable, and accountable and include state and community interventions, public education interventions, cessation programs, surveillance and evaluation and administration and management.¹

KEY COMPONENTS

State and Community-Based Interventions: CDC recommends states implement a community-based model that focuses on making tobacco less desirable, less acceptable and less accessible. CDC's recommendations for community-based interventions are based on the practice-based model used in many states, which integrates local and statewide policies and programs, chronic disease programs, interventions aimed at influencing youth, and activities focused on eliminating tobacco-related disparities.

- **The Statewide component is** responsible for implementing a coordinated, comprehensive tobacco control program and providing the information, guidance and resources needed to implement effective community programs.
- **Community programs** are essential to reducing tobacco use and in fact are the foundation of any statewide tobacco control program. A significant portion of a state's tobacco control funding should be provided to diverse groups at the local level, including local government entities, community organizations, local businesses, and other community partners. These community coalitions reach people where they live, work, play, learn, and worship to prevent initiation and encourage smoking cessation.

Public Education Efforts: Research has demonstrated that tobacco industry marketing increases the number of kids who try smoking and become regular smokers. One of the best ways to reduce the power of tobacco marketing is an intense campaign to counter these pro-smoking messages. Health communication campaigns prevent smoking initiation, promote cessation and change social norms related to tobacco use. These efforts include multiple paid media (TV, radio, print, web-based, etc.), earned media (press releases, local events and promotions), and other efforts.

Helping Smokers Quit (Cessation): A comprehensive tobacco control program should not only encourage smokers to quit but also help them so. Most smokers want to quit but have a very difficult time because nicotine is so powerfully addictive. State programs make evidence based treatments available to smokers to enhance success. These interventions include counseling via telephone (quitlines), in-person sessions, and the web. Helping adult smokers quit not only achieves immediate reductions in disease, death, and healthcare costs; it also creates an environment in which kids are less likely to smoke.

EVIDENCE OF SUCCESS

The empirical evidence regarding the effectiveness of comprehensive tobacco prevention and cessation programs is vast and growing. In 2007, the Institute of Medicine and the President's Cancer Panel both issued landmark reports that concluded there is overwhelming evidence that state comprehensive state tobacco control programs substantially reduce tobacco use and recommended that every state fund such programs at CDC-recommended levels.²

*State and Community-Based Tobacco Control Programs Reduce Tobacco Use / 2*

Data from numerous states that have implemented programs consistent with CDC guidelines show significant reductions in youth and adult smoking. The most powerful evidence, however, comes from national studies that look across states and control for as many of the relevant confounding factors as possible. These rigorous studies consistently show effects of tobacco prevention and cessation programs.

A recent (2008) study published in the *American Journal of Public Health*, examined state tobacco prevention and cessation funding levels from 1995 to 2003 and found that the more states spent on these programs, the larger the declines they achieved in adult smoking, even when controlling for other factors such as increased tobacco prices. The researchers also calculated that if every state had funded their programs at the levels recommended by the U.S. Centers for Disease Control (CDC) during that period, there would have been between 2.2 million and 7.1 million fewer smokers in the United States by 2003.³ The Campaign for Tobacco-Free Kids estimates that such smoking declines would have saved between 700,000 and 2.2 million lives as well as between \$20 billion and \$67 billion in health care costs.

The study described above adds to earlier research, using similar methods, which demonstrated the same type of relationship between program spending and youth smoking declines. A 2005 study concluded that if every state had spent the minimum amount recommended by the CDC for tobacco prevention, youth smoking rates nationally would have been between three and 14 percent lower during the study period, from 1991 to 2000. Further, if every state funded tobacco prevention at CDC minimum levels, states would prevent nearly two million kids alive today from becoming smokers, save more than 600,000 of them from premature, smoking-caused deaths, and save \$23.4 billion in long-term, smoking-related health care costs.⁴

A 2003 study published in the *Journal of Health Economics* found that states with the best funded and most sustained tobacco prevention programs during the 1990s – Arizona, California, Massachusetts and Oregon – reduced cigarette sales more than twice as much as the country as a whole (43 percent compared to 20 percent). This study, the first to compare cigarette sales data from all the states and to isolate the impact of tobacco control program expenditures from other factors that affect cigarette sales, demonstrates that the more states spend on tobacco prevention, the greater the reductions in smoking, and the longer states invest in such programs, the larger the impact. The study concludes that cigarette sales would have declined by 18 percent instead of nine percent between 1994 and 2000 had all states fully funded tobacco prevention programs.⁵

Data from numerous states provide additional evidence of the effectiveness of comprehensive tobacco prevention and cessation programs in reducing tobacco use among both adults and youth. Washington and New York are just two examples of this success.

Program Success – Washington State

The Washington State Tobacco Prevention and Control program was implemented in 1999 after the state Legislature set aside money from the Master Settlement Agreement to create a Tobacco Prevention and Control Account. Tobacco prevention and control received additional funds in 2001 when the state's voters passed a cigarette tax increase that dedicated a portion of the new revenue to tobacco prevention and cessation. According to a recent study in CDC's peer-reviewed journal, *Preventing Chronic Disease*, although Washington made progress in implementing tobacco control policies between 1990 and 2000, smoking prevalence did not decline significantly until after substantial investment was made in the state's comprehensive tobacco control program.⁶ As the data below demonstrate, Washington's comprehensive program is working.

- Since the program began, Washington's tobacco prevention efforts have cut smoking by 60 percent among sixth graders, 58 percent among eighth graders, 40 percent among tenth graders, and 43 percent among twelfth graders. Because of these declines, there are 65,000 fewer youth smokers in Washington.⁷
- Since the tobacco control program was implemented, adult smoking has declined by 24 percent, from 22.4 percent in 1999 to 16.5 percent in 2007, one of the lowest smoking rates in the



country.⁸ Washington's dramatic decline in adult smoking translates to more than 240,000 fewer smokers in the state, saving about \$2.1 billion in future health care costs.⁹

Program Success – New York

New York began implementing a comprehensive state tobacco control program in 2000 with funds from the Master Settlement Agreement and revenue from the state cigarette tax. As the data below demonstrate, New York's comprehensive approach is working. While declines in youth smoking nationally have slowed, New York's rates continue to decline steadily.

- Between 2000 and 2006, smoking among middle school students declined by 61 percent, (from 10.5 percent to 4.1 percent), and smoking among high school students declined by 40 percent, (from 27.1 percent to 16.3 percent).¹⁰
- Between 2000 and 2006, adult smoking declined by 15 percent, from 21.6 percent to 18.3 percent.¹¹

Campaign for Tobacco-Free Kids, December 4, 2008 / Meg Riordan

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