State of Tobacco Control 2008

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Disclaimer

The American Lung Association State of Tobacco Control 2008 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 introduced or acted upon, or cases decided, after this book went to press. The cut-off date for new laws to be considered was January 1, 2009.

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Executive Summary

The American Lung Association State of Tobacco Control 2008 report tracks progress on key tobacco control policies at the state and federal level and assigns grades to tobacco control laws and regulations enacted as of January 1, 2009. The federal government, all 50 states plus the District of Columbia are graded on their tobacco control laws to determine if they are adequately protecting their citizens from the terrible burden caused by tobacco use.

Health care reform and the extraordinary human and financial toll caused by chronic disease played a prominent role in the 2008 elections—and for good reason. Chronic diseases account for 75 percent of the nation's medical care costs each year,[1] a tremendous financial toll. And at the very heart of chronic disease is tobacco-caused death and disease. Tobacco use remains the number one cause of preventable death in the United States and its costs to the health care system and the economy are breathtaking. The Centers for Disease Control and Prevention (CDC) estimates that in 2004, smoking cost the U.S. economy more than $193 billion—including $96 billion in health care costs and $97 billion in lost productivity.[2] These statistics make clear that tobacco prevention and cessation must be at the heart of any effective health care reform plan.

The simple fact that study after study shows that the states that enact the policies that have been proven to save lives—high tobacco product taxes, tobacco prevention and cessation programs funded at levels recommended by CDC and comprehensive smokefree laws—will reap the financial rewards. Yet, despite this evidence, not one state in the entire U.S. received solid As in this year's report.

Many states have hardworking tobacco control coalitions that continually encounter strong resistance from their state legislators and powerful tobacco interests. The grades given in this report in no way reflect the degree of effort expended by the public health community. Quite simply, the grades reflect how well a state's tobacco control laws measure up to the best in the nation or goals set by federal agencies such as the CDC.

"In New York, we have seen how effective anti-smoking programs can be. In 2002, I signed a law prohibiting smoking in all workplaces. There was a huge outcry, but then something happened: people loved it. Bars and restaurants saw their business increase. Waitresses kissed me and told me I had saved their lives. And pretty soon, cities and states around the country—along with England, Ireland, France, Italy and other countries with high rates of smoking—began passing similar laws. Along with the smoking ban, we raised cigarette taxes in New York, ran hard-hitting public-education campaigns and provided free nicotine patches. The result? After 10 years of seeing no decline in smoking, we've cut smoking rates by 21 percent—and we've cut teen smoking by more than 50 percent. There are 300,000 fewer smokers in New York City than there were six years ago."

— New York City Mayor Michael Bloomberg, September 29, 2008.[3]

Tobacco Companies Remain an Obstacle

The tobacco companies continue to be a significant barrier to the enactment of strong and effective tobacco control policies at the state and federal level. More than two years after a federal court judge found the major tobacco companies guilty of civil racketeering charges, they continue to throw their political weight around Capitol Hill and in state capitals across the country.

Money remains at the heart of the companies' political influence. Campaign contributions from tobacco company officials and their political action com-

mittees (PACs) continue to line the coffers of candidates running for federal and state office. Over $3 million was contributed to both Democratic and Republican federal candidates for office during the 2007–2008 election cycle by the industry and its employees.[4] Tobacco companies also seek influence in state governments through significant campaign contributions to gubernatorial, legislative and other state level candidates. According to the National Institute on Money and State Politics, in the 2008 cycle according to data available as of December 10, the industry contributed over $3 million to state level office seekers as well.[5]

Elected Officials Fail to Act Again

There is no doubt as to what steps need to be taken in order to reduce the human and financial costs due to tobacco use in the U.S. In 2007, two significant reports were issued, calling even further attention to the need for federal and state governments to take urgent action to reduce the nation's tobacco epidemic. The Institute of Medicine's report *Ending the Tobacco Problem: A Blueprint for the Nation* and a report issued by the President's Cancer Panel entitled *Promoting Healthy Lifestyles: Policy, Program and Personal Recommendations for Reducing Cancer Risk* clearly articulate the need for Congress to give the Food and Drug Administration authority over manufactured tobacco products, as well as for state governments to fully fund tobacco prevention and cessation programs, increase state cigarette taxes and pass comprehensive smokefree laws. Sadly, what continues to occur is the failure of elected officials to act.

Political leaders at all levels must be held accountable for their failure to fully implement proven policies to reduce the death and disease caused by tobacco use. Everyone—from individuals suffering from tobacco-caused diseases; the families of people who have lost their lives as a result of their addiction; workers exposed to secondhand smoke; children who are targeted by the tobacco industry to become the industry's "replacement generation" and their parents; the media; to the taxpayers who foot the bill—must play a role in ensuring our elected officials are doing the right thing. The American Lung Association is committed to leading the fight to eliminate tobacco use in the United States.

Updates to *State of Tobacco Control*

State of Tobacco Control 2008 has been updated to reflect the current science behind and new information about tobacco control policies that has been learned since the report was first issued in 2003. These changes are outlined below, and in further detail in the Methodology section of the report.

The federal government grading criteria has not changed: it is still graded on the level of its cigarette excise tax, regulation of tobacco products by the U.S. Food and Drug Administration (FDA), federal coverage of cessation services, and the Framework Convention on Tobacco Control (FCTC)—the international tobacco control treaty. In the state section, updates were made to the tobacco control and prevention funding and the smokefree air sections.

The CDC's revised spending levels for tobacco control and prevention

spending were released in October 2007, and this is the first year states have been evaluated on these new recommendations in the *State of Tobacco Control* report. The science associated with Best Practices is clear and unambiguous: implementation of prevention and cessation programs at these levels and within the parameters outlined will result in fewer lives lost and fewer dollars spent due to tobacco use.

In the summer of 2006, the U.S. Surgeon General released a landmark report declaring that there is no safe level of exposure to secondhand smoke. The new grading criteria for smokefree laws reflect that criteria: only states that have passed comprehensive smokefree laws, including bars and restaurants, that protect all workers and the public, will receive As in this category.

The most major change was the inclusion of state cessation coverage. With the addition of the cessation coverage section, which evaluates states' commitments to helping smokers quit, the American Lung Association has become the only source for up-to-date information on state coverage of cessation services for Medicaid recipients. As a result of this change, grades will no longer be issued for youth access to tobacco laws. Information about youth access laws can now be found in an appendix in this report or in more detail on the State Legislated Actions on Tobacco Issues (SLATI) website.

The cessation coverage grade evaluates the provision of tobacco cessation treatments under health plans (Medicaid, state employee plans and requirements for private insurance), and should not be viewed as a complete assessment of a state's tobacco cessation efforts. State quitlines in particular are extremely valuable parts of tobacco cessation efforts in many states that are for the most part not evaluated in this grade.

1. Centers for Disease Control and Prevention (CDC), Chronic Disease Prevention and Health Promotion, http://www.cdc.gov/nccdphp/overview.htm.
2. CDC. *Smoking-Attributable Mortality, Morbidity and Economic Costs (SAMMEC)*. Adult Software. Atlanta, GA: U.S. Department of Health and Human Services, CDC; 2008.
3. Bloomberg, Michael. "Health. The Way to Save Millions of Lives is to Prevent Smoking." *Newsweek*. September 29, 2008.
4. Center for Responsive Politics, based on data obtained from the Federal Election Commission, July 28, 2008.
5. Institute on Money in State Politics. Available at http://www.followthemoney.org/database/IndustryTotals.phtml?f=0&s=0&b[]=G3100.

2008 Tobacco Control Trends

The American Lung Association State of Tobacco Control 2008 highlights the following trends:

■ In 2008, Only Two States Meet the Lung Association's Smokefree Air Challenge

In January 2006, the American Lung Association issued its Smokefree Air Challenge, urging all states and localities to pass comprehensive legislation prohibiting smoking in all public places and workplaces by December 31, 2010. As of January 1, 2009, 23 states and the District of Columbia have met that challenge.

2008 was a disappointing year: only two states—Iowa and Nebraska—met the challenge, compared to five states in 2007 and six states and the District of Columbia in 2006.

The Lung Association's Smokefree map shows that just over half of the 50 states have yet to pass a comprehensive smokefree law to protect their citizens. 2009 will be a pivotal year in the Smokefree Air Challenge.

A poll conducted by Courier and Lee Enterprises in September 2008 shows a majority of Iowans approve of the state's smokefree law.

■ Despite Historic Votes in Congress, U.S. Fails to Implement Meaningful Tobacco Control Legislation

Despite making dramatic progress on tobacco control legislation in 2008, the federal government still failed to pass any major tobacco control legislation. As more nations ratify and implement the Framework Convention on Tobacco Control, assist smokers in quitting, pass comprehensive laws that protect all workers from secondhand smoke and regulate the marketing and manufacture of tobacco products, the U.S. has once again failed to make substantive progress on any of those fronts.

On July 30th, the House passed the Family Smoking Prevention and Tobacco Control Act (HR 1108) 326 to 102. This bipartisan, veto-proof majority marks the first time the House has ever passed this landmark legislation. However, the Senate did not take action on the legislation in its final weeks, despite having 60 cosponsors. The failure of the Senate to act means the legislation must start over again in the 111th Congress. It also means tobacco products will continue to go unregulated by the federal government—despite killing more than 392,000 people each year.

The Bush Administration again failed to send the **Framework Convention on Tobacco Control (FCTC)** to the U.S. Senate for ratification. As of December 10, 2008, 161 nations had ratified the treaty. Although the U.S. signed the treaty in May of 2004, the treaty continues to undergo "interagency review" according to Administration officials.

In 2008, Senator Dick Durbin (D-IL) and Representatives Diana DeGette (D-CO) and Todd Platts (R-PA) introduced legislation that would require

Medicare and Medicaid to offer comprehensive cessation benefits to its recipients. The American Lung Association strongly supports these bills and urges their passage, to help all smokers get the assistance they need in order to quit.

■ Improving Policies to Help Smokers Quit is an Emerging Trend in Tobacco Control

As states increase their excise taxes and prohibit smoking in workplaces and other public places, tobacco control and public health experts are calling on states to help smokers end their deadly addiction.

In May 2008, the U.S. Public Health Service issued *Treating Tobacco Use and Dependence: 2008 Update*. The updated guidelines make clear that recommended treatments for tobacco use should be covered by public and private health benefit plans. This is particularly true for smokers enrolled in Medicaid, who smoke at rates almost 50 percent higher than the national average. Nationwide, 32.6 percent of the Medicaid population smokes compared to 22 percent of the general population ages 18 to 65.[1] Direct costs related to smoking in the Medicaid program amounted to an average of $607 million per state in 2004.[2]

With the release of the American Lung Association's State of Tobacco Control 2008, public health advocates, the media and policymakers will for the first time ever have access to the only current source for information on states' coverage of cessation services for Medicaid populations and state employee health insurance plans. These valuable data will make it possible for state advocates to understand what services are currently offered by states and advocate for all of the benefits recommended by the U.S. Public Health Service. Increasing the number of former smokers in the U.S.—which already stands at 47 million—will reduce the amount of death and disease caused by tobacco in the U.S.[3]

No states received As for offering comprehensive cessation benefits with few barriers to their Medicaid populations and state employees. Six states—Minnesota, New Mexico, North Dakota, Oregon, Rhode Island and Wisconsin—received Bs. Alabama, Connecticut, Georgia, Kentucky, Missouri and Tennessee offer no cessation benefits to their entire Medicaid population, while six states do not require any cessation coverage benefits for state employees.

Telephone-based cessation counseling is one of the interventions recommended by the Task Force on Community Preventive Services' *Guide to Community Preventive Services*. While all states offer some quitline services to their residents, Idaho, Nebraska, New Hampshire, South Carolina and Virginia rely solely on federal funding and provide no additional state funding for telephone counseling services.

In 2008, Arizona, Nebraska and Washington passed laws increasing Medicaid recipients' access to lifesaving cessation benefits.

■ Few States Increase Tobacco Taxes, A Missed Opportunity to Save Lives and Raise Revenues

Mirroring the unfortunate trend with fewer states passing smokefree laws in 2008, only three states—Massachusetts ($1.00), New Hampshire ($0.25) and New York ($1.25) plus the District of Columbia ($1.00)—increased their state's excise tax on cigarettes in 2008; Hawaii and Vermont implemented scheduled increases passed in previous years. This brings the national cigarette tax average to $1.19 a pack. With its increase, New York state has the largest tax in the nation at $2.75 per pack, while South Carolina continues to have the lowest (7 cents), having failed to increase its tax again this year.

Tobacco taxes are a proven and effective way to raise much-needed rev-

enue for state programs, including tobacco prevention and cessation programs, as well as reduce the number of adults and youth who smoke. As more states wrestle with budget deficits, shortfalls in funding for Medicaid programs and higher than acceptable smoking rates, tobacco taxes present a win-win for state officials.

As the price for cigarettes continues to increase, states must ensure they are taxing non-cigarette tobacco products at equivalent rates in order to maximize their revenues and increase the number of smokers who quit. Some smokers are purchasing products similar to cigarettes that are less expensive, such as little cigars and roll-your-own tobacco. Many states have legal loopholes that exempt these products from being taxed at the same rates as cigarettes. An analysis from the U.S. Alcohol and Tobacco Tax and Trade Bureau shows that sales in cigarettes declined 4.5 percent the first five months of 2008 as compared to that same time period in 2007. At the same time, sales of so-called small or little cigars and roll-your-own tobacco increased by more than 20 percent.[4]

■ States Continue to Fail to Adequately Fund Tobacco Control Programs

Despite the overwhelming evidence making clear that investing in tobacco control programs saves lives and saves money, states continue to shortchange prevention and cessation efforts—with tragic and costly results.

In October of 2007, the CDC issued updated recommended spending levels for state tobacco prevention and cessation programs as part of its updated *Best Practices for Comprehensive Tobacco Control Programs*. These new levels take into account each state's population, smoking prevalence and other demographics, including its media markets.

Only Alaska and Delaware funded their tobacco programs at 80 percent or more of levels recommended by the Centers for Disease Control and Prevention, earning them As in the *2008 State of Tobacco Control* report. These states have recognized the wisdom of such an investment, which will reduce the death and disease as well as the fiscal burden caused by tobacco use.

Based on the revised funding level recommendations, 41 states and the District of Columbia receive an "F"—having funded their comprehensive tobacco control programs at less than 50 percent of the recommended level.

As part of the original terms of the MSA, bonus payments totaling $1 billion were made to states in 2008, giving states another opportunity to use the funds for their original purpose of financing comprehensive prevention and cessation programs. However, only eight states increased their funding for tobacco control programs this year.

November 2008 marked the 10-year anniversary of the signing of the Master Settlement Agreement, the 46-state agreement with the major tobacco companies, which helped states recoup tobacco-related health care costs. The industry agreed to pay states $206 billion over 25 years. The other four states—Florida, Minnesota, Mississippi and Texas—settled their lawsuits separately for a combined total of $40 billion over 25 years.

■ Localities Prohibiting Sales of Tobacco Products in Pharmacies

In July, San Francisco's Board of Supervisors passed an ordinance prohibiting pharmacies from selling tobacco products. Boston's Public Health

Commission also approved similar regulations in December, which would ban tobacco sales on college campuses. Despite injunction requests filed by Philip Morris, the maker of Marlboro cigarettes, and Walgreens Pharmacy, the San Francisco ordinance went into effect on October 1, 2008. The regulations in Boston are scheduled to take effect in February 2009.

Proponents of such prohibitions argue the sale of tobacco products in pharmacies sends a message that is contradictory with pharmacies' wellness mission, and also works to de-normalize the sale and use of tobacco products.

Illinois, New Hampshire, New York, Rhode Island and Tennessee considered but did not pass similar measures in 2008.

■ Tobacco Companies Find New Ways to Keep Smokers Hooked

In the last two years, the two largest cigarette companies in the U.S.—Altria and Reynolds American—purchased the two largest smokeless tobacco companies—U.S. Smokeless Tobacco and Conwood. Altria and Reynolds are now selling smokeless tobacco products under their Marlboro and Camel brands, marketing their smokeless products as "work-friendly" alternatives if smokers are in a smokefree environment. One company is promoting its smokeless product as "Smokefree. Spitfree. Work-Friendly."

In October 2008, Camel announced that it will test market Camel Strips, Orbs and Sticks—three flavored dissolvable tobacco products. The featured flavors are "fresh" and "mellow." Reynolds has previously described mellow as "accented with toasted honey."

The promotion of smokeless tobacco products as an alternative to quitting is troubling. The American Lung Association urges the adoption of tobacco-free policies and strongly encourages states, localities, companies and others to provide comprehensive cessation benefits when implementing smokefree policies to ensure that smokers are given the help they need to quit—not switch.

1. Centers for Disease Control and Prevention (CDC). National Center for Health Statistics. *National Health Interview Survey, 2007*. Analysis by the American Lung Association, Research and Program Services Division using SPSS and SUDAAN software.
2. CDC. *Sustaining State Programs for Tobacco Control: Data Highlights 2006.* 2006. Available at: http://www.cdc.gov/tobacco/data_statistics/state_data/data_highlights/2006/00_pdfs/DataHighlights06rev.pdf.
3. CDC. National Center for Health Statistics. *National Health Interview Survey, 2007*. Analysis by the American Lung Association, Research and Program Services Division using SPSS and SUDAAN software.
4. Alcohol and Tobacco Tax and Trade Bureau. Reporting Period: May, 2008. http://www.ttb.gov/statistics/200805tobacco.pdf.

Federal Overview

Close to 393,000 people die annually from tobacco-related diseases[1] and approximately 1,100 kids become new, regular daily smokers each day.[2] Despite those staggering numbers, the U.S. Congress and the Bush Administration have failed to implement policies that will stem the nation's tobacco epidemic. This report grades the federal government on four major policy areas: Legislation granting the U.S. Food and Drug Administration (FDA) the authority to regulate tobacco products, federal efforts to help smokers quit, the federal cigarette excise tax and the Framework Convention on Tobacco Control (FCTC).

The standards used to evaluate federal tobacco control policies are fully explained in the Methodology section.

1. CDC. *Smoking-Attributable Mortality, Morbidity and Economic Costs (SAMMEC)*. Adult Software. Atlanta, GA: U.S. Dept. of Health and Human Services, CDC; 2008.
2. Substance Abuse and Mental Health Services Administration, U.S. Dept of Health and Human Services (HHS), *Results from the 2007 National Survey on Drug Use and Health, 2008*. Available at: http://www.oas.samhsa.gov/NSDUHlatest.htm.

State Overview

Each day, 1,215 people die from tobacco-related diseases.[1] Despite the overwhelming evidence that states can significantly help current smokers quit and reduce the number of kids who start to smoke by implementing proven tobacco control measures, very few states have taken the steps to do so. *State of Tobacco Control* evaluates state tobacco control policies in four areas: smokefree air, tobacco prevention and control funding, cigarette taxes and cessation coverage.

The methodologies and standards used to evaluate state tobacco control policies are fully explained in the Methodology section.

2008 Smokefree Air Highlights

In 2006, the American Lung Association issued its *Smokefree Air Challenge*, calling on all states and communities to enact smokefree air laws that protect everyone. Since that time, 14 states and the District of Columbia have passed comprehensive laws prohibiting smoking in public places and workplaces, including restaurants and bars.

In 2008, only two states—Iowa and Nebraska—passed comprehensive laws that protect workers and the public from the dangers of secondhand smoke. These two states represent significant progress in making the Midwest smokefree. Smokefree laws have been most prolific on the east and west coasts of the U.S.; only within the last few years have other states started to follow suit. Passage of comprehensive laws in Iowa and Nebraska will not only save lives but also demonstrate the benefits of smokefree air to other states in the middle of our country.

Pennsylvania also passed legislation in 2008 that prohibits smoking in a number of public places, including restaurants. However, the weak law still permits smoking in taverns, casinos, private clubs and nursing homes—and preempts localities from passing stronger laws that would protect everyone from exposure to deadly secondhand smoke.

Comprehensive legislation came up for debate in Michigan and Wisconsin, but neither state successfully passed a bill into law.

In the *State of Tobacco Control 2008*, 33 states and the District of Columbia receive passing grades.[2] However, 16 states still receive an "F" for their weak and ineffective smokefree laws—which translates into millions of people in those states still exposed to deadly secondhand smoke at their workplaces.

Native Americans have the highest smoking prevalence of any racial or ethnic group in the U.S. Recognizing the dire impact tobacco use has on its people, the Navajo Nation Council voted to prohibit the non-ceremonial use of tobacco products in all public areas of the reservation, thereby protecting all Navajo citizens from the dangers of secondhand smoke and encouraging people to quit. Tragically, Navajo Nation President Joe Shirley Jr. vetoed the

States that have Passed Comprehensive Smokefree Laws:

Arizona (2007)
California (1998)
Colorado (2006)
Connecticut (2004)
Delaware (2002)
District of Columbia (2007)
Hawaii (2006)
Illinois (2008)
Iowa (2008)
Maine (2003)
Maryland (2008)
Massachusetts (2004)
Minnesota (2007)
Montana (2009)*
Nebraska (2009)*
New Jersey (2006)
New Mexico (2007)
New York (2003)
Ohio (2006)
Oregon (2009)
Rhode Island (2005)
Utah (2009)
Vermont (2005)
Washington (2005)

*Montana and Nebraska's laws take full effect in 2009.

measure, which had passed the council on a 42 to 27 vote, and the council failed to override the veto. The American Lung Association urges President Shirley to reconsider his position and commends the members of the council that voted for the measure and to override President Shirley's veto for their courageous actions.

The Society of Actuaries estimates that the direct and indirect costs attributed to secondhand smoke exposure in the U.S. are $10 billion each year.[3]

2008 Tobacco Prevention and Control Funding Highlights

Adequate funding of state tobacco prevention and cessation programs ensures that states can put evidence-based measures in place to reduce tobacco use among both youth and adults. Unfortunately, no states fund these lifesaving programs at the new levels recommended by the Centers for Disease Control and Prevention (CDC). The CDC updated its estimates of adequate funding in its publication, Best Practices for Comprehensive Tobacco Control Programs 2007, using the lessons learned from a decade of tobacco control programs.

Only two states—Alaska and Delaware—receive As in the *State of Tobacco Control 2008* report for providing funding at 80 percent or more of the recommended level. Tragically, 41 states and the District of Columbia receive Fs and one state—South Carolina—spends no state dollars (only the small allotment of money from the CDC) on its prevention and cessation programs.

Only seven states—Alaska, Connecticut, Florida, Mississippi, Missouri, Nebraska and Oklahoma—increased funding by a significant amount for their tobacco control programs in 2008. In November 2008, North Dakota voters passed a ballot initiative which is expected to bring funding for tobacco control programs to the CDC-recommended level in 2009.

A February 2008 study in the American Journal of Public Health concluded that if every state had funded their tobacco prevention and cessation programs at levels recommended by the CDC between 1995 and 2003, there would have been 2.2 million to 7.1 million fewer smokers in the U.S. in 2003,[5] resulting in hundreds of thousands of lives and billions of dollars saved. Despite the overwhelming evidence, no states currently fund their tobacco prevention programs at the levels recommended by CDC.

In Ohio, Governor Ted Strickland and the Ohio legislature dissolved the highly effective Ohio Tobacco Prevention Foundation and used the funds for a stimulus package. This short-sighted attack on one of the nation's most successful programs will ultimately result in higher bills for taxpayers who will be forced to pay for health care and lost productivity costs for smokers. The Foundation's programs were credited with reducing smoking by 38.6 percent among high school students and 47.4 percent among middle school students from 2000 to 2006.[4]

2008 State Cigarette Excise Tax Highlights

Only three states plus the District of Columbia increased their excise tax on cigarettes in 2008—Massachusetts, by $1.00; New Hampshire, by $0.25; New York, by $1.25; and the District of Columbia, by $1.00. Hawaii and Vermont implemented scheduled increases passed in previous years. This brings the national cigarette tax average to $1.19 per pack. With its increase, New York state has the largest tax in the nation at $2.75 per pack, while South Carolina continues to have the lowest (7 cents), having failed to increase its tax again this year. Despite having the support of the governor, a proposal to increase Kentucky's excise tax by $0.70 was also defeated.

Twelve states—Alaska, Arizona, Connecticut, Hawaii, Maine, Maryland, Massachusetts, Michigan, New Jersey, New York, Rhode Island, Washington—and the District of Columbia have a tax at or above $2.00 per pack. Eleven states—mostly in the southeastern United States—have a tax of less

Top Five State Cigarette Tax Rates:

New York	$2.75 per pack
New Jersey	$2.575 per pack
Massachusetts	$2.51 per pack
Rhode Island	$2.46 per pack
Washington	$2.025 per pack

For a complete list of state cigarette tax rates, click here.

than 50 cents per pack.

To combat the growing problem of cigarette users switching to little cigars, several states, including Massachusetts, New York and Rhode Island changed their tobacco tax laws, so that these little cigars are now taxed at the same rate as cigarettes. Little cigars look very similar to cigarettes, and are made of tobacco, just like cigarettes. All states should change their tax rates on little cigars, to eliminate this loophole that encourages people to switch to little cigars rather than quit smoking.

2008 Cessation Coverage Highlights

States that cover cessation treatments through their Medicaid programs, state employee health plans, private insurance plans and quitlines save lives and money. In 2006, a review published in the *American Journal of Preventive Medicine* rated smoking cessation treatment as one of the top three highest ranking preventive services for clinical and cost effectiveness, recommending that all insurance plans provide these treatments to their patients.[6] This is a new grading category in the *2008 State of Tobacco Control* report.

No states received As for offering comprehensive cessation benefits with few barriers to their Medicaid populations and state employees. Six states—Minnesota, New Mexico, North Dakota, Oregon, Rhode Island and Wisconsin—receive Bs because their coverage is still good overall, but has a few more limitations. Alabama, Connecticut, Georgia, Kentucky, Missouri and Tennessee offer no cessation benefits to their entire Medicaid population, while six states do not require any cessation coverage benefits for state employees.

In 2008, Arizona, Nebraska and Washington passed laws increasing Medicaid recipients' access to lifesaving cessation benefits.

Seven states—Indiana, Massachusetts, Minnesota, Nebraska, Nevada, Oregon and Pennsylvania—offer both group and individual counseling as well as all seven of the pharmacotherapies approved by the U.S. Food and Drug Administration (FDA) and recommended by the U.S. Public Health Service for use in quitting smoking under their state Medicaid programs.

1. CDC. *Smoking-Attributable Mortality, Morbidity and Economic Costs (SAMMEC).* Adult Software. Atlanta, GA: U.S. Department of Health and Human Services, CDC; 2008.
2. Nebraska receives an incomplete grade because although the state's law was passed in 2008, it does not take effect until June 1, 2009. Montana receives an incomplete grade because loopholes in the state's law close October 1, 2009 due to a law passed in 2005.
3. Behan D, et al. *Economic Effects of Environmental Tobacco Smoke.* The Society of Actuaries. March 31, 2005. Report can be found at: http://www.soa.org/files/pdf/ETSReportFinalDraft(Final%203).pdf.
4. Ohio Department of Health. 2000 and 2006 Ohio Youth Tobacco Survey. Available at: http://www.odh.ohio.gov/odhPrograms/hprr/tob_risk/tob_surv1.aspx.
5. Farrelly, M, et al. "The Impact of Tobacco Control on Adult Smoking." *Am J Public Health.* 2008; 98: 304-309, 10.2105/AJPH.2006.106377.
6. Maciosek MV, Coffield AB, Edwards NM, Goodman MJ, Flottemesch TJ, Solberg LI. Priorities among effective clinical preventive services: results of a systematic review and analysis. *Am J Prev Med.* 2006; 31(1):52-61.

The American Lung Association's Commitment

For more than 100 years, the American Lung Association has been the lead organization working to prevent lung disease and promote lung health, including fighting illness and death caused by tobacco use. Unfortunately, lung disease death rates continue to increase while other leading causes of death have declined.

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 horrible public health scourge could be tamed. With the same intent, the American Lung Association targeted tobacco use and 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 free of charge online at www.ffsonline.org. The American Lung Association also provides free telephone counseling to help smokers quit at 1-800-LUNGUSA.

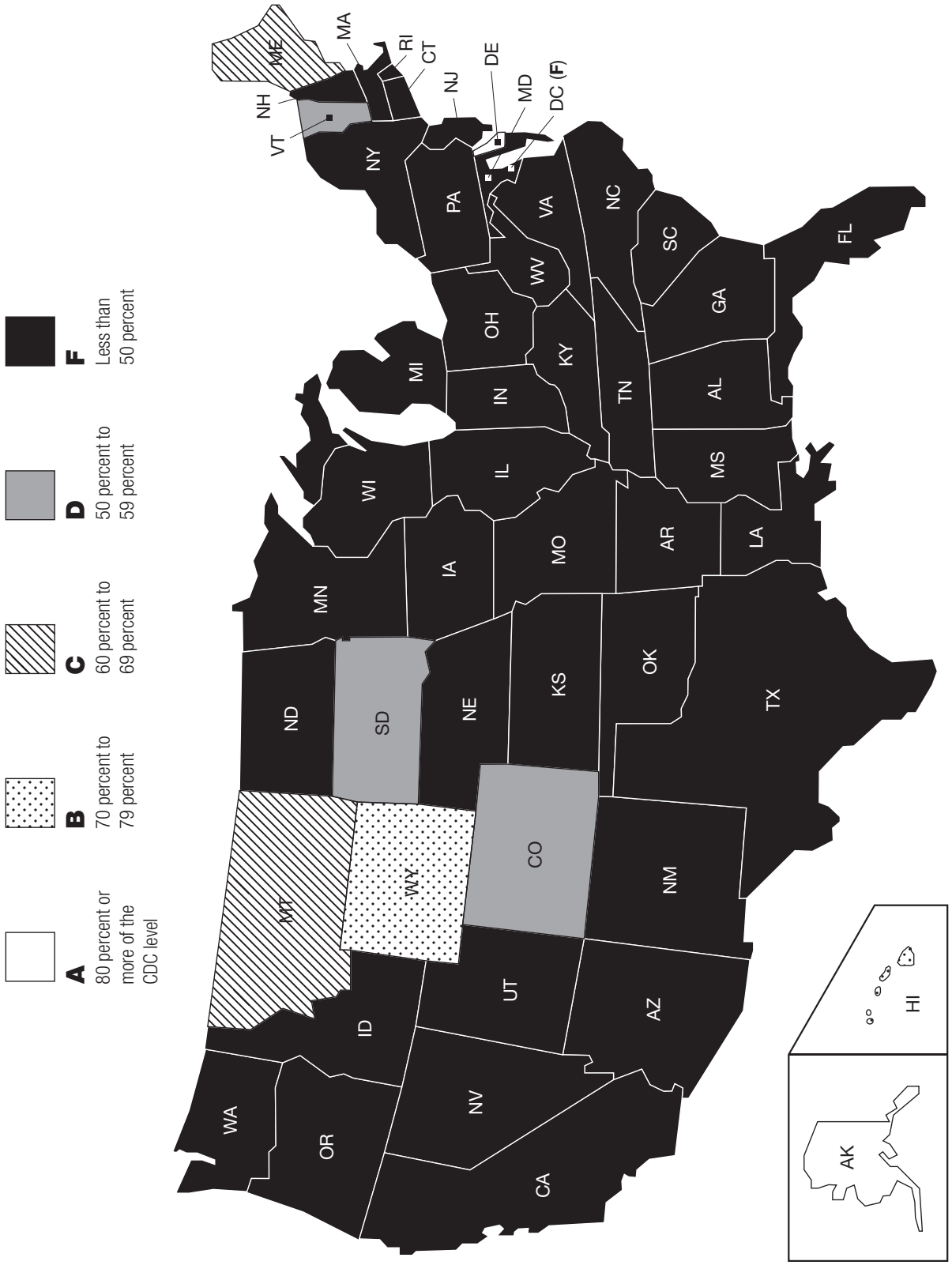
From successfully advocating for smokefree air laws to holding the tobacco industry accountable for its wrongdoing, the American Lung Association has been a leader in tobacco control advocacy on the international, national, state and local levels. In addition, the American Lung Association was among the first to offer a proven effective teen smoking-cessation program, Not-On-Tobacco (N-O-T). N-O-T has been designated a Model Program by both the Substance Abuse and Mental Health Services Administration and the Department of Justice's Office of Juvenile Justice and Drug Prevention.

In addition, the American Lung Association is a leader in the battle against air pollution and its devastating impact on human health. More recently, the American Lung Association has taken the lead in responding to the dramatic increase in asthma and chronic obstructive pulmonary disease (COPD). Smoking causes almost 90 percent of COPD cases and both asthma and COPD can be exacerbated by exposure to secondhand smoke. 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 State of Tobacco Control 2008* is a call to action for national and state elected officials: Meet the challenge and enact strong tobacco control laws so that everyone in the United States can breathe easier.

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

Tobacco Prevention and Control Spending Map



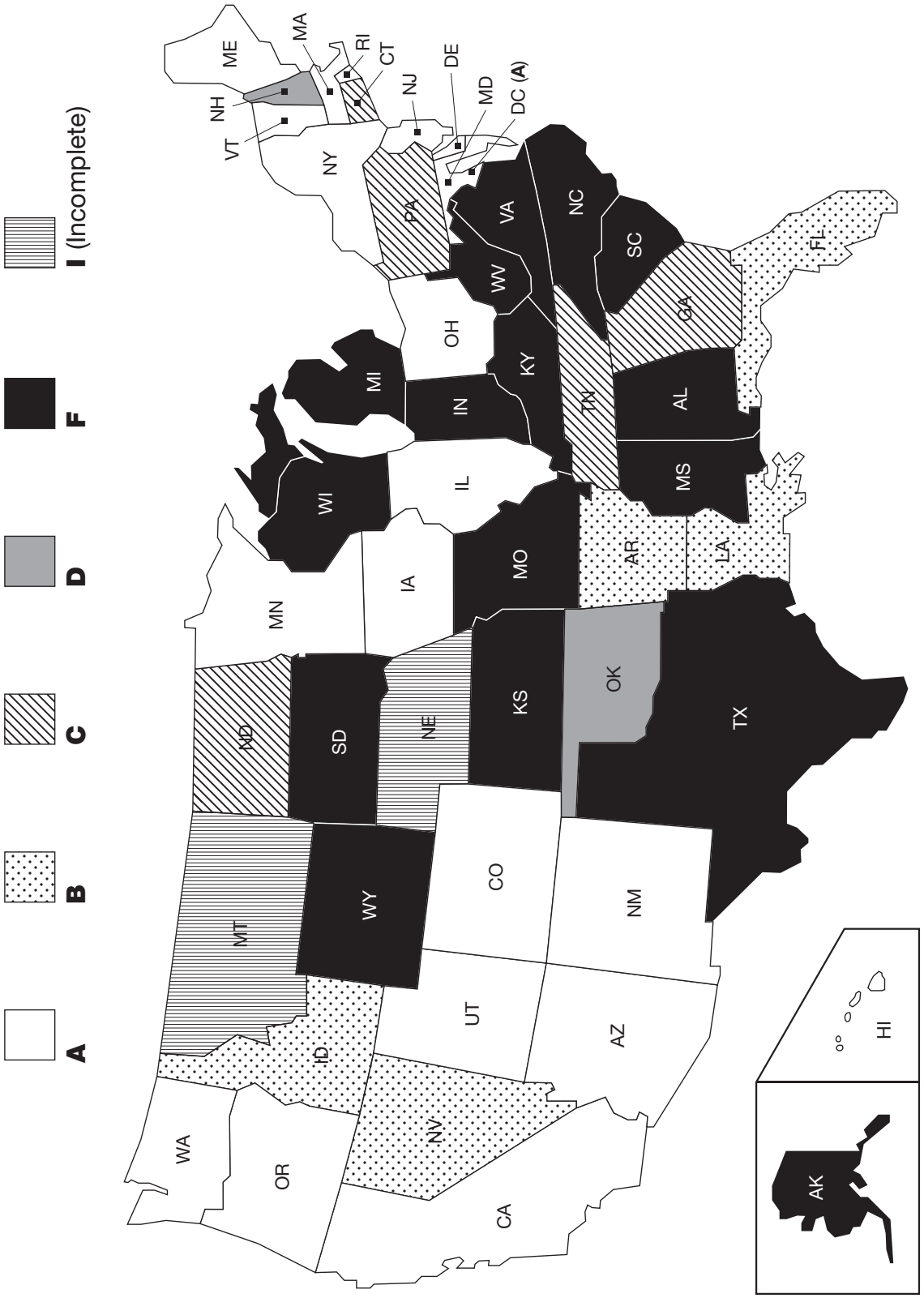
Tobacco Prevention and Control Spending Overview

State	Settlement Expenditures	Tax Expenditures	Other State Expenditures	Total State Expenditures	CDC Funded Expenditures	Total Expenditures	CDC Best Practice Recommendation	Grade
Alabama	$940,485	$0	$237,940	$1,178,425	$1,093,613	$2,272,038	$56,700,000	F
Alaska	$0	$0	$7,856,000	$7,856,000	$952,412	$8,808,412	$10,700,000	A
Arizona	$0	$22,413,100	$0	$22,413,100	$347,402	$22,760,502	$68,100,000	F
Arkansas	$15,982,716	$0	$0	$15,982,716	$910,357	$16,893,073	$36,400,000	F
California	$0	$77,693,000	$0	$77,693,000	$409,031	$78,102,031	$441,900,000	F
Colorado	$0	$26,400,000	$0	$26,400,000	$1,093,115	$27,493,115	$54,400,000	D
Connecticut	$7,412,456	$0	$0	$7,412,456	$889,343	$8,301,799	$43,900,000	F
Delaware	$10,665,600	$0	$0	$10,665,600	$551,846	$11,217,446	$13,900,000	A
District of Columbia	$3,600,000	$0	$0	$3,600,000	$438,258	$4,038,258	$10,500,000	F
Florida	$59,519,954	$0	$0	$59,519,954	$705,865	$60,225,819	$210,900,000	F
Georgia	$2,281,670	$0	$0	$2,281,670	$902,043	$3,183,713	$116,500,000	F
Hawaii	$10,480,090	$0	$66,000	$10,546,090	$763,562	$11,309,652	$15,200,000	B
Idaho	$2,120,300	$230,000	$0	$2,350,300	$940,746	$3,291,046	$16,900,000	F
Illinois	$8,500,000	$0	$0	$8,500,000	$972,978	$9,472,978	$157,000,000	F
Indiana	$13,950,000	$0	$1,116,000	$15,066,000	$855,124	$15,921,124	$78,800,000	F
Iowa	$6,937,806	$1,857,164	$1,580,310	$10,375,280	$833,761	$11,209,041	$36,700,000	F
Kansas	$1,000,000	$0	$0	$1,000,000	$1,026,429	$2,026,429	$32,100,000	F
Kentucky	$2,793,000	$0	$510,000	$3,303,000	$939,064	$4,242,064	$57,200,000	F
Louisiana	$500,000	$7,095,570	$0	$7,595,570	$907,923	$8,503,493	$53,500,000	F
Maine	$10,896,673	$0	$0	$10,896,673	$794,968	$11,691,641	$18,500,000	C
Maryland	$18,441,859	$0	$1,117,540	$19,559,399	$993,392	$20,552,791	$63,300,000	F
Massachusetts	$0	$0	$12,225,000	$12,225,000	$1,284,492	$13,509,492	$90,000,000	F
Michigan	$0	$3,680,000	$0	$3,680,000	$1,374,750	$5,054,750	$121,200,000	F
Minnesota	$17,325,168	$0	$3,200,000	$20,525,168	$988,676	$21,513,844	$58,400,000	F
Mississippi	$11,700,000	$0	$0	$11,700,000	$445,576	$12,145,576	$39,200,000	F
Missouri	$1,700,000	$0	$0	$1,700,000	$953,317	$2,653,317	$73,200,000	F

Tobacco Prevention and Control Spending Overview

State	Settlement Expenditures	Tax Expenditures	Other State Expenditures	Total State Expenditures	CDC Funded Expenditures	Total Expenditures	CDC Best Practice Recommendation	Grade
Montana	$8,476,567	$0	$0	$8,476,567	$793,875	$9,270,442	$13,900,000	C
Nebraska	$3,006,000	$0	$500,000	$3,506,000	$1,022,755	$4,528,755	$21,500,000	F
Nevada	$3,456,544	$0	$0	$3,456,544	$707,071	$4,163,615	$32,500,000	F
New Hampshire	$0	$0	$200,000	$200,000	$858,560	$1,058,560	$19,200,000	F
New Jersey	$0	$8,600,000	$500,000	$9,100,000	$1,050,687	$10,150,687	$119,800,000	F
New Mexico	$9,615,000	$0	$0	$9,615,000	$940,567	$10,555,567	$23,400,000	F
New York	$0	$0	$80,400,000	$80,400,000	$1,544,471	$81,944,471	$254,300,000	F
North Carolina	$17,100,000	$0	$0	$17,100,000	$1,378,253	$18,478,253	$106,800,000	F
North Dakota	$3,134,198	$0	$0	$3,134,198	$952,598	$4,086,796	$9,300,000	F
Ohio	$0	$0	$6,507,250	$6,507,250	$1,126,657	$7,633,907	$145,000,000	F
Oklahoma	$15,700,000	$1,300,000	$1,000,000	$18,000,000	$1,093,550	$19,093,550	$45,000,000	F
Oregon	$0	$7,900,000	$0	$7,900,000	$901,930	$8,801,930	$43,000,000	F
Pennsylvania	$32,054,000	$0	$0	$32,054,000	$1,062,934	$33,116,934	$155,500,000	F
Rhode Island	$0	$0	$925,736	$925,736	$949,656	$1,875,392	$15,200,000	F
South Carolina	$0	$0	$0	$0	$1,003,690	$1,003,690	$62,200,000	F
South Dakota	$0	$5,000,000	$0	$5,000,000	$793,727	$5,793,727	$11,300,000	D
Tennessee	$0	$0	$5,000,000	$5,000,000	$1,056,098	$6,056,098	$71,700,000	F
Texas	$11,050,003	$0	$2,000,000	$13,050,003	$801,733	$13,851,736	$266,300,000	F
Utah	$4,023,900	$3,131,700	$0	$7,155,600	$1,001,838	$8,157,438	$23,600,000	F
Vermont	$5,224,947	$0	$0	$5,224,947	$939,747	$6,164,694	$10,400,000	D
Virginia	$12,700,000	$0	$0	$12,700,000	$879,582	$13,579,582	$103,200,000	F
Washington	$0	$0	$27,191,000	$27,191,000	$1,163,230	$28,354,230	$67,300,000	F
West Virginia	$0	$0	$5,678,687	$5,678,687	$965,109	$6,643,796	$27,800,000	F
Wisconsin	$0	$0	$15,250,000	$15,250,000	$981,707	$16,231,707	$64,300,000	F
Wyoming	$4,105,575	$0	$1,915,024	$6,020,599	$854,999	$6,875,598	$9,000,000	B

Smokefree Air Map



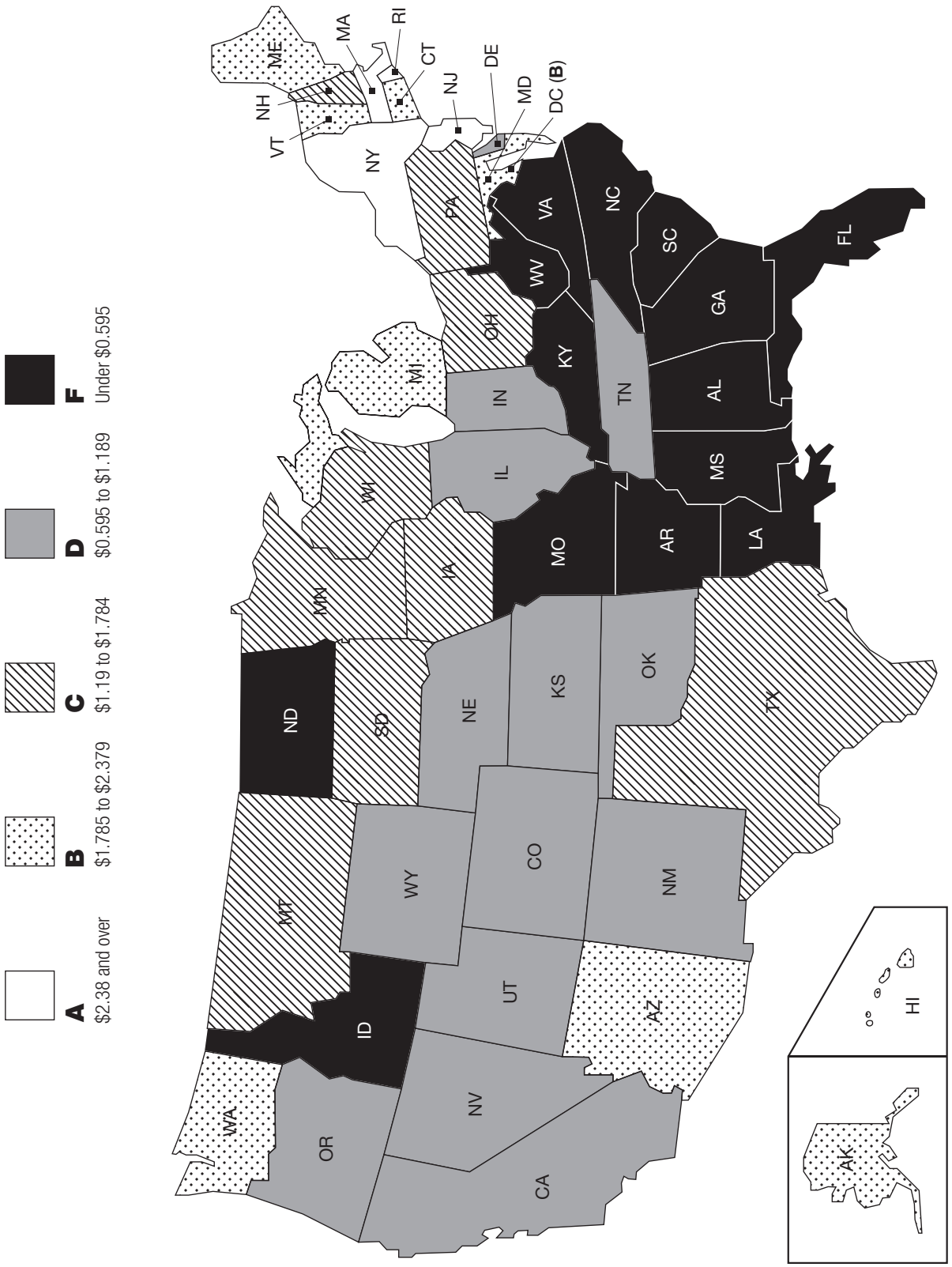
State	Government Worksites	Private Worksites	Schools	Childcare Facilities	Restaurants	Bars	Casinos/Gaming Establishments	Retail Stores	Recreation/ Cultural Facilities	Penalties	Enforcement	Total Score	Grade
Alabama	2	1	2	2	0	0	0	2	2	5	4	20	F
Alaska	2	1	3	4	1	0	N/A	1	1	4	4	21	F
Arizona	4	4	5	4	4	4	4	4	4	5	4	46	A
Arkansas	4	3	4	4	3	1	1	4	4	4	4	36	B
California	5	3	4	4	3	3	3	3	3	5	4	40	A
Colorado	5	3	4	4	4	3	4	4	4	4	1	40	A
Connecticut	4	3	4	3	4	3	4	4	4	3	3	39	C
Delaware	4	4	4	4	4	5	4	4	4	5	4	46	A
District of Columbia	4	4	4	4	4	2	N/A	4	4	2	4	36	A
Florida	4	4	4	4	4	1	4	4	4	5	3	41	B
Georgia	4	3	4	4	3	1	N/A	3	4	2	3	31	C
Hawaii	5	5	4	4	4	5	N/A	4	4	4	4	43	A
Idaho	4	3	4	4	4	0	4	4	4	3	2	36	B
Illinois	5	5	4	4	4	5	4	4	4	5	4	48	A
Indiana	1	0	1	1	0	0	0	1	0	2	1	7	F
Iowa	4	4	5	4	4	4	1	4	4	4	4	42	A
Kansas	1	0	3	3	1	0	0	1	1	4	2	16	F
Kentucky	1	0	1	0	0	0	0	0	0	1	0	3	F
Louisiana	4	4	4	4	4	0	1	4	4	5	2	36	B
Maine	3	3	5	4	4	4	3	4	4	5	3	42	A
Maryland	4	4	4	4	4	4	4	4	4	3	3	42	A
Massachusetts	4	4	4	4	4	3	4	4	4	4	3	42	A
Michigan	1	0	3	4	1	0	0	1	1	4	2	17	F
Minnesota	3	3	4	4	4	5	4	4	4	3	3	41	A
Mississippi	3	0	4	0	0	0	0	0	0	2	2	11	F
Missouri	2	1	3	4	1	0	0	1	1	2	1	16	F

State	Government Worksites	Private Worksites	Schools	Childcare Facilities	Restaurants	Bars	Casinos/Gaming Establishments	Retail Stores	Recreation/ Cultural Facilities	Penalties	Enforcement	Total Score	Grade
Montana	4	4	3	4	3	1	1	4	4	4	3	35	I*
Nebraska	2	1	1	4	1	0	4	1	1	2	1	18	I**
Nevada	4	4	5	4	4	1	1	4	4	3	3	37	B
New Hampshire	2	2	4	4	4	3	2	2	2	4	4	33	D
New Jersey	4	4	5	4	4	2	2	4	4	5	3	41	A
New Mexico	5	4	4	4	4	3	0	4	4	4	4	40	A
New York	4	4	5	4	4	2	4	4	4	4	4	43	A
North Carolina	1	0	4	0	0	0	N/A	0	0	1	0	6	F
North Dakota	4	4	4	4	2	0	1	4	4	4	1	32	C
Ohio	4	4	4	4	4	5	4	4	4	3	4	44	A
Oklahoma	3	3	4	4	3	0	3	4	4	2	4	34	D
Oregon	5	5	4	4	4	3	4	4	4	4	4	45	A
Pennsylvania	4	4	4	4	2	0	2	4	4	4	4	36	C
Rhode Island	4	4	4	4	4	3	2	4	4	4	4	41	A
South Carolina	1	0	2	4	0	0	N/A	0	1	2	0	10	F
South Dakota	4	4	4	4	2	0	0	4	4	4	0	30	F
Tennessee	4	3	4	4	3	1	N/A	4	4	3	4	34	C
Texas	0	0	1	4	0	0	0	0	1	2	1	9	F
Utah	4	4	5	4	4	5	N/A	4	4	4	3	41	A
Vermont	4	2	4	4	4	4	N/A	4	4	3	3	36	A
Virginia	1	0	3	3	1	0	0	1	1	2	1	13	F
Washington	5	5	4	4	4	5	4	4	4	4	4	47	A
West Virginia	1	0	4	1	0	0	0	0	0	1	0	7	F
Wisconsin	2	1	3	4	1	0	0	1	1	2	1	16	F
Wyoming	0	0	0	0	0	0	0	0	0	0	0	0	F

*Montana gets an "I" for Incomplete because they passed a smokefree law in 2005, but parts of it were delayed from taking effect until October 1, 2009.

** Nebraska gets an "I" for Incomplete because they passed a smokefree law in 2008, but it does not take effect until June 1, 2009.

Cigarette Excise Tax Map



Cigarette Excise Tax Overview

State	Tax Rate (cents 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	B
Arizona	$2.00	2006	$0.82	B
Arkansas	$0.59	2003	$0.25	F
California	$0.87	1999	$0.50	D
Colorado	$0.84	2005	$0.64	D
Connecticut	$2.00	2007	$0.49	B
Delaware	$1.15	2007	$0.60	D
District of Columbia	$2.00	2008	$1.00	B
Florida	$0.339	1990	$0.099	F
Georgia	$0.37	2003	$0.25	F
Hawaii	$2.00	2008	$0.20	B
Idaho	$0.57	2003	$0.29	F
Illinois	$0.98	2002	$0.40	D
Indiana	$0.995	2007	$0.44	D
Iowa	$1.36	2007	$1.00	C
Kansas	$0.79	2003	$0.09	D
Kentucky	$0.30	2005	$0.27	F
Louisiana	$0.36	2002	$0.12	F
Maine	$2.00	2005	$1.00	B
Maryland	$2.00	2008	$1.00	B
Massachusetts	$2.51	2008	$1.00	A
Michigan	$2.00	2004	$0.75	B
Minnesota	$1.504	2008	$0.014	C
Mississippi	$0.18	1985	$0.07	F
Missouri	$0.17	1993	$0.04	F
Montana	$1.70	2005	$1.00	C
Nebraska	$0.64	2002	$0.30	D
Nevada	$0.80	2003	$0.45	D

Cigarette Excise Tax Overview

State	Tax Rate (cents per pk. of 20)	Year of Last Change	Amount of Last Change	Grade
New Hampshire	$1.33	2008	$0.25	C
New Jersey	$2.575	2006	$0.175	A
New Mexico	$0.91	2003	$0.70	D
New York	$2.75	2008	$1.25	A
North Carolina	$0.35	2006	$0.05	F
North Dakota	$0.44	1993	$0.15	F
Ohio	$1.25	2005	$0.70	C
Oklahoma	$1.03	2005	$0.80	D
Oregon	$1.18	2004	-$0.10	D
Pennsylvania	$1.35	2004	$0.35	C
Rhode Island	$2.46	2004	$0.75	A
South Carolina	$0.07	1977	$0.01	F
South Dakota	$1.53	2006	$1.00	C
Tennessee	$0.62	2007	$0.42	D
Texas	$1.41	2006	$1.00	C
Utah	$0.695	2002	$0.18	D
Vermont	$1.99	2008	$0.20	B
Virginia	$0.30	2005	$0.10	F
Washington	$2.025	2005	$0.60	B
West Virginia	$0.55	2003	$0.38	F
Wisconsin	$1.77	2008	$1.00	C
Wyoming	$0.60	2003	$0.48	D

State Cigarette Excise Taxes

As of January 1, 2009

Current Cigarette Tax Average: $1.19 per pack

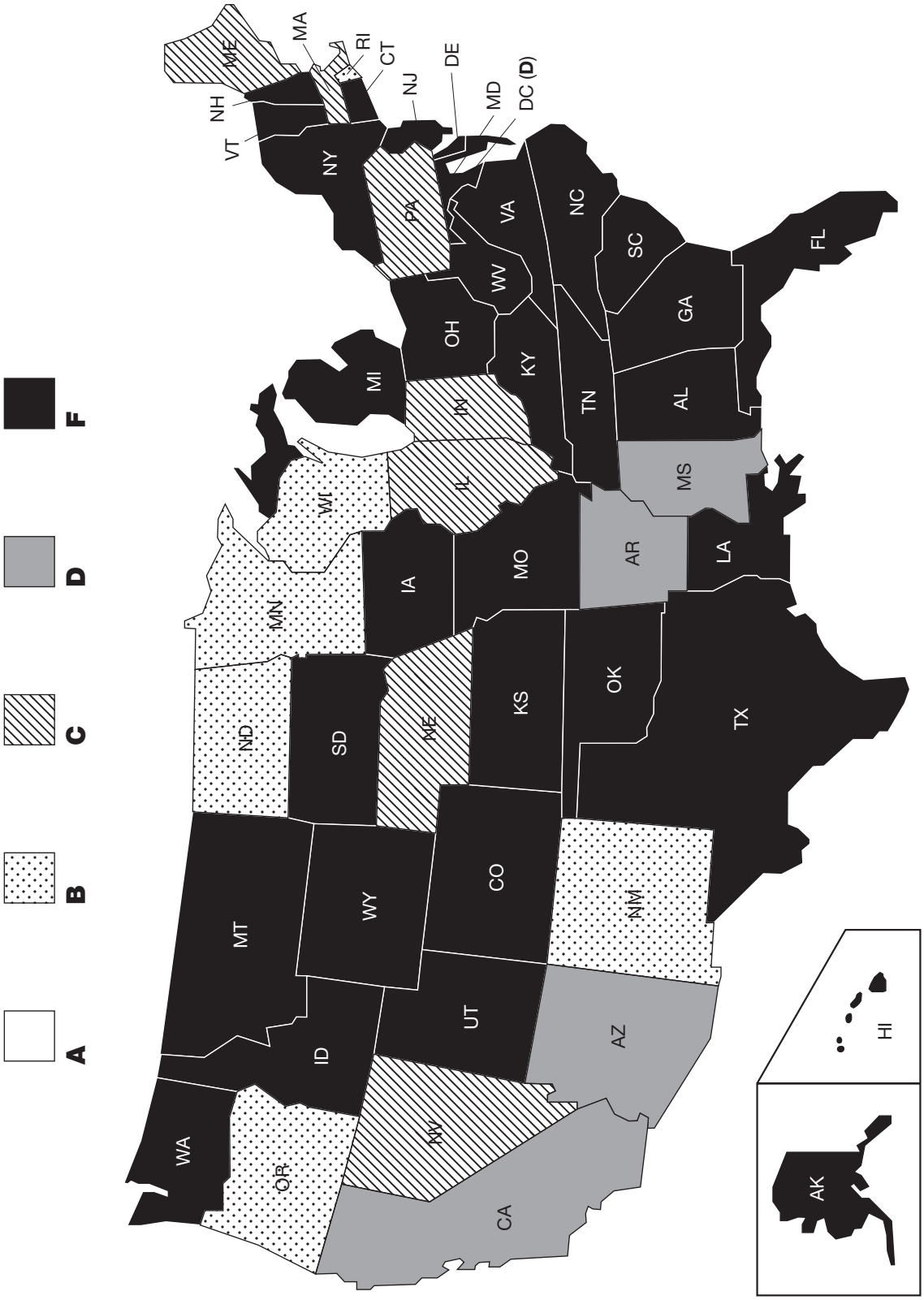
Sorted by Tax Rate From Highest to Lowest

State	Tax Rate (per pack of 20)
New York	$2.75
New Jersey	$2.575
Massachusetts	$2.51
Rhode Island	$2.46
Washington	$2.025
Alaska	$2.00
Arizona	$2.00
Connecticut	$2.00
District of Columbia	$2.00
Hawaii	$2.00
Maine	$2.00
Maryland	$2.00
Michigan	$2.00
Vermont	$1.99
Wisconsin	$1.77
Montana	$1.70
South Dakota	$1.53
Minnesota	$1.504
Texas	$1.41
Iowa	$1.36
Pennsylvania	$1.35
New Hampshire	$1.33
Ohio	$1.25
Oregon	$1.18
Delaware	$1.15
Oklahoma	$1.03
Indiana	$0.995
Illinois	$0.98
New Mexico	$0.91
California	$0.87
Colorado	$0.84
Nevada	$0.80
Kansas	$0.79
Utah	$0.695
Nebraska	$0.64
Tennessee	$0.62
Wyoming	$0.60
Arkansas	$0.59
Idaho	$0.57
West Virginia	$0.55
North Dakota	$0.44
Alabama	$0.425
Georgia	$0.37
Louisiana	$0.36
North Carolina	$0.35
Florida	$0.339
Kentucky	$0.30
Virginia	$0.30
Mississippi	$0.18
Missouri	$0.17
South Carolina	$0.07

Sorted Alphabetically by State Name

State	Tax Rate (per pack of 20)
Alabama	$0.425
Alaska	$2.00
Arizona	$2.00
Arkansas	$0.59
California	$0.87
Colorado	$0.84
Connecticut	$2.00
Delaware	$1.15
District of Columbia	$2.00
Florida	$0.339
Georgia	$0.37
Hawaii	$2.00
Idaho	$0.57
Illinois	$0.98
Indiana	$0.995
Iowa	$1.36
Kansas	$0.79
Kentucky	$0.30
Louisiana	$0.36
Maine	$2.00
Maryland	$2.00
Massachusetts	$2.51
Michigan	$2.00
Minnesota	$1.504
Mississippi	$0.18
Missouri	$0.17
Montana	$1.70
Nebraska	$0.64
Nevada	$0.80
New Hampshire	$1.33
New Jersey	$2.575
New Mexico	$0.91
New York	$2.75
North Carolina	$0.35
North Dakota	$0.44
Ohio	$1.25
Oklahoma	$1.03
Oregon	$1.18
Pennsylvania	$1.35
Rhode Island	$2.46
South Carolina	$0.07
South Dakota	$1.53
Tennessee	$0.62
Texas	$1.41
Utah	$0.695
Vermont	$1.99
Virginia	$0.30
Washington	$2.025
West Virginia	$0.55
Wisconsin	$1.77
Wyoming	$0.60

Cessation Coverage Grading Map



Cessation Coverage Grading

State	State Medicaid Program			State Employee Health Plan			State Funding For Quitline	Score	Private Insurance Mandate (bonus)	Total Score	Grade
	Medications	Counseling	Barriers to Coverage	Medications	Counseling	Barriers to Coverage					
Alabama	0	1	6	4	4	1	1	17	0	17	F
Alaska	9	3	3	2	0	1	1	19	0	19	F
Arizona	10	0	9	4	1	1	1	26	0	26	D
Arkansas	7	8	6	2	3	1	1	28	0	28	D
California	5	5	8	3	4	1	1	27	1	28	D
Colorado	10	2	2	1	3	1	1	20	1	21	F
Connecticut	0	0	0	3	1	1	0	5	0	5	F
Delaware	9	0	4	0	1	0	1	15	0	15	F
District of Columbia	7	7	8	2	2	1	1	28	0	28	D
Florida	7	8	3	0	1	1	1	21	0	21	F
Georgia	0	0	0	0	1	1	1	3	0	3	F
Hawaii	8	1	4	2	3	2	1	21	0	21	F
Idaho	9	5	4	1	1	1	0	21	0	21	F
Illinois	10	0	8	4	5	1	1	29	0	29	C
Indiana	10	10	4	2	2	1	1	30	0	30	C
Iowa	7	5	4	0	1	0	1	18	0	18	F
Kansas	6	0	7	2	1	1	1	18	0	18	F
Kentucky	0	1	10	2	3	1	1	18	0	18	F
Louisiana	9	0	6	0	0	0	1	16	0	16	F
Maine	10	5	4	4	4	1	1	29	0	29	C
Maryland	5	3	3	0	0	0	1	12	2	14	F
Massachusetts	10	10	7	0	1	0	1	29	0	29	C
Michigan	7	0	7	2	3	1	1	21	0	21	F
Minnesota	10	10	9	3	1	1	1	35	0	35	B
Mississippi	10	6	8	0	0	0	1	25	0	25	D
Missouri	0	0	0	1	1	1	1	4	0	4	F

State	State Medicaid Program			State Employee Health Plan			State Funding For Quitline	Score	Private Insurance Mandate (bonus)	Total Score	Grade
	Medications	Counseling	Barriers to Coverage	Medications	Counseling	Barriers to Coverage					
Montana	10	3	4	0	0	0	1	18	0	18	F
Nebraska	10	10	5	4	0	1	0	30	0	30	C
Nevada	10	6	5	4	5	1	1	32	0	32	C
New Hampshire	7	6	6	0	2	1	0	22	0	22	F
New Jersey	6	10	3	0	1	0	1	21	3	24	F
New Mexico	7	2	8	4	5	1	1	28	5	33	B
New York	9	2	8	2	1	1	1	24	0	24	F
North Carolina	10	0	9	1	2	1	1	24	0	24	F
North Dakota	8	8	5	4	5	1	1	32	1	33	B
Ohio	10	0	9	1	1	1	1	23	0	23	F
Oklahoma	10	3	6	2	1	1	1	24	0	24	F
Oregon	10	10	9	2	1	1	1	34	0	34	B
Pennsylvania	10	10	8	1	1	1	1	32	0	32	C
Rhode Island	8	10	6	3	2	1	1	31	5	36	B
South Carolina	10	0	4	3	1	1	0	19	0	19	F
South Dakota	5	0	9	0	0	0	1	15	0	15	F
Tennessee	0	0	0	4	0	1	1	6	0	6	F
Texas	9	0	7	0	1	0	1	18	0	18	F
Utah	8	2	7	2	0	1	1	21	0	21	F
Vermont	10	0	5	2	3	1	1	22	0	22	F
Virginia	10	1	7	3	1	1	0	23	0	23	F
Washington	7	3	8	3	1	1	1	24	0	24	F
West Virginia	6	2	5	4	2	1	1	21	0	21	F
Wisconsin	9	8	9	3	2	1	1	33	0	33	B
Wyoming	8	5	5	0	0	0	1	19	0	19	F

Information on State Youth Access Laws

State	Minimum Age to Buy Tobacco Products	Has Requirements on Packaging and Labeling of Tobacco Products	Restricts Customer Access to Tobacco Products	Requires ID Before Selling Tobacco Products	Restricts Placement of Tobacco Product Vending Machines	Restricts Free Distribution/Sampling of Tobacco Products
Alabama	19	Yes	No	No	No	No
Alaska	19	Yes	Yes	No	Yes	No
Arizona	18	Yes	No	Yes	Yes	No
Arkansas	18	Yes	Yes	No	Yes	Yes
California	18	Yes	Yes	Yes	Yes	Yes
Colorado	18	Yes	No	Yes	Yes	No
Connecticut	18	Yes	No	Yes	Yes	Yes
Delaware	18	Yes	Yes	Yes	Yes	Yes
District of Columbia	18	Yes	No	Yes	Yes	Yes
Florida	18	Yes	Yes	No	Yes	No
Georgia	18	Yes	No	Yes	Yes	Yes
Hawaii	18	Yes	No	Yes	Yes	Yes
Idaho	18	Yes	Yes	No	Yes	Yes
Illinois	18	Yes	Yes	No	Yes	No
Indiana	18	Yes	Yes	No	Yes	No
Iowa	18	Yes	Yes	No	Yes	Yes
Kansas	18	Yes	No	No	Yes	Yes
Kentucky	18	Yes	No	Yes	Yes	No
Louisiana	18	Yes	No	Yes	Yes	No
Maine	18	Yes	Yes	Yes	Yes	No
Maryland	18	Yes	No	No	Yes	No
Massachusetts	18	Yes	Yes	Yes	Yes	Yes
Michigan	18	Yes	No	No	Yes	No
Minnesota	18	Yes	Yes	No	Yes	Yes
Mississippi	18	Yes	No	No	Yes	No
Missouri	18	Yes	Yes	Yes	Yes	No

State	Minimum Age to Buy Tobacco Products	Has Requirements on Packaging and Labeling of Tobacco Products	Restricts Customer Access to Tobacco Products	Requires ID Before Selling Tobacco Products	Restricts Placement of Tobacco Product Vending Machines	Restricts Free Distribution/Sampling of Tobacco Products
Montana	18	Yes	No	Yes	Yes	No
Nebraska	18	Yes	No	No	Yes	Yes
Nevada	18	Yes	Yes	No	Yes	No
New Hampshire	18	Yes	No	Yes	Yes	Yes
New Jersey	19	Yes	No	No	No	No
New Mexico	18	Yes	Yes	No	Yes	No
New York	18	Yes	Yes	Yes	Yes	Yes
North Carolina	18	Yes	No	Yes	Yes	No
North Dakota	18	Yes	No	No	Yes	No
Ohio	18	Yes	No	No	Yes	No
Oklahoma	18	Yes	Yes	Yes	Yes	Yes
Oregon	18	Yes	Yes	No	Yes	No
Pennsylvania	18	Yes	Yes	Yes	Yes	Yes
Rhode Island	18	Yes	No	No	Yes	Yes
South Carolina	18	Yes	No	Yes	Yes	No
South Dakota	18	Yes	No	No	Yes	Yes
Tennessee	18	Yes	No	Yes	Yes	Yes
Texas	18	Yes	Yes	Yes	Yes	Yes
Utah	19	Yes	Yes	No	Yes	Yes
Vermont	18	Yes	Yes	No	Yes	No
Virginia	18	Yes	No	Yes	Yes	No
Washington	18	Yes	No	Yes	Yes	Yes
West Virginia	18	No	No	No	Yes	No
Wisconsin	18	Yes	No	No	Yes	Yes
Wyoming	18	No	Yes	No	Yes	No

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 State of Tobacco Control 2008 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 http://slati/lungusa.org. The American Lung Association has published this comprehensive summary of state tobacco control laws since 1988.

State of Tobacco Control 2008's state smokefree air and state tobacco control and prevention programs grading methodology has been updated. Changes to the methodology are described in the appropriate sections below. The state cessation coverage section is new to the report this year.

CALCULATION OF FEDERAL GRADES

Tobacco control and prevention measures at the federal level are graded in four distinct areas: Food and Drug Administration regulation of tobacco products; coverage of tobacco cessation treatment and promotion; 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.

Food and Drug Administration Regulation of Tobacco Products

The criteria for strong and effective Food and Drug Administration regulation of tobacco products are based on *Critical Elements of Any Legislation to Grant FDA Authority to Regulate Tobacco Products* developed by the American Lung Association, American Cancer Society, American Heart Association and Campaign for Tobacco-Free Kids.

FDA Regulation of Tobacco Products: Target is FDA having strong and unfettered authority over tobacco products that includes the critical elements of strong legislation.

Grade	Target
A	FDA has strong and unfettered authority
F	FDA does not have strong and unfettered authority

Cessation

In 2002, the Secretary of U.S. Department of Health and Human Services convened a Subcommittee on Cessation of the Interagency Committee on

Smoking and Health. The Secretary charged the 16-member subcommittee with the responsibility of developing a set of bold, science-based steps that the federal government could undertake to dramatically reduce tobacco use rates in the United States. In 2003, the subcommittee issued a *National Action Plan for Tobacco Cessation*. The cessation criteria used in the *American Lung Association State of Tobacco Control 2008* are based on the performance of the federal government in each of the four quantifiable recommendations for the federal government laid out by the subcommittee.

The cessation grades break down as follows:

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

National Tobacco Quitline Network (5 points): Target is the establishment of a federally-funded National Tobacco Quitline Network that will provide universal access to evidence-based counseling and medication for tobacco cessation via a nationwide toll-free telephone number portal to state quitlines and grants to states to establish and/or enhance quitline services.

+5 = Congress appropriates the recommended $3.2 billion for the National Tobacco Quitline Network. Congress funds grants to states and a toll-free number that serves as a portal to the appropriate state quitline.

+2 = Implements a National Tobacco Quitline Network, consisting of grants to states and a toll-free number that serves as a portal to state quitlines, and provides some funding.

+1 = Designs a National Tobacco Quitline Network, consisting of grants to states and a toll-free number that serves as a portal to state quitlines, but provides no funding.

0 = No provision

National Media Campaign (5 points): Target is the establishment of an ongoing, extensive, paid media campaign to help Americans quit using tobacco.

+5 = Congress appropriates the recommended $1 billion in funding for a campaign and the national media campaign is implemented.

+2 = Implements a national media campaign to help Americans quit and provides some funding.

+1 = Designs a national media campaign to help Americans quit but provides no funding.

0 = No campaign

Federal Coverage of Cessation Benefits (5 points): Target is coverage of evidence-based counseling and medication for tobacco cessation that follows the U.S. Public Health Service Guideline for tobacco cessation (updated in

May 2008) included in benefits provided to all federal beneficiaries and in all federally funded healthcare programs.

+5 = Meets requirement for providing coverage through all federally funded healthcare programs.

+3 = Provides coverage to all federal employees, most Medicare and Medicaid beneficiaries; exempts other programs.

+2 = Provides coverage to all federal employees, and some Medicare or Medicaid beneficiaries.

+1 = Provides coverage to all federal employees, some Medicare beneficiaries or some Medicaid beneficiaries.

0 = No coverage

Smokers' Health Fund (5 points): Target is the establishment and funding of a Smokers' Health Fund to carry out all of the recommendations of the National Action Plan for Tobacco Cessation of at least $14 billion per year. This fund would be supported by a proposed $2.00 increase in the federal cigarette excise tax and similar increases in the excise taxes on other tobacco products. Score is based on two components: whether the required excise tax increase was enacted and whether the fund was established to support cessation activities.

+5 = Meets recommendation of a $2.00 cigarette tax increase including a proportional increase in the excise tax on other tobacco products. At least 50 percent of the funds from the tax increase are designated to implement the activities delineated in the National Action Plan.

+2 = Establishes a fund to support cessation activities but does not include a cigarette tax increase.

0 = No coverage

Bonus points (2 points): The *National Action Plan for Tobacco Cessation* suggested two more federal initiatives: to fund research into tobacco dependence at $500 million per year; and to invest in training and education of clinicians at $500 million per year. A bonus point is awarded for implementation of each initiative.

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 on page 40.

The Excise Tax grades break down as follows:

Grade	Tax
A	$2.38 and up
B	$1.785 to $2.379
C	$1.19 to $1.784
D	$0.595 to $1.189
F	Under $0.595

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.

Grade	Criteria
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 spending, smokefree air laws; state cigarette excise tax; and, for the first time in this report, coverage of cessation treatment. 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, last 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 provided by the CDC) served as the numerator. After calculating the percentage of the CDC recommendation each state had funded, grades were assigned according to the following formula.

Grade	Percent of CDC Recommended Level
A	80 percent or more
B	70 percent to 79 percent

C 60 percent to 69 percent
D 50 percent to 59 percent
F 50 percent or less

Since *State of Tobacco Control 2008* uses the updated CDC-recommended spending levels, grades in this category are not comparable to the *State of Tobacco Control 2007* or earlier reports.

Limitation of Grading System on State Tobacco Control Expenditures

The American Lung Association evaluates neither the expenditure each state makes in each of the CDC categories nor 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. The CDC recommends a *comprehensive* program and 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 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)" (J.F. Chriqui 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.

New for *State of Tobacco Control 2008*, one new category for bars has been added to all states. Another category applies to the majority but not all states (because some states do not have/allow them), Casinos/Gaming Establishments. Adding these categories is necessary because since 2002, a number of states have prohibited smoking in bars and casinos/gaming establishments. And states need to be recognized in the grading system for protecting workers in these places from secondhand smoke. **Due to the addition of these categories this year, Smokefree Air grades for this year's report are not comparable to grades from the *State of Tobacco Control 2007* report.**

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 high 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 high 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 standard (90 to 100 percent) earned an A. Those receiving scores falling between 80 and 89 percent got a grade of B, between 70 and 79 percent a C and between 60 and 69 percent a D. Those that fell below 60 percent received an F. The points break down as follows:

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

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

- Preemption: 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: 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 smokefree ordinances will receive an A, over 80 percent a B, over 65 percent a C, over 50 percent a D and anything under 50 percent will not be considered.[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 and/or location of smoking area. 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 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 and/or 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 and/or location of smoking area, and 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.

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 and/or location of smoking area, and if laws only applied to some but not all recreational and/or 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 the smokers or the proprietors/employers, or penalties that only applied to some but not all offenses. 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, 2009 was $1.19 per pack. The range of state excise taxes ($0.07 to $2.75) is divided into quintiles.

The excise tax grades break down as follows:

Grade	Tax
A	$2.38 and up
B	$1.785 to $2.379
C	$1.19 to $1.784
D	$0.595 to $1.189
F	Under $.0595

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 2002 Massachusetts had the highest cigarette tax at $1.51 per pack, a value that would put them only in the middle of the states in 2007. As cigarette taxes rise in the future, the mean will change and the grades will be adjusted to reflect the new mean.

Cessation Coverage

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.

The state cessation coverage grading system used in the report is based on the Guideline. This is a new grading category for *State of Tobacco Control 2008*, and replaces youth access laws as a grading category. Youth access laws as a stand-alone tobacco control measure had a history of mixed evidence of effectiveness. Further, there is an urgent need to broaden coverage of tobacco cessation services under public and private health insurance plans to make it easier for smokers to access the tools they need to quit. Selected information on youth access laws is available in an appendix in this report.

The American Lung Association collected and analyzed all the data about cessation coverage in the report. That analysis forms the basis of the rating system below. Points were assigned in each category based on targets established according to the Guideline recommendations. The majority of the points under the cessation coverage section are awarded for coverage under a state's Medicaid program. This is due to smoking rates among the Medicaid population being much higher than the general population, and the importance of covering treatments to help smokers quit for low-income populations who are less able to pay for treatments on their own.

The cessation coverage grades are based on the maximum number of total points, a score of 41. A score of 41 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. States receiving scores in the top 10 percent of the standard (90-100 percent) got an A. Those receiving scores that fell between 80-89 percent got a grade of B, between 70-79 percent a C and between 60-69 percent a D. Those that fell below 60 percent received an F. The grades break down as follows:

Grade	Points Earned
A	37 to 41
B	33 to 36
C	29 to 32
D	25 to 28
F	0 to 24

Because the cessation coverage category is a new addition to the report in 2008, grades in this section are not comparable to any previous report.

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 for quality of the coverage, i.e., only some health plans/managed care organizations provide coverage;

2) States receive up to 10 points for coverage of counseling: 5 points for each type of counseling (individual and group). Deductions were made for lacking quality of coverage, i.e., coverage only applies to pregnant women,

only some health plans/managed care organizations provide coverage;

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 Plans (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 given for coverage of medications; deductions were made for lacking quality of coverage, i.e., only some health plans/managed care organizations provide coverage;

2) 0 to 4 points given for coverage of counseling; deductions were made for lacking quality of coverage, i.e., only some health plans/managed care organizations provide coverage; a bonus point (+1) is available in this section if phone and/or online counseling is covered;

3) 0 to 2 points given if coverage is free of barriers.

State Quitlines (1 point): Target is a quitline that is not entirely funded by the federal government. The federal government provides very limited funding, and additional funding is needed to provide adequate quitline services to smokers. Other funding sources include state general funds, settlement funds, and private sources.

1) 1 point given if a state contributes some funding to the operation of its quitline

Standards for Private Insurance Coverage (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.

Limitations of Grading System on Cessation Coverage

The cessation coverage grade evaluates the provision of tobacco cessation treatments under health plans (Medicaid, state employee plans and requirements for private insurance). The grade should not be viewed as an assessment of all tobacco cessation efforts in a state. State quitlines in particular are extremely valuable parts of tobacco cessation efforts in many states that are not evaluated in this grade accept for one point given for a state providing funding for its quitline.

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/2006/2006.htm.

Federal and State Report Cards

United States Report Card

Grades:

Food and Drug Administration Regulation of Tobacco Products	**F**

Legislation giving the U.S. Food and Drug Administration regulatory authority over manufactured tobacco products passed the U.S. House of Representatives but was not voted on by the Senate.

Cessation	**F**

Nationwide Quitline: **Minimal**

National Media Campaign: **None**

Federal Coverage of Cessation Services: **Minimal**

Smokers Health Fund: **None**

Cigarette Tax	**F**

Tax rate per pack of 20: $0.39

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.

Behind the Scenes

Despite widespread support in Congress for strong tobacco control policies, the federal government's history of failing to enact meaningful policy change continued in 2008.

While ultimately failing to pass the Congress in 2008, progress was made in advancing the Family Smoking Prevention and Tobacco Control Act, legislation granting the U.S. Food and Drug Administration regulatory authority over manufactured tobacco products. In March, the U.S. House of Representatives' Committee on Energy and Commerce began its work on the legislation. While experiencing strong support across parties, it faced opposition from the Bush Administration which issued a veto threat in July, just before the full House of Representatives voted on this critical public health legislation. Despite that, the House of Representatives went on to pass the bill on an overwhelmingly bipartisan basis—326 to 102. While the legislation secured 60 cosponsors in the Senate—the number necessary to stop a filibuster of the legislation—the Senate ultimately failed to consider the legislation before adjourning for the year.

The federal government once again did not implement the 2003 tobacco cessation recommendations of the U.S. Department of Health and Human Services' Interagency Committee on Smoking and Health. In July, Senator Dick Durbin (IL) and Representatives Diana DeGette (CO) and Todd Platts (PA) introduced legislation supported by the American Lung Association that would take a significant step in addressing the Interagency's recommendations by providing comprehensive cessation treatments for Medicare and Medicaid patients. The legislation would ensure that Medicare recipients have access to cessation counseling as well as medications through Medicare Part D drug plans. The proposed bills also would provide cessation medication and counseling coverage for Medicaid recipients. Currently, this coverage is optional for state Medicaid plans, and most states do not provide all of these life-saving benefits. Sadly, the U.S. continues to fail to help its smokers quit—something that would save lives and save money.

The Bush Administration ended its second term without forwarding the Framework Convention on Tobacco Control to the U.S. Senate for ratification. The Framework is the first ever public health treaty, and is in effect in 160 nations. The U.S. signed the treaty in 2004 but since that time, it has been undergoing "interagency review," according to the Bush Administration.

With the new Congress and a new Administration likely to be more sympathetic to tobacco control, 2009 could be the year the federal government begins to address the terrible burden caused by tobacco in the United States. The stop-gap measure for the State Children's Health Insurance Program (SCHIP) will expire in March 2009 at which time an increase in the federal cigarette and tobacco product taxes is the likely revenue source for the program's continuation.

United States Facts

Economic Costs Due to Smoking:	$192,775,000,000
Adult Smoking Rate:	19.8%
High School Smoking Rate:	20.0%
Middle School Smoking Rate:	6.3%
Smoking Attributable Deaths:	392,681
Smoking Attributable Lung Cancer Deaths:	125,522
Smoking Attributable Respiratory Disease Deaths:	103,338

Adult smoking rate is taken from the 2007 National Health Interview Survey. High school smoking rate is taken from the 2007 Youth Risk Behavior Surveillance System. Middle school smoking rate is taken from the 2006 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.

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

American Lung Association
National Headquarters
Washington DC Office:
1301 Pennsylvania Ave., NW, Suite 800
Washington, DC, 20004
(202)785-3355
www.lungusa.org

New York City Office:
61 Broadway
New York, NY 10006
(212) 315-8700
www.lungusa.org

Alabama Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$2,272,038*
CDC Best Practices State Spending Recommendation:	$56,700,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — F

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Restricted**

Private Worksites: **Restricted**

Schools: **Restricted**

Child Care Facilities: **Restricted**

Restaurants: **No provision**

Bars: **No provision**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **Restricted**

Recreational/Cultural Facilities: **Restricted**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

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

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

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **No coverage**

Counseling: **Covers individual counseling (pregnant women only)**

Barriers to Coverage: **Limits on duration, prior authorization required**

STATE EMPLOYEE HEALTH PLAN:

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

Counseling: **Covers individual and group counseling**

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

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See See **Alabama Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Alabama is committed more than ever to our visionary goal of eliminating tobacco-related lung disease throughout Alabama. The Lung Association is a member of the influential Coalition for a Tobacco-Free Alabama which is working to reduce tobacco use in the state by creating smokefree environments, increasing tobacco taxes, and providing comprehensive tobacco prevention and cessation services at levels recommended by the Centers for Disease Control and Prevention for Alabama's youth and adult smokers.

The biggest measure pushed by the coalition and Lung Association during the 2008 legislative session in Alabama was legislation that would make most public places and workplaces, including all restaurants, smokefree statewide. Stand-alone bars would have been exempted. The bill was sponsored by a long-time champion on this issue Sen. Vivian Figures from Mobile in the state Senate, and handled by Rep. Mary Sue McClurkin of Pelham in the state House of Representatives who has survived past battles with cancer.

The measure was approved by an overwhelming vote of 28-3 in the Senate, but was unable to be brought up for a full House vote on the last day of the legislative session. Gov. Bob Riley who gave up smoking recently said he would have signed the bill into law if it had been approved.

A survey of 500 registered voters in Alabama released in January 2008 and conducted by Opinion Research Associates in Little Rock, Arkansas revealed that 78 percent responded in favor of a law making all Alabama workplaces smokefree. The same study showed that 92 percent agreed that no one should be exposed to secondhand smoke in the workplace.

The slow but steady decline in Alabama's adult smoking rate continued; 22.5 percent of Alabama adults were current smokers in 2007, down from 23.3 percent of adults in 2006. However, high school smoking rates remain depressingly high at 26.8 percent, according to the 2006 Alabama Youth Tobacco Survey. These statistics demonstrate the need for Alabama to get serious about reducing tobacco use by increasing funding for state tobacco control programs and increasing its relatively low cigarette tax.

The American Lung Association in Alabama is confident that the progress towards passing smokefree legislation this year will translate into success during the 2009 legislative session.

Alabama State Facts

Economic Costs Due to Smoking:	$3,678,740,000
Adult Smoking Rate:	22.5%
High School Smoking Rate:	26.8%
Middle School Smoking Rate:	13.0%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school and middle school smoking rates are taken from the 2006 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. **Data on the number of deaths are not comparable by state.** 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 3188
Bessemer, AL 35023
(205) 491-1241
www.lungusa.org/alabama

Alaska Report Card

Grades:

Tobacco Prevention and Control Spending — A

FY2009 Tobacco Control Program Funding: $8,808,412*

CDC Best Practices State Spending Recommendation: $10,700,000

The **American Lung Association** recognizes Alaska for funding its tobacco control program at above 80% of the CDC recommended level, earning it an "A" in this category.

*Includes FY2009 funding from the Centers for Disease Control and Prevention

Smokefree Air — F*

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Restricted**

Private Worksites: **Restricted**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Restricted**

Bars: **No provision**

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

Retail Stores: **Restricted**

Recreational/Cultural Facilities: **Restricted**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: AK STAT. §§ 18.35.300 et seq.

*Approximately 45.5% of Alaska's population is covered by a comprehensive smokefree local ordinance. 50% of the population must be covered to earn a better grade.

Cigarette Tax — B

Tax Rate per pack of 20: $2.00

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT Lozenge, Chantix, Zyban**

Counseling: **Covers individual counseling**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, prior authorization required, minimal co-payments required, stepped care therapy required, combination therapy required**

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers NRT Nasal spray, Chantix, Zyban**

Counseling: **No coverage**

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

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See See **Alaska Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Alaska is a key partner in the effort to sustain and increase funding for Alaska's comprehensive tobacco prevention and control program. We had another successful year in 2008.

In May, the Legislature passed its Fiscal Year 2009 budget, which included a small increase in funding from the Tobacco Use Education and Cessation Fund over the Fiscal Year 2008 level for a total of $7.856 million. Added to federal funds from the U.S. Centers for Disease Control and Prevention (CDC), the state of Alaska devotes almost $8.8 million to its tobacco prevention and cessation program. This brings Alaska close to the $10.7 million level recommended by the CDC.

On the local level, Juneau, the state capital of Alaska, became completely smokefree on January 2, 2008, when bars were finally required to prohibit smoking due to an ordinance passed in 2004. Restaurants have been smokefree since 2005. The biggest city in Alaska, Anchorage, prohibited smoking in virtually all public places and workplaces, including restaurants and bars, in July 2007.

However, it was discovered after bars went smokefree that due to a technical loophole in the ordinance, private clubs were not included under Juneau's law. So, a revised ordinance was brought before the Juneau city council in February to close the private club loophole as well as other exemptions for tobacco retail stores and private functions in otherwise public places. In March, the revised ordinance was approved by the city council, and took effect in April.

Implementation of strong state and local tobacco control policies in Alaska appear to be paying off. Alaska's adult smoking rate declined to 22.2 percent in 2007 from 24.2 percent in 2006, and the high school smoking rate stands at 17.8 percent in 2007, well below the nationwide high school smoking rate of 20 percent.

As we look forward to 2009, the American Lung Association in Alaska will continue to work with statewide partners to improve lung health in the state. It will have an integral role in ensuring that Alaska maintains current funding levels for its tobacco prevention and control program. The Lung Association will also work on building support for a comprehensive smokefree air law on the statewide level, and will continue to be a well-respected authority on public health in Alaska.

Alaska State Facts

Economic Costs Due to Smoking:	$448,937,000
Adult Smoking Rate:	22.2%
High School Smoking Rate:	17.8%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 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. **Data on the number of deaths are not comparable by state.** 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
(800) LUNG-USA
www.lungusa.org

Arizona Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$22,760,502*
CDC Best Practices State Spending Recommendation:	$68,100,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — A

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

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

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: AZ REV. STAT. ANN. §§ 36-601.01 & 36-798.03

Cigarette Tax — B

Tax Rate per pack of 20: $2.00

Cessation Coverage — D

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT Inhaler, NRT Lozenge, Chantix, Zyban**

Counseling: **No coverage**

Barriers to Coverage: **Limits on duration**

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT Inhaler, NRT Lozenge, Chantix, Zyban**

Counseling: **Covers phone counseling**

Barriers to Coverage: **Lifetime limit on quit attempts**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Arizona Cessation Coverage 1-pager** for specific sources

The **American Lung Association** recognizes Arizona for providing coverage for all 7 recommended tobacco cessation medications under its State Medicaid program for the first time in 2008, and establishing few barriers to that coverage.

Behind the Scenes

The American Lung Association in Arizona continues to be a leader on tobacco control issues in Arizona. The Lung Association, along with the American Cancer Society and American Heart Association, fought in 2008 to ensure that nicotine replacement therapy medications are provided to those who might not normally be able to afford them. A new study was also released in 2008 showing that Arizona's smokefree law has not affected the overall economy.

During the 2008 Legislative session, the Lung Association was very involved in the passage of Senate Bill 1418, a measure that would give Arizonans on its state Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), access to tobacco use cessation medications. AHCCCS receives federal, state and county funding, as well as some money from Arizona's tobacco tax to fund its operations. The passage of this measure will ensure that AHCCCS will provide nicotine replacement therapies and tobacco use medications to those who are deemed eligible.

This legislation was vitally important considering that an estimated 400,000 AHCCCS recipients are tobacco users. Legislators from both sides of the aisle agreed that the passage of this bill will lead to a savings for Arizona in the long run due to the decreased occurrence of deadly tobacco-related illnesses.

Legislation requiring fire-safety standards for cigarettes was also approved by the state legislature in 2008, and will take effect in August 2009. Arizona joins more than 35 states and the District of Columbia with nearly identical laws.

Also, in September 2008, a study conducted by researchers at Arizona State University's W.J. Carey School of Business for the Arizona Department of Health Services showed that Arizona's smokefree workplace law that took effect in May 2007 has had no negative impact on restaurants and bars across the state. The study used both sales records and surveys of business owners. The study proves that Arizona's smokefree workplace law has done its job of protecting all Arizona citizens from secondhand smoke without harming business.

The American Lung Association in Arizona is committed to bringing practical, common sense tobacco control reforms to the state of Arizona. We look forward to continuing to protect the health of all Arizonans for many years to come.

Arizona State Facts

Economic Costs Due to Smoking:	$3,194,074,000
Adult Smoking Rate:	19.8%
High School Smoking Rate:	22.2%
Middle School Smoking Rate:	6.8%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/arizona

Arkansas Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$16,893,073*
CDC Best Practices State Spending Recommendation:	$36,400,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — B

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

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

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Restricted***

Bars: **Restricted***

Casinos/Gaming Establishments: **Restricted**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: AR CODE ANN. §§ 20-27-1801 et seq., 20-27-704 et seq., 22-3-220, 6-21-609 & 20-78-217.

* 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:	$0.59

Cessation Coverage — D

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, Chantix, Zyban**

Counseling: **Covers group and individual counseling**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, prior authorization required, combination therapy required**

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers NRT Patch, Chantix and Zyban**

Counseling: **Covers Individual, phone and online counseling**

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

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Arkansas Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Arkansas continues to partner with a coalition of health advocates seeking to improve tobacco control policies in this state. By advocating for strong smokefree air laws, and carrying on our efforts to increase the tobacco tax along with promoting tobacco prevention and cessation programs, the Lung Association remains determined to eliminate the devastating impact of tobacco use on the citizens of Arkansas.

For many years Arkansas has been one of the few states that funded its state tobacco control program close to or above the minimum level of funding recommended by the Centers for Disease Control and Prevention (CDC). However, the CDC updated its recommendations on what states should spend on tobacco control programs in 2007, and now recommends that Arkansas spend $36.4 million on these vital public health programs. In FY2009, the Master Settlement Agreement revenue dedicated for tobacco control programs is about $17 million, close to half of the new recommended level.

July 2008 marked the two-year anniversary of Arkansas' adoption of a strong smokefree air law that prohibited smoking in most public places and workplaces, including restaurants. Public support for this law continues to grow. The Lung Association will continue to work with our partners and stakeholders to advocate for extending the law to include small workplaces and bars.

While national smoking rates for high school kids have stopped declining, Arkansas's rate has hit a historic low, according to a new study by the Arkansas Department of Health. The Arkansas Youth Tobacco Survey released in November 2007 showed that between 2000 and 2007, the rate of current cigarette smoking dropped from 35.8 to 20.4 percent among Arkansas's high school students, cutting the rate almost in half.

The Arkansas legislature meets every two years and will convene in January 2009. In addition to advancing a $1.00 increase in the cigarette excise tax, other legislative priorities include requiring only cigarettes that meet specific fire-safety standards to be sold in the state in an effort to reduce cigarette-caused fires, as well as changing the state's cigarette tax stamp to assist with tracking stolen, smuggled or counterfeited tobacco products.

In addition, in 2009 the American Lung Association in Arkansas will continue to seek to strengthen tobacco control policies, preserve funding for tobacco control and prevention activities, and build stronger grassroots efforts to reduce the grip of tobacco on the people of our state.

Arkansas State Facts

Economic Costs Due to Smoking:	$2,271,726,000
Adult Smoking Rate:	22.4%
High School Smoking Rate:	20.7%
Middle School Smoking Rate:	9.5%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 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. **Data on the number of deaths are not comparable by state.** 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
One Castle Rock Cove, Suite 101
Little Rock, AR 72212
(501)224-0773
www.lungusa.org/arkansas

California Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$78,102,031*
CDC Best Practices State Spending Recommendation:	$441,900,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

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**

Bars: **Restricted**

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

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

Cessation Coverage — D

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **All plans cover NRT Patch and Zyban; coverage of other medications varies by health plan**

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

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, minimal co-payments required, combination therapy required**

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers NRT Patch, NRT Nasal spray, NRT inhaler Chantix, Zyban**

Counseling: **Coverage 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 combination therapy**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **California Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The year 2008 marked the 20th anniversary of the passage of Proposition 99, which increased the state's tobacco tax 25 cents per pack and directed 25 percent of the revenues to tobacco control programs and tobacco research. The American Lung Association in California was a co-sponsor of Proposition 99, and since its inception, has carried out numerous local, regional and statewide advocacy and programs that have dramatically reduced tobacco consumption, created smokefree public and work places, and prevented thousands of premature deaths. Yet, tobacco is still a major problem with nearly four million smokers, rising youth smoking rates, and a relentless tobacco industry that spends more than a billion dollars a year promoting tobacco use.

In response, the Lung Association continues to lead efforts to pass local and statewide policies that will reduce tobacco use and create a healthier state. In 2008, tobacco control advocates promoted smokefree multi-unit housing in apartment buildings, complexes and senior or low-income housing. Several cities passed ordinances that require landlords to designate a certain percentage of their apartment units as nonsmoking.

In addition, many communities are considering policies to protect their residents from secondhand smoke in outdoor areas. More than 20 cities and counties have passed comprehensive outdoor secondhand smoke ordinances, which prohibit smoking in numerous outdoor settings, including restaurant dining, entryways to buildings, public events, recreation areas, service areas, sidewalks and worksites. Another ground-breaking law was passed by San Francisco that prohibits sales of tobacco products at all pharmacies.

The state legislature was relatively quiet in 2008, passing just two tobacco-related bills, of which only one was signed by Gov. Arnold Schwarzenegger. That measure, Assembly Bill 3010, allows the state Mental Health Director to prohibit smoking by both patients and staff on the grounds of the state's five mental hospitals.

Legislation to address health care access and the more than six million Californians without health coverage dominated the 2008 legislative session. The centerpiece was a bill (AB X1-1) sponsored by Governor Schwarzenegger and then Assembly Speaker Fabian Núñez that would have provided universal health care and financed it with a combination of fees on employers, consumers and a $1.75 tobacco tax increase. Ultimately, this legislation, which did not earmark any of the tobacco tax revenues for tobacco control purposes, was defeated and no other health care reform measures were pursued. An analysis by the American Lung Association in California's Center for Tobacco Policy and Organizing showed that Philip Morris USA, Inc. spent nearly $900,000 lobbying against AB X1-1. This amount is more than Philip Morris spent in the entire previous two-year reporting period. The Center for Tobacco Policy & Organizing tobacco industry lobbying and campaign contributions reports are available at: www.Center4TobaccoPolicy.org/tobaccomoney.

California State Facts

Economic Costs Due to Smoking:	$18,135,550,000
Adult Smoking Rate:	14.3%
High School Smoking Rate:	15.4%
Middle School Smoking Rate:	6.1%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school and middle school smoking rates are taken from the 2006 California 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/california

Colorado Report Card

Grades:

Tobacco Prevention and Control Spending	**D**

FY2009 Tobacco Control Program Funding: $27,493,115*

CDC Best Practices State Spending Recommendation: $54,400,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

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**

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

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

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: CO 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: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT Inhaler, NRT Lozenge, Chantix and Zyban**

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

Barriers to Coverage: **Limits on duration, lifetime limit on quit attempts, annual limit on quit attempts, prior authorization required, minimal co-payments required, combination therapy required**

STATE EMPLOYEE HEALTH PLAN:

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

Counseling: **Counseling coverage varies by health plan**

Barriers to Coverage: **Some plans have limits on duration, a lifetime limit on quit attempts, require prior authorization and/or require co-payments**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **Yes**

Citation: See **Colorado Cessation Coverage 1-pager** for specific sources

Behind the Scenes

In 2008, the American Lung Association in Colorado has been working hard with our state and local partners on a variety of tobacco issues to improve the health of all Coloradans and lessen the social and economic burden of tobacco use within the state.

2008 was a great year for hospitals in Colorado! Not only have a majority of hospitals in Colorado adopted policies for smokefree or tobacco-free campuses, but in Denver the city council adopted an ordinance that prohibits smoking surrounding the perimeter of all Denver area hospitals. This ordinance is important for patients and visitors alike of metro area hospitals that are no longer forced to walk through clouds of cigarette smoke to enter these facilities.

The Lung Association and our coalition partners continue to work to protect the health of employees who, despite the Colorado Clean Indoor Air Act, are still being exposed to secondhand smoke where they work. State law currently exempts places of employment with three or fewer employees, and four "smoking lounges" at Denver International Airport (DIA). In 2008, a campaign was begun to educate the public about the existence of these smoking lounges, and eventually eliminate them by strengthening a Denver mayoral executive order.

Secondhand smoke exposure in multi-unit housing is prevalent throughout the state. Whether an individual lives in public or private housing, living next to a person who smokes can greatly impact one's daily life since often smoke seeps between units. During 2008, the Lung Association has been working with a variety of homeowners' association boards, public housing authorities and individuals to draft model policies, educate the public about secondhand smoke infiltration and assist individuals as they file grievances to protect their health and home.

Looking forward to 2009, the American Lung Association in Colorado will continue our efforts to lessen the impact of tobacco use in our state. In particular, we will be focusing on issues relating to youth access to tobacco products and working with our state and local partners to address troublesome "loopholes" in the Colorado Clean Indoor Air Act. The goal is to clarify and revise state law to make it clear to all Coloradans that there is no safe level of exposure to secondhand smoke and the social and economic costs of tobacco use on the state is a burden we can no longer afford to bear.

Colorado State Facts

Economic Costs Due to Smoking:	$2,400,564,000
Adult Smoking Rate:	18.7%
High School Smoking Rate:	18.1%
Middle School Smoking Rate:	2.6%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Colorado Youth Risk Behavior Survey. Middle school smoking rate is taken from the Colorado Healthy Kids Survey on Tobacco, 2006.

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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/colorado

Connecticut Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding: $8,301,799*

CDC Best Practices State Spending Recommendation: $43,900,000

The **American Lung Association** recognizes Connecticut for significantly increasing funding for its tobacco control program this year.

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — C

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Restricted**

Schools: **Prohibited**

Child Care Facilities: **Restricted**

Restaurants: **Prohibited**

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

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

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: CT GEN. STAT. §§ 19a-342 et seq.; 31-40q; 53-344 & Regulations: Pub. Health Code 19a-79-7(d)(9).

Cigarette Tax — B

Tax Rate per pack of 20: $2.00

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **No coverage**

Counseling: **No coverage**

Barriers to Coverage: **N/A**

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers NRT Patch, NRT nasal spray, NRT inhaler, Chantix and Zyban**

Counseling: **Coverage of phone counseling, online counseling and quit kits vary by health plan**

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

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Connecticut Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Connecticut continued to fight for increased state spending on tobacco control and prevention. Together with our partners and coalition members, we were unrelenting in emphasizing to the legislature that Connecticut remains "dead last" in terms of the amount of Master Settlement Agreement funds spent for the purpose they were intended. In addition, the state is one of just six that does not provide coverage for tobacco cessation services under the state Medicaid program.

The American Lung Association in Connecticut and our partners led efforts to earmark close to $7 million for tobacco prevention and cessation initiatives from the state Tobacco and Health Trust Fund, the majority of which funds a hotline to help smokers quit and a marketing campaign. Both the governor and legislature were under fire from the Connecticut U.S. Congressional delegation for the state's low rank in spending on prevention and cessation. They asked the governor for a detailed accounting of how Master Settlement Agreement funds have been spent since the state started receiving the money. The governor has made no detailed response to date.

The 2008 legislature defeated a bill to prohibit smoking in vehicles when children are present. For the second consecutive year, the Lung Association was the sole supporter of this legislation among coalition members. We are expecting broader support for this measure in the 2009 session.

Also, a bill failed that would have prohibited smoking in casinos, a loophole in the smokefree law passed in 2003. The issue was contentious between tribal leaders and leaders of the union that represents casino workers. The state attorney general promised to work with the casino owners to eliminate smoking without a specific statute. This issue remains unresolved.

In 2009, the American Lung Association in Connecticut will continue in its leadership role to advocate for policies that reduce the impact of tobacco use. Together with our partners, the Lung Association will support an increase in the cigarette tax of as much as $1.00 per pack. This effort is designed to further discourage smoking, especially among youth. At this time, a $1.00 increase in the cigarette tax would place Connecticut as the national leader.

Connecticut State Facts

Economic Costs Due to Smoking:	$2,474,139,000
Adult Smoking Rate:	15.4%
High School Smoking Rate:	21.1%
Middle School Smoking Rate:	3.4%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/connecticut

Delaware Report Card

Grades:

Tobacco Prevention and Control Spending — A

FY2009 Tobacco Control Program Funding:	$11,217,446*
CDC Best Practices State Spending Recommendation:	$13,900,000

The **American Lung Association** recognizes Delaware for funding its tobacco control program at above 80% of the CDC recommended level, earning it an "A" in this category.

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — A

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

Casinos/Gaming Establishments: **Prohibited**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: DE CODE ANN. tit. 16 §§ 2901 et seq.

Cigarette Tax — D

Tax Rate per pack of 20:	$1.15

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **NRT Gum, NRT Patch, NRT Nasal spray, NRT inhaler, NRT lozenge and Chantix**

Counseling: **No coverage**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, prior authorization required, minimal co-payments required, stepped care required and combination therapy required**

STATE EMPLOYEE HEALTH PLAN:

Medications: **No coverage**

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

Barriers to Coverage: **N/A**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Delaware Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Delaware had a successful year in accomplishing its public policy agenda. Efforts to maintain Delaware's funding for tobacco control programs during a tight budget year was a priority for the Lung Association in 2008.

The Delaware Health Fund, a repository for Master Settlement monies was established in 1999. All settlement dollars go into the fund to support specific health-related issues identified in the original authorizing legislation, including tobacco control. No monies can supplant existing budgeted dollars. Despite a deficit year for the state budget, the Delaware General Assembly approved $10.6 million for tobacco prevention and cessation programs through community-based organizations.

Due to the Centers for Disease Control and Prevention (CDC) updating its recommendations on what states should spend on tobacco control programs in 2007, Delaware will be about $2 million short of the new $13.7 million recommended spending level when federal funding from the CDC is factored in.

Delaware has consistently funded these vital public health programs close to or above recommended levels, and it is beginning to pay off. Delaware's adult smoking rate dropped dramatically from 2006 to 2007, according to the CDC's Behavioral Risk Factor Surveillance System, from 21.7 percent in 2006 to 18.9 percent in 2007, falling below the national average of 19.8 percent for the first time in years. High school smoking rates also saw a small decline from 21.2 percent in 2005 to 20.2 percent in 2007.

In 2009, the American Lung Association in Delaware will continue to lead the fight to protect people from the dangers of secondhand smoke, prevent kids from starting to smoke and motivate adults to quit.

Delaware State Facts

Economic Costs Due to Smoking:	$678,008,000
Adult Smoking Rate:	18.9%
High School Smoking Rate:	20.2%
Middle School Smoking Rate:	9.4%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2004 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. **Data on the number of deaths are not comparable by state.** 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
1021 Gilpin Avenue, Suite 202
Wilmington, DE 19806-3280
(302) 655-7258
www.lungusa.org/delaware

District of Columbia Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$4,038,258*
CDC Best Practices State Spending Recommendation:	$10,500,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — A

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Childcare Facilities: **Prohibited**

Restaurants: **Prohibited**

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

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

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; 7-1704; & DC Municipal Reg. § 3502.5

Cigarette Tax — B

Tax Rate per pack of 20:	$2.00*

The **American Lung Association** recognizes the District of Columbia for increasing its cigarette tax by $1.00 to $2.00 per pack.

*On October 1, 2008, the cigarette tax increased from $1.00 to $2.00 per pack.

Cessation Coverage — D

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Coverage for NRT Gum, NRT Patch, NRT Lozenge, Zyban and Chantix varies by health plan**

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

Barriers to Coverage: **Limits on duration**

CITY EMPLOYEE HEALTH PLAN:

Medications: **Coverage for NRT Gum, NRT Patch, NRT nasal spray, NRT Inhaler, NRT Lozenge, Zyban and Chantix varies by health plan**

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

Barriers to Coverage: **Limits on duration, annual limits on quit attempts, requiring co-payments and combination therapy varies by health plan**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **District of Columbia Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in the District of Columbia has now completed two full years of the three-year $10 million city tobacco prevention and cessation program, the DC Tobacco Free Families Campaign, with funds allocated directly to the Lung Association from the District government. The primary goal of the Campaign is to reduce tobacco-related health disparities in the District. As part of the Campaign, the Lung Association has assisted as the lead agency in putting together the DC Tobacco Free Coalition, the members of which are working together to create a network of tobacco control advocates.

The Campaign, which is a partnership of the Lung Association, the American Cancer Society and the city Department of Health, includes evidence-based programs, including a major media campaign to encourage smokers to quit and to keep homes and vehicles tobacco-free. It primarily targets the Medicaid and medically-underserved communities, which have high rates of tobacco use. All program components are taken from the Public Health Services Guidelines on Treating Tobacco Dependence and the Centers for Disease Control and Prevention's Best Practices for Tobacco Control Programs. These include training DC healthcare providers on effective tobacco dependence treatments, free nicotine replacement therapies and a 24/7 quitline operated by the American Cancer Society. Community-based grants are given to local organizations, and community-based Freedom From Smoking programs also have been implemented as part of the comprehensive approach to reducing tobacco use in the District.

Legislatively, a major victory was scored in the city council when the cigarette tax was doubled to $2.00 a pack, which became effective October 1, 2008. Legislation was also approved establishing fire-safety standards for cigarettes. Other legislation planned for the 2008-2009 session includes requiring signage at the point of sale, increasing the price of "other tobacco products" to equal the cigarette tax rate, and prohibiting smoking in vehicles carrying children.

District residents suffer from some of the worst tobacco-related disease rates in the country. The diverse population and the low-literacy problems in the District present unique challenges for public health advocates; however, the Lung Association has been successful in finding the right mix of community partners to implement the comprehensive tobacco control program. The Lung Association has more than 50 community partners working together to integrate tobacco control into other chronic disease prevention and management outreach programs. And it is making a difference! Quitline data collected since the program began show that more than 70 percent of the callers are from the targeted areas and demographic groups, and calls to the quitline have increased by more than 400 percent.

District of Columbia Facts

Economic Costs Due to Smoking:	$626,555,000
Adult Smoking Rate:	17.2%
High School Smoking Rate:	10.6%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 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. **Data on the number of deaths are not comparable by state.** 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
530 7th Street, SE
Washington, DC 20003
(202) 546-5864
www.lungusa.org/districtofcolumbia

Florida Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding: $60,225,819*

CDC Best Practices State Spending Recommendation: $210,900,000

The **American Lung Association** recognizes Florida for increasing funding for its state tobacco control program this year.

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — B

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Restricted***

Casinos/Gaming Establishments: **Prohibited**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes****

Citation: FL. STAT. chap. 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 — F

Tax Rate per pack of 20: $0.339

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, Chantix and Zyban**

Counseling: **Covers group and individual counseling**

Barriers to Coverage: **Stepped care required for all health plans; some plans have limits on duration, a lifetime limit on quit attempts, an annual limit on quit attempts and/or require co-payments**

STATE EMPLOYEE HEALTH PLAN:

Medications: **No coverage**

Counseling: **Some health plans cover group and/or phone counseling**

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

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Florida Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Florida's primary goal remains to vigorously fight to keep Florida's air healthy and Florida's residents tobacco free. Throughout Florida, the Lung Association is working with local groups, partnerships and coalitions to reduce people's exposure to secondhand smoke and to help those addicted to tobacco to quit. In addition, the Lung Association is active in an alliance to increase Florida's cigarette tax, one of the lowest in the nation.

Each year, the Lung Association and our partners work to maintain the integrity and intent of Florida's Constitutional Amendment that requires the Florida Legislature to allocate at least 15 percent of the tobacco settlement payments to a tobacco prevention program approved by voters in November 2006. The program is administered by the Florida Department of Health with an Advisory Council's oversight. During the 2008 legislative session, the Lung Association was successful in preventing efforts to earmark the money for special projects thus allowing the program to allocate funds, as intended, with a significant amount going toward a counter-marketing campaign, as well as support for cessation and community efforts that target youth and policy change.

Florida's cigarette excise tax continues to be one of the lowest in the nation. A poll conducted in January 2006 showed that an overwhelming 73 percent of likely Florida voters would personally favor raising the cigarette tax by $1.00 per pack to specifically provide more money for programs to help people quit smoking, prevent kids from starting to smoke and improve Florida's health care programs. Additionally, the poll demonstrated that raising the cigarette tax would not have a negative impact on those legislators seeking re-election. Despite this overwhelming support, few Florida legislators would commit to this important tobacco use prevention policy. The Lung Association continues to work with an alliance and other partners to educate elected officials on the value of raising the cigarette excise tax.

In 2009, the American Lung Association in Florida will continue its leadership role in working with the Florida Department of Health and the Florida Legislature to ensure a highly effective tobacco prevention and control program. Additionally, the Lung Association will be vigilant in protecting Florida's Clean Indoor Air Act prohibiting smoking in almost all public places and workplaces and will work to convince legislators of the value of protecting our youth from a lifetime of tobacco addiction by increasing Florida's cigarette tax.

Florida State Facts

Economic Costs Due to Smoking:	$12,879,031,000
Adult Smoking Rate:	19.3%
High School Smoking Rate:	15.9%
Middle School Smoking Rate:	6.1%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2007 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/florida

Georgia Report Card

Grades:

Tobacco Prevention and Control Spending	**F**

FY2009 Tobacco Control Program Funding:	$3,283,713*
CDC Best Practices State Spending Recommendation:	$116,500,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air	**C**

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Restricted**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Restricted**

Bars: **Restricted**

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

Retail Stores: **Restricted**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: GA. CODE ANN. §§ 16-12-2 & 31-12A-1 et.seq.

Cigarette Tax	**F**

Tax Rate per pack of 20:	$0.37

Cessation Coverage	**F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **No coverage**

Counseling: **No coverage**

Barriers to Coverage: **N/A**

STATE EMPLOYEE HEALTH PLAN:

Medications: **No coverage**

Counseling: **Some plans cover group counseling**

Barriers to Coverage: **None**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Georgia Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Georgia seeks to strengthen tobacco control policy in four areas: increased taxes on tobacco products, tobacco use prevention funding, Medicaid coverage for smoking cessation services and protecting all workers in Georgia from secondhand smoke.

House Bill 1197, aimed at increasing Georgia's cigarette tax by $1.00 per pack, was introduced in the 2008 session of the General Assembly by Rep. Ron Stephens and supported by the Lung Association, and our public health partners. The legislation attracted 12 co-sponsors and reflected bipartisan support. A subcommittee hearing was held on the measure but was not called for a vote. Georgia's state revenues dropped precariously toward the end of the year as the state's economy worsened. Revenues from a cigarette tax increase have been mentioned as an option for state leaders struggling to meet expenses in 2009.

Polling in February 2008 confirmed that 75 percent of Georgia voters support a $1 per pack increase in the state's cigarette tax. Those in support include 73 percent of Republicans, 79 percent of Democrats and 71 percent of Independents. Even a 63 percent majority of smokers support the tobacco tax increase to fund health care.

Georgia funds tobacco use prevention programs at a subsistence level of a little more than $2 million, despite receiving $160 million in 2008 from the Tobacco Master Settlement Agreement. House Appropriations Health Subcommittee Chair Mark Butler introduced legislation creating an oversight committee to evaluate and recommend the best, most effective tobacco use prevention efforts for Georgia. House Bill 887 passed overwhelmingly in the legislature. However, Governor Perdue vetoed the legislation.

Georgia is one of only six states that does not provide any coverage for Medicaid recipients seeking help to quit smoking. House members sought to initiate this coverage with a $3 million allocation in the budget, but Senate Appropriations members did not agree and the funding was dropped. Georgia could receive matching federal funds for providing this service.

The Lung Association is part of Smoke Free Atlanta, a group of organizations and community members working to build support for a comprehensive smokefree air law for the city of Atlanta. Georgia has 26 local ordinances stronger than the state law. Smoke Free Atlanta's success will encourage other communities to pass comprehensive smokefree air ordinances.

In 2009, the American Lung Association in Georgia will continue to lead the fight to protect people from the dangers of secondhand smoke, prevent kids from starting to smoke and motivate adults to quit.

Georgia State Facts

Economic Costs Due to Smoking:	$5,681,925,000
Adult Smoking Rate:	19.4%
High School Smoking Rate:	18.6%
Middle School Smoking Rate:	8.5%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2005 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. **Data on the number of deaths are not comparable by state.** 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
Smyrna, GA 30080-3862
(770) 434-5864
www.lungusa.org/georgia

Hawaii Report Card

Grades:

Tobacco Prevention and Control Spending — B

FY2009 Tobacco Control Program Funding:	$11,309,652*
CDC Best Practices State Spending Recommendation:	$15,200,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Cigarette Tax — B

Tax Rate per pack of 20: $2.00*

The **American Lung Association** recognizes Hawaii for increasing its cigarette tax by $0.20 to $2.00 per pack.

*On September 30, 2008, the cigarette tax increased from $1.80 to $2.00 per pack.

Smokefree Air — A

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

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

Retail Stores: **Prohibited**

Recreation/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: HI REV. STAT. ANN. § 302A-142; HI Admin. Rules 8-31-1 to 8-31-6; 346-151 & 346-158.

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, Chantix and Zyban varies by health plan**

Counseling: **No coverage for individual counseling, group counseling coverage varies by health plan**

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

STATE EMPLOYEE HEALTH PLAN:

Medications: **Some health plans cover NRT Gum, NRT Patch, NRT Inhaler, Chantix and/or Zyban**

Counseling: **Coverage varies by health plan**

Barriers to Coverage: **None**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Hawaii Cessation Coverage 1-pager** for specific sources

* Barriers to coverage could include: Limits on duration, annual limit on quit attempts, requiring prior authorization, requiring co-payments, requiring stepped care and/or requiring combination therapy

Behind the Scenes

The American Lung Association in Hawaii continues its leadership role in fighting for everyone's right to breathe clean air in Hawaii. Through press conferences, television appearances, letters to the editor, testimonies, prevention and cessation programs and public speaking engagements, the American Lung Association of Hawaii has worked to reduce secondhand smoke and encourage smokers to quit. The Lung Association remains an active member of the Coalition for a Tobacco Free Hawaii.

The Lung Association rallied with other coalition members to defeat legislative attempts backed by very boisterous bar owners and smokers' rights groups to roll back or modify the November 16, 2006 comprehensive statewide smokefree air law. The Lung Association also opposed punitive measures relating to the possession of tobacco products by minors, advocating instead for increased education and cessation programs for youth and better enforcement of laws prohibiting underage sales. These measures were defeated. Of additional interest was a 2009 sunset clause in the current law requiring sellers of tobacco products to be licensed. Unfortunately, attempts to remove the sunset requirement failed.

Thanks to strong support from many groups including the local office of the American Lung Association of Hawaii on the Big Island of Hawaii, a new ordinance was passed prohibiting smoking in all county parks, beaches, and recreational areas. The Mayor vetoed the bill, but the Hawaii County Council overrode that veto.

In 2009, the American Lung Association in Hawaii will continue to work with the coalition; a major focus will be to increase the tax on all non-cigarette tobacco products sold in Hawaii. This tax is currently forty percent of the wholesale price and has not been raised since 1995. The approach will be to significantly increase the percentage of tax on the wholesale price and avoid switching to a weight-based tax for spit tobacco, which has resulted in under-taxing premium and lightweight products in other states. Premium spit tobacco products are the ones most preferred by youth. A bill removing the 2009 sunset clause in the licensing law will also be supported. Additionally, any attempts to raid the Master Settlement Agreement Tobacco Trust Fund will be strongly opposed.

Hawaii State Facts

Economic Costs Due to Smoking:	$686,772,000
Adult Smoking Rate:	17.0%
High School Smoking Rate:	12.8%
Middle School Smoking Rate:	4.9%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2005 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. **Data on the number of deaths are not comparable by state.** 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
680 Iwilei Road, Suite 575
Honolulu, HI 96817
(808) 537-5966
www.lungusa.org/hawaii

Idaho Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$3,291,046*
CDC Best Practices State Spending Recommendation:	$16,900,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — B

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Restricted**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **No provision**

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

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: ID 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 NRT Gum, NRT Patch, NRT Nasal spray, NRT lozenge, Chantix and Zyban**

Counseling: **Covers group counseling**

Barriers to Coverage: **Annual limit on quit attempts, combination therapy required**

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers Chantix and Zyban**

Counseling: **Covers online counseling**

Barriers to Coverage: **Annual limit on quit attempts**

OTHER PROVISIONS:

State Funding for Quitline: **No**

Private Insurance Mandate: **No**

Citation: See **Idaho Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Idaho participates in the Coalition for a Healthy Idaho and works for change in tobacco control policy on the state and local level. The Lung Association advocates for strong clean indoor air laws and increased spending on tobacco prevention and cessation programs with an emphasis on programs to decrease youth smoking rates.

The 2008 legislative session in Idaho was relatively uneventful on tobacco control issues, although legislation was approved requiring cigarettes to self-extinguish when not being smoked to help reduce cigarette-caused fires.

Legislators also approved the expenditure of over $2.35 million in Master Settlement Agreement dollars and tobacco tax revenues for tobacco prevention and control initiatives. The American Lung Association in Idaho received $170,300 to continue its Teens against Tobacco Use (TATU) program and run its Not-On-Tobacco (NOT) program throughout the state.

In November 2006, voters enacted a constitutional amendment that restructured the way Master Settlement Agreement payments are allocated each year, putting 80 percent each year starting in 2007 into a newly-created Idaho Millennium Permanent Endowment Fund, and 20 percent into the already existing Idaho Millennium Fund. Only a small portion of the interest from both funds can be spent each year, but it also protects the money from being raided for other purposes.

In 2004, Idaho's statewide smokefree air law was strengthened by the legislature and provided smokefree air in many public places and workplaces, including in all restaurants. During 2007, the law was strengthened to include bowling alleys. However, workers are still exposed to secondhand smoke in stand-alone bars.

Although there was no activity to close the stand-alone bars loophole at the statewide level in 2008, a campaign was started in Boise, the state capitol, to make stand-alone bars smokefree at the city level. Currently, community support is being built with the next step being introduction of legislation in the city council.

As it moves forward, the American Lung Association in Idaho will continue to advocate for increased spending on tobacco prevention and cessation programs, and will work with our coalition partners to devise potential strategies to increase the state's cigarette tax.

Idaho State Facts

Economic Costs Due to Smoking:	$685,273,000
Adult Smoking Rate:	19.1%
High School Smoking Rate:	20.0%
Middle School Smoking Rate:	9.4%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2003 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. **Data on the number of deaths are not comparable by state.** 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
(800) LUNG-USA
www.lungusa.org

Illinois Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$9,472,978*
CDC Best Practices State Spending Recommendation:	$157,000,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — A

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

Casinos/Gaming Establishments: **Prohibited**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: 410 IL COMP. STAT 82/1 et seq.; 105 ILCS § 5/10-20.5b; 105 ILCS § 5/34-18.11 & 225 ILCS § 10/5.5

Cigarette Tax — D

Tax Rate per pack of 20:	$0.98

Cessation Coverage — C

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT inhaler, NRT lozenge, Chantix and Zyban**

Counseling: **No coverage**

Barriers to Coverage: **Prior authorization required**

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT inhaler, NRT lozenge, Chantix and Zyban**

Counseling: **Covers group and individual counseling; coverage of other forms of counseling vary by health plan**

Barriers to Coverage: **Annual limit on quit attempts and combination therapy required**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Illinois Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Illinois continues to lead statewide clean indoor air and tobacco control efforts. January 1, 2008 was the historic implementation date of the new Smoke Free Illinois Act, which requires all workplaces, restaurants, bars and casinos to be smokefree.

Implementation of the new law as well as constant defense against weakening amendments was the focus of 2008. There were six serious attempts to weaken the Act by exempting casinos, exempting private clubs and bars as well as one attempt to completely repeal the Act. All weakening amendments were defeated. As the economy continues to deteriorate and gambling revenues decline we expect more and more attempts to exempt the casinos from the Act despite the fact that these workers would be exposed to toxic secondhand smoke once again.

The American Lung Association in Illinois helped to implement the Act by providing 55,000 No-Smoking window clings to businesses throughout the state, as well as worked with statewide and national coalition partners to develop a business kit that was distributed to 27,000 hospitality businesses throughout the state.

On February 13, the Lung Association hosted a Smoke Free Illinois Celebration to recognize and celebrate the 60-plus local smoke free coalitions and our sponsoring legislators for all their years of hard work and dedication.

In May, a statewide telephone poll confirmed that Illinois residents strongly support the new Smoke Free Illinois Act. Seventy three percent of Illinois registered voters favor the new law, while only twenty five percent oppose it. Sixty-three percent felt the casinos should be included in the law, while only twenty-six percent felt casinos should be exempted. The poll showed strong support for the new law across all demographics: age, political party, region of the state and education level.

At www.SmokeFreeIllinois.org you may view the Smoke Free Illinois Act, polling information, indoor air quality studies, and celebration pictures and the history of the Smoke Free Illinois campaign.

In 2009, the American Lung Association in Illinois will continue in its leadership role to advocate for policies to reduce the impact of tobacco use. The 2009 legislative session will likely see several more attempts to weaken our strong smokefree air law. The Lung Association will continue to ward off these attempts to weaken the law and will continue to work to increase the cigarette tax, and increase funding to statewide tobacco prevention and cessation efforts.

Illinois State Facts

Economic Costs Due to Smoking:	$8,317,453,000
Adult Smoking Rate:	20.1%
High School Smoking Rate:	19.9%
Middle School Smoking Rate:	8.8%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2006 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/illinois

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

Indiana Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$15,921,124*
CDC Best Practices State Spending Recommendation:	$78,800,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — F

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Restricted**

Private Worksites: **No provision**

Schools: **Restricted**

Child Care Facilities: **Restricted**

Restaurants: **No provision**

Bars: **No provision**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **Restricted**

Recreational/Cultural Facilities: **No provision**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: IN STAT. ANN. §§ 16-41-37-1 et seq. & 34-28-5-4.

The Smokefree Air grade only examines state tobacco control law and does not reflect local smokefree ordinances. Indiana 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:	$0.995

Cessation Coverage — C

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT inhaler, NRT lozenge, Chantix and Zyban**

Counseling: **Covers individual and group counseling**

Barriers to Coverage: **Limits on duration, limit on annual quit attempts, minimal co-payments, stepped care and combination therapy required**

STATE EMPLOYEE HEALTH PLAN:

Medications: **All health plans cover Chantix and Zyban; some plans cover NRT Gum, NRT Patch, NRT Nasal spray and NRT inhaler**

Counseling: **Some health plans cover group counseling, phone counseling and/or quit kits**

Barriers to Coverage: **Co-payments required, combination therapy required**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Indiana Cessation Coverage 1-pager** for specific sources

Behind the Scenes

Throughout 2008, the American Lung Association in Indiana worked diligently to meet and exceed our goals pertaining to tobacco control policies all around Indiana. The Lung Association continues to take leadership roles in coalition and legislative activities throughout the state, working to improve tobacco control policies and smokefree air on a local and state level. Additionally, the Lung Association worked to improve our tobacco prevention and cessation resources throughout the state, in efforts to reach more constituents seeking our assistance.

During the 2008 Indiana state legislative session, Rep. Charlie Brown introduced a comprehensive smokefree air bill in the state legislature. While the bill did not make it to the floor before adjournment, the recess has provided the Indiana Campaign for Smokefree Air coalition partners' time to increase the coalition's statewide grassroots efforts and identify and work with key legislators who will support the bill during the 2009 session. The bill to create a smokefree Indiana will protect all workers from secondhand smoke exposure, including those who work in restaurants, bars, private clubs and casinos.

The Lung Association, in collaboration with multiple local and state-wide partners, are working within various communities in the state to encourage the passing of comprehensive smokefree ordinances. Twenty-eight communities in Indiana are now covered by comprehensive smokefree laws which are protecting over 1.8 million residents, an increase of over 100,000 Indiana residents from 2007.

Recent polling and studies from the Indiana Campaign for Smokefree Air show that a majority of Indiana residents (60%) support a smokefree statewide law that includes indoor public places, including workplaces, public buildings, offices, casinos, restaurants and bars. Nearly half of the voters (47%) strongly favor such a law.

The Lung Association continues to train our volunteers in our Freedom From Smoking program, and has over 200 facilitators in various locations around the state poised to provide much needed tobacco education and cessation resources when policies that increase the demand for cessation services are enacted.

As the 2009 Legislative session opens, the American Lung Association in Indiana is well-poised to aggressively push for a statewide, comprehensive smokefree law that will protect all the citizens and employees of the state. Gov. Mitch Daniels and his administration are strong supporters of this law, and many key decision-makers of the Indiana legislature support this crucial law for all Indiana residents and employees. The American Lung Association in Indiana will continue to advocate for local and statewide initiatives that promote healthy habits and environments for all Indiana residents.

Indiana State Facts

Economic Costs Due to Smoking:	$4,804,232,000
Adult Smoking Rate:	24.1%
High School Smoking Rate:	22.5%
Middle School Smoking Rate:	7.7%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2006 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/indiana

Iowa Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding: $11,209,041*

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

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — A

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

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

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: IOWA CODE §§ 142D.1 to 142D.9 & 237A.3B

The **American Lung Association** recognizes Iowa for passing a strong smokefree law that protects almost all workers from secondhand smoke.

Cigarette Tax — C

Tax Rate per pack of 20: $1.36

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT gum, NRT patch, Chantix and Zyban**

Counseling: **Covers individual counseling**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, prior authorization required, minimal co-payments required, and combination therapy required**

STATE EMPLOYEE HEALTH PLAN:

Medications: **No coverage**

Counseling: **Covers online counseling**

Barriers to Coverage: **N/A**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Iowa Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Iowa, along with our advocates and partners, have had back-to-back years of tobacco control legislative victory. The Iowa legislature gave us the one-two punch by increasing the cigarette tax by $1.00 per pack in March 2007 and passing the Iowa Smokefree Air Act that went into effect July 1, 2008.

The battle was hard fought to pass a smokefree law that would cover as many Iowans as possible, with much political maneuvering between the Iowa House and Senate. Smokefree air bills went between the two legislative chambers a total of six times and narrowly passed with an exemption for casino floors. Iowa's Governor Chet Culver signed the bill into law on April 15, with the Smokefree Air Act going into effect July 1, 2008.

The process of drafting and implementing strong administrative rules began immediately following the signing of the bill. The Lung Association assisted the Iowa Department of Public Health by developing, printing and distributing more than 77,000 of the required no smoking signs and 15,000 information cards with key administrative rule information and smoking cessation resources to businesses, schools and local governments.

As a result of two years of strong tobacco control measures, Iowa has experienced a dramatic increase in demand for smoking cessation services. There have been more than 22,000 calls to the state's tobacco quit line this year, more calls than all of the six previous years of its existence combined. This has led to some promising declines in adult (21.5% in 2006 to 19.8% in 2007) and high school (22.2% in 2005 to 18.9% in 2007) smoking rates.

Despite the increase in cessation demands and Smokefree Air Act implementation and enforcement, the Iowa Department of Public Health Tobacco Use Prevention and Control's budget was cut by more than $2 million to about $11.2 million in FY2009. Initial appropriation legislation called for an even more significant decrease in funding, but through legislative efforts by the Lung Association and its partners, we restored a significant amount to tobacco prevention and control.

The American Lung Association in Iowa is pleased with the progress made in the past two years in the state of Iowa. We are excited to put Iowa on the list of smokefree states and we will continue to work until every Iowan is protected from secondhand smoke.

Iowa State Facts

Economic Costs Due to Smoking:	$1,910,667,000
Adult Smoking Rate:	19.8%
High School Smoking Rate:	18.9%
Middle School Smoking Rate:	3.6%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2006 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/iowa

Kansas Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$2,026,429*
CDC Best Practices State Spending Recommendation:	$32,100,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — F

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Restricted**

Private Worksites: **No provision**

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

Child Care Facilities: **Prohibited (home-based child care facilities exempt)**

Restaurants: **Restricted**

Bars: **No provision**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **Restricted**

Recreational/Cultural Facilities: **Restricted**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: KS STAT. ANN. §§ 21-4009 et seq.

The Smokefree Air grade only examines state tobacco control law and does not reflect local smokefree ordinances. Kansas 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: $0.79

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Patch, Chantix and Zyban**

Counseling: **No coverage**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, and minimal co-payments required**

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers NRT nasal spray, NRT inhaler, Chantix and Zyban**

Counseling: **Covers phone counseling**

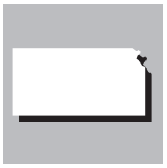
Barriers to Coverage: **Annual limit on quit attempts, co-payments required and combination therapy required**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Kansas Cessation Coverage 1-pager** for specific sources



Behind the Scenes

Smokefree worksites absorbed a great deal of energy from the American Lung Association in Kansas and its partners in 2008. Two bills failed to advance, which, because of some of the provisions they contained, was good news.

Senate Bill 493 was brought to the Judiciary Committee by five senators with an opt-out clause requiring a vote to accept or reject a smokefree law for each individual county. Luckily, it failed to make it to a vote in the committee.

The Senate Ways and Means Committee considered Senate Bill 660, a comprehensive bill with exemptions (including the casino floor of a casino yet to be built in southeast Kansas). This bill was voted out favorably by the committee but did not advance any further.

Meanwhile, on the local level, the Lung Association partnering with Clean Air Wichita and other community groups, worked on a comprehensive clean indoor air ordinance for Wichita, one of the biggest cities in Kansas. Unfortunately, the ordinance that passed was riddled with loopholes making it largely ineffective. We will continue to work to strengthen this ordinance in hopes of protecting the health of all who work, live, and play in Wichita.

At the same time, the community of Derby—just 15 miles south of Wichita—significantly strengthened its smokefree ordinance. The new ordinance removes an exemption for businesses with cereal malt beverage licenses and prohibits smoking within 20 feet of the main entrances and air intake units of public places and workplaces. This is the only community in the state of Kansas to take a weak ordinance and strengthen it. Both the Wichita and Derby ordinances went into effect in September 2008.

Other communities currently looking at adopting smokefree air ordinances include Emporia, Winfield, Holton, and Manhattan. Numerous communities in the Kansas City area have adopted or are considering ordinances as well.

More introductions are expected at the statewide level on smokefree air in the 2009 legislative session, including versions by the Kansas Health Policy Authority and the governor. The good news is citizens appear ready to rid the state of secondhand smoke.

A 2007 statewide poll by the Sunflower Foundation found that voters feel positive about tobacco cessation efforts and support a smokefree ordinance for workplaces and public facilities, along with an increased tax on tobacco products. In fact, 71 percent of Kansas voters favor a law prohibiting smoking in all indoor workplaces and public facilities.

Other goals for 2009 include working towards increasing the tobacco tax by $0.60 per pack and increasing tobacco control program funding.

Kansas State Facts

Economic Costs Due to Smoking:	$1,700,505,000
Adult Smoking Rate:	17.9%
High School Smoking Rate:	20.6%
Middle School Smoking Rate:	N/A
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 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. **Data on the number of deaths are not comparable by state.** 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
40 Via Roma
Wichita, KS 74120
(316) 687-3888
www.lungusa.org/kansas

Kentucky Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$4,242,064*
CDC Best Practices State Spending Recommendation:	$57,200,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

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**

Bars: **No provision**

Casinos/Gaming Establishments: **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.

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:	$0.30

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **No coverage**

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

Barriers to Coverage: **Limits on duration**

STATE EMPLOYEE HEALTH PLAN:

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

Counseling: **Covers group counseling**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, co-payments required and combination therapy required**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Kentucky Cessation Coverage 1-pager** for specific sources

Behind the Scenes

Kentucky continues to lead the nation in percentage of adult smokers and rates near the top in youth smoking and smoking among pregnant women. In addition, the national smoking rate continues to decline at a much quicker pace than does Kentucky's. Yet, the state remains reluctant to support policies that have been proven to reduce tobacco use in other states. Thus, Kentuckians continue to suffer disproportionately both from the disease and death that accompany tobacco addiction, as well as from the massive health care costs associated with treating sick smokers.

Although it is encouraging to the American Lung Association in Kentucky that the general public and even the business community have embraced the strategies necessary to cut smoking rates in the Bluegrass state, legislative resistance continues to pose a barrier to achieving significant tobacco control progress. For example, during the 2008 legislative session, the governor announced his support for a 70-cent increase in the tax. Disappointingly, the House narrowly passed an anemic 25-cent increase before the Senate refused to move any increase at all.

In the 2007 legislative session, a bill providing comprehensive cessation services to all Medicaid members passed both chambers by a wide margin; however, the legislature failed to fund the initiative, so implementation has not followed passage of the law. Funding for tobacco control has also been disappointing. The 2000 legislature appropriated a small percentage of Master Settlement Agreement (MSA) payments for tobacco cessation and prevention activities. As the overall MSA payments have decreased each year so too has the amount appropriated to tobacco control. Although several bills have been filed that would have increased funding over the intervening years, the legislature has rejected these proposals.

Due to the lack of positive action at the state level, Kentucky's most profound success in tobacco control continues to take place at the local level in the form of local smokefree ordinances. To date, nearly one in three Kentuckians live and work in a community that enjoys smokefree indoor air. Indeed, work has recently begun on planning for the early stages of a smokefree statewide initiative. The American Lung Association in Kentucky will be a leader in this effort.

Kentucky State Facts

Economic Costs Due to Smoking:	$3,767,220,000
Adult Smoking Rate:	28.2%
High School Smoking Rate:	26.0%
Middle School Smoking Rate:	12.1%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2006 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. **Data on the number of deaths are not comparable by state.** 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
P.O. Box 9067
Louisville, KY 40209-0067
(502) 363-2652
www.lungusa.org/kentucky

Louisiana Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$8,503,493*
CDC Best Practices State Spending Recommendation:	$53,500,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — B

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **No provision**

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

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: LA REV. STAT. §§ 40:1300.251 to 40:1300.263; 17:240 & 40:2115

Cigarette Tax — F

Tax Rate per pack of 20:	$0.36

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT inhaler, Chantix and Zyban**

Counseling: **No coverage**

Barriers to Coverage: **Minimal co-payments required and combination therapy required**

STATE EMPLOYEE HEALTH PLAN:

Medications: **No coverage**

Counseling: **No coverage**

Barriers to Coverage: **N/A**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Louisiana Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Louisiana continues to work towards a healthier Louisiana by advocating for tobacco control policies proven to reduce tobacco use. In collaboration with our public health partners, community coalitions, and scientific medical advisors, we continue to significantly reduce exposure to secondhand smoke for all Louisiana citizens particularly in public places, worksites, and restaurants.

During the past legislative session, the Lung Association and our partners with the Coalition for Tobacco Free Louisiana continued to educate Louisiana's citizens about the benefits of the recently enacted Louisiana Smoke Free Air Act. This important piece of legislation, which took effect January 1, 2007, has dramatically reduced exposure to secondhand smoke across the state. This is important because exposure to secondhand smoke is associated with an increased risk for sudden infant death syndrome (SIDS), asthma, bronchitis, and emphysema in young children, and lung cancer and heart disease in adults.

The Act has been well received by citizens, business owners, and restaurants. In fact, a recent study showed that 81 percent of Louisiana's registered voters support the fact that smoking is no longer allowed in restaurants. However, the job is not complete on secondhand smoke as smoking is still allowed in stand-alone bars and casinos exposing workers in those establishments to a witch's brew of toxic chemicals.

Unfortunately, 22.6 percent of Louisiana adults still smoke, according to the Centers for Disease Control and Prevention's 2007 Behavioral Risk Factor Surveillance System, well above the nationwide smoking rate of 19.8 percent. Smoking also exacts some harsh costs on Louisiana's economy costing the state over $3.5 billion in healthcare costs and lost productivity each year. Louisiana's cigarette tax remains quite low at only 36 cents per pack, and only $8.8 million is being spent on tobacco control programs in FY2009, well short of the $53.5 million level recommended by the Centers for Disease Control and Prevention.

The American Lung Association in Louisiana will continue to provide education and resources to support the successful implementation of the Louisiana Smoke Free Air Act, and work to close the remaining loopholes in the law. We will also work with our partners to increase the tobacco tax and protect the remainder of the Master Settlement Agreement dollars from being sold off to investors for bonds.

Louisiana State Facts

Economic Costs Due to Smoking:	$3,512,013,000
Adult Smoking Rate:	22.6%
High School Smoking Rate:	N/A
Middle School Smoking Rate:	N/A
Smoking Attributable Deaths:	6,449
Smoking Attributable Lung Cancer Deaths:	2,301
Smoking Attributable Respiratory Disease Deaths:	1,404

Adult smoking rate is taken from CDC's Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. Current high school and middle school smoking rates are 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/louisiana

Maine Report Card

Grades:

Tobacco Prevention and Control Spending — C

FY2009 Tobacco Control Program Funding:	$11,691,641*
CDC Best Practices State Spending Recommendation:	$18,500,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — A

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Restricted**

Private Worksites: **Restricted**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

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

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: ME REV. STAT. ANN. tit. 22 §§ 1541 et seq.; 1580 et seq.; 1578-B; & CODE OF ME RULES 10-144, Ch. 250

Cigarette Tax — B

Tax Rate per pack of 20:	$2.00

Cessation Coverage — C

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT inhaler, NRT lozenge, Chantix and Zyban**

Counseling: **Covers individual counseling**

Barriers to Coverage: **Limits on duration, annual and lifetime limit on quit attempts, prior authorization required, minimal co-payments required, stepped care required**

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT inhaler, NRT lozenge, Chantix and Zyban**

Counseling: **Covers individual and group counseling**

Barriers to Coverage: **Annual and lifetime limit on quit attempts, co-payments required**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Maine Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The Maine Coalition on Smoking or Health, a broad coalition of organizations and individuals co-founded by the American Lung Association in Maine has worked on tobacco prevention and control issues for more than 27 years.

The 2008 legislative session had its ups and downs. Considering the negative state budgetary climate, efforts of the coalition and the Lung Association to protect tobacco funds held by the Fund for a Healthy Maine were relatively successful. A total of $10 million over the biennium was diverted by the supplemental biennial budget. However, all but $1.4 million of this was unallocated 'reserve' funds. This was in part because tobacco payments actually received exceeded the state's conservative projections. This means that there were no cuts to existing Fund for a Healthy Maine programs.

Maine's total revised tobacco program funding for FY2009 of $10,896,793—is between 60 and 70 percent of the new $18.5 million level recommended by the U.S. Centers for Disease Control and Prevention (CDC) when funding from the U.S. CDC is included.

Two other tobacco control laws were passed which further Maine's tobacco control agenda:

1) Prohibiting smoking in vehicles with children under 16; smoking is a primary offense punishable by a fine of $50. The law is effective September 1, 2008, although law enforcement officials are required to give warnings for the first year.

2) Amended the flavored cigarettes and cigars law to limit an exemption under the law to a product whose characterizing flavor is 'not one known to appeal or likely to appeal to youth.' A manufacturer granted an exemption also is required to notify the Attorney General of a material change in the product. Final rules to implement this change are currently pending.

A law was also passed, effective in March 2008, that repealed the ban on the sale of hard snuff which had been in effect since September 2007.

A law passed that affects the funding mechanisms for the state-sponsored health plan, DirigoChoice, and would use as a partial source of its funding $5 million from tobacco dollars held by the Fund for a Healthy Maine. These funds were taken from unallocated funds held in reserve so no existing programs were impacted.

In the next legislative session, priorities for the coalition and the American Lung Association in Maine will be to provide greater statutory protection for tobacco program funding, support an increase in the cigarette tax and the low rate of tax for non-cigarette tobacco products, and to continue to monitor the implementation of the ban on flavored cigarettes and cigars.

Maine State Facts

Economic Costs Due to Smoking:	$1,084,231,000
Adult Smoking Rate:	20.2%
High School Smoking Rate:	14.0%
Middle School Smoking Rate:	6.0%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2007 Maine Youth Risk Behavior 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/maine

Maryland Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding: $20,552,791*

CDC Best Practices State Spending Recommendation: $63,300,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — A

OVERVIEW OF SMOKEFREE AIR LAW(S):

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited (allows for an economic hardship waiver)**

Casinos/Gaming Establishments: **Prohibited**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: MD. CODE ANN., HEALTH-GEN. §§ 24-205 & 24-501 to 24-511; MD. CODE ANN., LAB. & EMPLOY. §§ 5-101 & 5-608; and CODE OF MD. REGS. tit. 13A §§ 02.04 et seq.

Cigarette Tax — B

Tax Rate per pack of 20: $2.00

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Coverage of NRT Gum, NRT Patch, NRT lozenge, Chantix and Zyban varies by health plan**

Counseling: **Covers group and individual counseling**

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

STATE EMPLOYEE HEALTH PLAN:

Medications: **No coverage**

Counseling: **No coverage**

Barriers to Coverage: **N/A**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **Yes**

Citation: See **Maryland Cessation Coverage 1-pager** for specific sources

* Barriers could include: Limits on duration, annual or lifetime limit on quit attempts, prior authorization required, co-payments required, stepped care required and/or combination therapy required.

Behind the Scenes

The American Lung Association in Maryland has helped bring about important policy changes in tobacco control that have improved life for the citizens of Maryland. The Lung Association, in conjunction with other tobacco control advocacy groups, continues to support legislation that will promote lung health and reduce tobacco use in Maryland.

We have begun to see the results of our 2007 advocacy successes. The Clean Indoor Air Act of 2007 took effect in February 2008, and now, all indoor areas open to the public in Maryland are smokefree. The state's cigarette excise tax doubled in January 2008, from $1.00 to $2.00 per pack, as a result of legislation passed in 2007. Subsequently, Maryland's cigarette sales decreased by 25 percent in 2008, and calls to the statewide quitline in February 2008 increased by 116 percent when compared to February 2007. Maryland's adult (17.1% in 2007) and high school (16.8% in 2007) smoking rates are already significantly lower than the nationwide rates, and these policies should help lower them further.

In 2008, legislation was proposed to create an exception to the Clean Indoor Air Act, allowing smoking in specified open-air structures of a bar or restaurant. Our advocacy efforts helped to defeat the bill. We also gave support to the following bills: an increase in the excise tax for cigars, snuff and chew tobacco, and to use that new revenue to fund programming to reduce tobacco use; re-defining cigarettes to include small cigars; and a prohibition on smoking in vehicles containing passengers up to 6 years old. These bills did not pass, but the groundwork has been laid for our work in 2009.

Continued funding of tobacco use prevention and cessation programs from the state's allocation of Master Settlement Agreement (MSA) dollars is an annual battle with the budget committees. The MSA allocation for Fiscal Year 2009 was about $19.6 million, which combined with federal funding from the Centers for Disease Control and Prevention gives Maryland about $20.6 million in total funding.

Tobacco control is a top priority for the American Lung Association in Maryland. Our goals are to ensure that no one is exposed involuntarily to tobacco smoke and to reduce the incidence of youth initiation and all smoking. Priorities in 2009 will include blocking any legislation that undermines the Clean Indoor Air Act and supporting legislation that will reduce youth access to tobacco. The Lung Association will continue to lead the grassroots efforts on smokefree air in our state through advocacy and education.

Maryland State Facts

Economic Costs Due to Smoking:	$3,658,579,000
Adult Smoking Rate:	17.1%
High School Smoking Rate:	16.8%
Middle School Smoking Rate:	3.7%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2006 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. **Data on the number of deaths are not comparable by state.** 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
Executive Plaza 1, Suite 600
11350 McCormick Road
Hunt Valley, MD 21031
(410) 560-2120
www.lungusa.org/maryland

Massachusetts Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$13,509,492*
CDC Best Practices State Spending Recommendation:	$90,000,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Cigarette Tax — A

Tax Rate per pack of 20: $2.51*

The **American Lung Association** recognizes Massachusetts for increasing its cigarette tax by $1.00 to $2.51 per pack.

*On July 1, 2008, the cigarette tax increased from $1.51 to $2.51 per pack.

Smokefree Air — A

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

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

Casinos/Gaming Establishments: **Prohibited**

Retail Stores: **Prohibited**

Recreation/Cultural: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: MA GEN. LAWS Ch. 270, § 22

Cessation Coverage — C

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT inhaler, NRT lozenge, Chantix and Zyban**

Counseling: **Covers individual and group counseling**

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

STATE EMPLOYEE HEALTH PLAN:

Medications: **No coverage**

Counseling: **Some plans cover individual counseling**

Barriers to Coverage: **None**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Massachusetts Cessation Coverage 1-pager** for specific sources

Behind the Scenes

In 2008, the American Lung Association in Massachusetts worked with statewide tobacco coalitions and partners to advocate for increased funding for the state tobacco control program, to make the Medicaid smoking cessation benefit a permanent benefit, to increase tobacco taxes and continue to support the statewide smokefree workplace law.

This session, the Massachusetts legislature took historic action by increasing the state cigarette tax by $1.00 to $2.51 per pack. This gives Massachusetts the third highest state cigarette tax in the nation. The legislature also reclassified "little cigars" as cigarettes. As a result, "little cigars" are now taxed at the same rate as cigarettes; closing a loophole that allowed these products that look nearly identical to cigarettes to be sold at much lower prices. The revenue raised through these tax increases is earmarked to fund the implementation of the Massachusetts Health Reform Act of 2006, which set up a system for everyone in Massachusetts to have health insurance.

In addition, a two-year pilot program (created by the Health Reform Act) that expanded state Medicaid services to include smoking cessation services was made permanent this session. While this means that additional money will be spent on tobacco control initiatives in Massachusetts, the amount will depend on utilization of cessation services by Medicaid recipients. More than 32,000 Medicaid subscribers have accessed the benefit in its first 13 months.

The Massachusetts smokefree workplace law passed in 2004 continues to be successful. About 30 communities have taken the law a step further and completely prohibited smoking in private clubs.

Despite these victories, the Massachusetts legislature decided to only level fund the Massachusetts Tobacco Control Program; approving $12.75 million in funding as part of the FY2009 budget. Like last year, this year's budget remains well below the level of funding recommended by the Centers for Disease Control and Prevention, and a far cry from the level the program was funded at previously.

Locally, the city of Boston approved several new regulations that would restrict where tobacco products can be sold and expand Boston's smoking restrictions. Tobacco sales at Boston drugstores and on college campuses will be prohibited starting in February 2009. Boston's local smokefree law would also be extended to patios of restaurants and bars with outside service, on loading docks, and in all the city's hotels, inns, and bed and breakfasts. Regulations were also approved that give more support to smokers who want to quit.

The American Lung Association in Massachusetts will continue to seek increased funding for tobacco use prevention and education programs to help reduce the toll of tobacco use on Massachusetts' citizens.

Massachusetts State Facts

Economic Costs Due to Smoking:	$4,998,943,000
Adult Smoking Rate:	16.4%
High School Smoking Rate:	17.7%
Middle School Smoking Rate:	N/A
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/massachusetts

Michigan Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$5,054,750*
CDC Best Practices State Spending Recommendation:	$121,200,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

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: **Restricted**

Bars: **No provision**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **Restricted**

Recreational/Cultural Facilities: **Restricted**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: MI COMP. LAWS §§ 289.707a; 333.12601 et seq.; 750.473; 722.111 et. seq.; 333.12905; 333.12915 & Exec. Order 1992-3

Cigarette Tax — B

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; coverage of other medications 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:

Medications: **Coverage of medications varies by health plan**

Counseling: **Coverage of counseling varies by health plan**

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

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Michigan Cessation Coverage 1-pager** for specific sources

* Barriers could include: Limits on duration, annual or lifetime limit on quit attempts, prior authorization required, co-payments required, stepped care required and/or combination therapy required.

Behind the Scenes

The American Lung Association in Michigan was very disappointed that the legislature failed to approve a comprehensive, statewide smoke-free bill that protects all workers in the state from secondhand smoke. However, the measure did make it farther than it ever has before in 2008.

In early 2008, Senate Majority Leader, Mike Bishop, a public opponent of a statewide smokefree law, referred a bill passed by the Michigan House of Representatives in December 2007 that included exemptions for casinos and cigar bars to the Government Operations and Reform Committee, a committee that has historically been a place where bills are sent to die.

However, constant pressure was placed on Bishop as well as the other Senators by our amazing advocates to let them know that the citizens of Michigan want to work in an environment free of secondhand smoke. In a somewhat surprising move, in early May, Bishop allowed a discharge vote on the measure. The Senate modified the bill, wiping out all exemptions! The bill passed overwhelmingly in the Senate and was sent to the House for a concurrence vote.

Next in July, the House passed a different bill again with exemptions for casinos and cigar bars, but the version the Senate had passed was still able to be voted on. Then after several months of delay the House held a vote in November to agree to the Senate-passed version, but it failed by six votes. So, a conference committee composed of House and Senate members was then appointed in December to try to work out differences between the two bills.

Tragically, the House and Senate were not able to work out their differences before the legislative session ended December 18th. This means that Michigan workers will continue to be needlessly exposed to toxic secondhand smoke. However, clearly this issue is not going away, and the Lung Association will continue the fight in 2009 to make Michigan completely smokefree.

In the meantime, activity continues at the local level. As of September 2008, 21 counties and four cities have smokefree workplaces; counties and cities can not prohibit smoking in restaurants and bars due to a provision in state law that prevents local communities from doing so.

Despite the State's economic woes, Michigan's FY2009 budget includes approximately $5.1 million for tobacco prevention initiatives—about $1.4 million in federal funding from the Centers for Disease Control and Prevention and $3.7 million from the Healthy Michigan fund.

Moving into its second century, the American Lung Association in Michigan will continue to advocate for smokefree worksites and educate legislators about the need to fund comprehensive tobacco prevention and education programs.

Michigan State Facts

Economic Costs Due to Smoking:	$7,259,672,000
Adult Smoking Rate:	21.1%
High School Smoking Rate:	18.0%
Middle School Smoking Rate:	7.2%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2003 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. **Data on the number of deaths are not comparable by state.** 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 401
Oak Park, MI 48237
(248) 784-2000
www.lungusa.org/michigan

Minnesota Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$21,513,844*
CDC Best Practices State Spending Recommendation:	$58,400,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Cigarette Tax — C

Tax Rate per pack of 20: $1.504*

*Tax rate changes annually on August 1, increased by $0.014 this year.

Smokefree Air — A

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

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

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: MN STAT. ANN. §§ 144.411 to 144.417; &16B.24(9)

Cessation Coverage — B

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT inhaler, NRT lozenge, Chantix and Zyban**

Counseling: **Covers individual and group counseling**

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

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT inhaler, Chantix and Zyban**

Counseling: **Covers phone counseling, online counseling and quit kits**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts and co-payments required**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Minnesota Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Minnesota working together collaboratively with tobacco control partners and as members of the Minnesota Smoke-Free Coalition focused on keeping the Freedom to Breathe Act intact during this first legislative session post enactment of the law.

Following the passage of the law and between legislative sessions, partners across the state recognized supportive legislators in local media. Physician leadership across the state was an important part of this positive recognition of decision makers.

Minnesota's smokefree law (effective Oct. 1, 2007) covers most workplaces employing two or more people, including bars, restaurants and private clubs as well as public places. The law does allow for smoking during "theatrical performances" and does not provide a clear definition around that exemption.

Bar owners opposed to the law orchestrated "theater nights" in a handful of venues across the state. Claiming that smoking patrons were "actors" and part of the theatrical presentation in protest of the law, these establishments worked hard to have the law re-opened during the 2008 session. Because the law had been thoroughly debated during the past legislative session, going through 19 committees with 109 amendment attempts, leadership did not want to reopen the dialogue around the law and supported our efforts to continue with implementation and compliance efforts.

An attempt was made in the Minnesota House of Representatives to weaken the bill by adding a last minute amendment to other legislation, allowing for poorly defined "smoking shacks." Advocates around the state engaged with decision-makers to clarify this potential weakening of the law. The shack idea never had the support of the governor, and since no similar idea emerged in final Senate legislation, thankfully, the "smoking shack" idea went nowhere.

Polls conducted in the state and released in January 2008 confirmed that Minnesotans strongly support this law with 76 percent support of which 44 percent were strong supporters.

A report on the impact to charitable gambling was due to the legislature at the end of March 2008. Anticipating that report, research showing that hospitality workers have significantly reduced exposure to a tobacco-specific cancer causing chemical since the passage of the law was released at the same time, keeping the focus on the positive health impacts both in the media and with decision makers.

In 2009, the American Lung Association in Minnesota will continue to work together with tobacco control partners to keep the smokefree air law strong, increase the cigarette tax and increase funding for comprehensive tobacco control to the level recommended by the Centers for Disease Control and Prevention.

Minnesota State Facts

Economic Costs Due to Smoking:	$3,207,071,000
Adult Smoking Rate:	16.5%
High School Smoking Rate:	23.0%
Middle School Smoking Rate:	1.5%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school (12th grade only) and middle school (6th grade only) smoking rates are taken from the 2007 Minnesota Student 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/minnesota

Mississippi Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding: $12,145,576*

CDC Best Practices State Spending Recommendation: $39,200,000

The **American Lung Association** recognizes Mississippi for increasing funding for its state tobacco control program this year.

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — F

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Restricted**

Private Worksites: **No provision**

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

Child Care Facilities: **No provision**

Restaurants: **No provision**

Bars: **No provision**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **No provision**

Recreational/Cultural Facilities: **No provision**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: MS CODE ANN. §§ 29-5-161 & 97-32-29

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: $0.18

Cessation Coverage — D

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT inhaler, NRT lozenge, Chantix and Zyban**

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

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

STATE EMPLOYEE HEALTH PLAN:

Medications: **No coverage**

Counseling: **No coverage**

Barriers to Coverage: **N/A**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Mississippi Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Mississippi continues to be a part of leading 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.

During the 2008 legislative session, the legislature appropriated $10.25 million to the Office of Tobacco Control, an office of the Mississippi State Department of Health. The agency continues to develop and implement a comprehensive, statewide tobacco prevention and cessation program that is consistent with the recommendations from the Best Practices for Comprehensive Tobacco Control Programs published by the U.S. Centers for Disease Control and Prevention (CDC).

The Lung Association and other health advocacy groups are working to reduce the death and disease caused by secondhand smoke. Multiple pieces of legislation were introduced in 2008 that would provide statewide smokefree environments; all measures failed. Health advocates continued to make progress on the local level. Thirteen cities, including the state capital Jackson, joined 17 other municipalities totaling 30 smokefree ordinances in Mississippi (20 of which are 100% comprehensive). However, this still only protects around 18 percent of Mississippians from secondhand smoke. A statewide smokefree law will be a priority for advocates during the 2009 legislative session.

The cigarette tax took on a life of its own during the 2008 session. A bill was introduced which included the tax as a part of a bill dealing with the state Medicaid program. It eventually passed the House with a vote of 75-41. It was then sent to the Senate, but not acted upon because of opposition from Senate leadership. The regular session ended without full funding for Medicaid being approved as well.

During a special session in June 2008, a public opinion poll was conducted with two significant findings. First, 69 percent of people favored raising the state cigarette tax by $1.00 to fund Medicaid. Second, four out of 5 voters said the state should increase the tobacco tax by $1.00 per pack to address the Medicaid funding shortfall. Yet, after the special session ended, all measures to increase the cigarette tax to fund Medicaid died. Still another year and Mississippi's cigarette tax ranks 49th in the nation, having not been increased since 1985.

During the 2009 Mississippi Legislative session, the American Lung Association in Mississippi will continue to work with other health organizations to ensure successful passage of statewide smokefree legislation that would cover all Mississippians, an increased tobacco tax and advocate for essential tobacco prevention and cessation funding. We will continue to work through various organizations like the Communities for a Clean Bill of Health, Smokefree Mississippi and the Mississippi Tobacco Control Network.

Mississippi State Facts

Economic Costs Due to Smoking:	$2,345,142,000
Adult Smoking Rate:	23.9%
High School Smoking Rate:	19.2%
Middle School Smoking Rate:	8.4%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2006 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/mississippi

Missouri Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding: $2,653,317*

CDC Best Practices State Spending Recommendation: $73,200,000

The **American Lung Association** recognizes Missouri for increasing funding for its state tobacco control program this year.

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — F

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Restricted**

Private Worksites: **Restricted**

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

Child Care Facilities: **Prohibited**

Restaurants: **Restricted**

Bars: **No provision**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **Restricted**

Recreational/Cultural Facilities: **Restricted**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: MO REV. STAT. §§ 191.765 to 191.777

Cigarette Tax — F

Tax Rate per pack of 20: $0.17

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **No coverage**

Counseling: **No coverage**

Barriers to Coverage: **N/A**

STATE EMPLOYEE HEALTH PLAN:

Medications: **Coverage of NRT Nasal spray, Chantix and/or Zyban varies by health plan**

Counseling: **Coverage of online counseling varies by health plan**

Barriers to Coverage: **Prior authorization required, co-payments required**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Missouri Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Missouri is a leader in advocating for increased tobacco control. Together with our volunteers, e-advocates and partner health organizations, we are working toward reducing the burden that tobacco use has on the people of Missouri.

In past years we encountered multiple legislative efforts to preempt local governments from passing smokefree policies. Given all the work being done at the local level by advocates, we surprisingly did not have this legislative fight in 2008 to thwart local control. Gov. Matt Blunt's support for local control helped set the tone for this success. Kansas City voters approved an initiative for smokefree workplaces including bars and restaurants on April 8. This positive policy change for a major city is a big win in Missouri.

Our 2008 legislature appropriated $1.5 million of Master Settlement Agreement funds for youth tobacco prevention. This $1.5 million is in addition to $200,000 our Department of Health and Senior Services will award in a grant for a tobacco use prevention media education program. The $1.5 million will be used to fund community and school programs in 160 schools.

The Missouri Foundation for Health (MFH) has given a $3 million grant to the Missouri Department of Health & Senior Services to enhance its tobacco quitline—$1 million per year over three years. MFH, the largest health care foundation in the state, was created in 2000 following Blue Cross Blue Shield of Missouri's conversion from nonprofit to for-profit status. The Centers for Disease Control will add an additional $200,000 in FY2009 for Missouri's quitline.

Poll results released in August show strong support across the city of St. Louis for smokefree workplaces. By nearly a two-to-one margin (61 percent to 36 percent), city residents support prohibiting smoking "in most indoor public places, including all workplaces, public buildings, offices, restaurants, bars and casinos." The citywide survey of 500 registered voters was released by Smoke-Free St. Louis City, a coalition of nearly 1,000 individuals and over 30 community groups and businesses.

In 2009, the American Lung Association in Missouri will continue its leadership role to advocate for policies to reduce the impact of tobacco use. The Lung Association is active with the new statewide tobacco control coalition, Tobacco Free Missouri, serving on the board and on the public policy committee. Our legislative priorities for 2009 include securing dedicated funding from the Master Settlement Agreement revenue stream for comprehensive tobacco control programs, state licensure of all retail tobacco outlets, continued local control of tobacco policies, and funding of the Missouri HealthNet drug formulary to include tobacco cessation pharmaceuticals and services.

Missouri State Facts

Economic Costs Due to Smoking:	$4,755,871,000
Adult Smoking Rate:	24.5%
High School Smoking Rate:	23.8%
Middle School Smoking Rate:	6.9%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/missouri

Montana Report Card

Grades:

Tobacco Prevention and Control Spending — C

FY2009 Tobacco Control Program Funding:	$9,270,442*
CDC Best Practices State Spending Recommendation:	$13,900,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — I*

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Restricted***

Bars: **Restricted***

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

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: MT CODE ANN. §§ 20-1-220; 50-40-101 et seq.; & 50-40-201

* Montana passed a law in 2005 that prohibited smoking in most public places and workplaces, including almost all restaurants. However, a few restaurants, bars/taverns and casinos were exempted until October 1, 2009. So, they earn an "I" for Incomplete this year because these changes to their law will take effect in 2009.

Cigarette Tax — C

Tax Rate per pack of 20:	$1.70

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT inhaler, NRT lozenge, Chantix and Zyban**

Counseling: **Covers individual counseling**

Barriers to Coverage: **Limits on duration, Lifetime limit on quit attempts, Prior authorization required, co-payments required, stepped care required**

STATE EMPLOYEE HEALTH PLAN:

Medications: **No coverage**

Counseling: **No coverage**

Barriers to Coverage: **N/A**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Montana Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Montana is working with local and statewide tobacco coalitions to ensure significant policy change in tobacco control. The Lung Association and its public health partners have secured passage of public policies that strengthen tobacco control efforts within the state and keep tobacco issues a priority.

Montana's legislature only meets once every two years, so there was no legislative session in Montana in 2008. Montana is spending about $9.3 million on its state tobacco control program this fiscal year when money from the U.S. Centers for Disease Control and Prevention (CDC) is included, which is between 60 and 70 percent of the CDC-recommended level of $13.9 million. In 2009, advocates will work to defend the current level of funding and ensure additional funds are used to bolster these important programs and save lives.

Advocates have been working to educate Montana citizens and policy makers about full implementation of the historic Montana Clean Indoor Air Act originally passed in 2005. In October 2009, all indoor public places and workplaces in Montana will be totally smokefree, including restaurants, bars and casinos.

A new statewide "I Can't Wait" campaign began in the summer of 2008 that includes printed and electronic media (radio and television), along with buttons and bumper stickers. This campaign is helping educate Montana citizens, businesses, and lawmakers about the law. Montanans were surveyed about the law in September 2008 with 84 percent agreeing the rights of customers and employees to breathe clean air is more important than the rights of smokers to smoke in indoor workplaces.

The Lung Association has helped bring together and participate in a new coalition of multi-denominational faith communities and leaders from across Montana. In November 2008, more than 50 places of worship across the state will host a "Smokefree Sabbath" and discuss Montana's Clean Indoor Air Act and the health value it provides to our communities and citizens.

Even so, the tobacco industry is fully expected to try to change or overturn the law when the legislature convenes in 2009. The Lung Association will work with the legislature and Governor to protect the law and the health of our citizens. Advocates have also set up an innovative website, www.smokefreemontana.org, which provides information on and promotes the Montana Clean Indoor Air Act.

During the 2009 legislative session, the American Lung Association in Montana and its public health partners will work with the legislature and the Governor to continue funding vital tobacco prevention and cessation programs and will consider an increase in the tobacco tax to help save lives and keep our children from starting to use tobacco.

Montana State Facts

Economic Costs Due to Smoking:	$602,630,000
Adult Smoking Rate:	19.5%
High School Smoking Rate:	20.0%
Middle School Smoking Rate:	N/A
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 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. **Data on the number of deaths are not comparable by state.** 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
825 Helena Avenue
Helena, MT 59601
(406) 442-6556
www.lungusa.org/montana

Nebraska Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$4,582,755*
CDC Best Practices State Spending Recommendation:	$21,500,000

The **American Lung Association** recognizes Nebraska for increasing funding for its state tobacco control program this year.

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — I*

OVERVIEW OF STATE SMOKING RESTRICTIONS:

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

Private Worksites: **Restricted**

Schools: **Restricted**

Child Care Facilities: **Prohibited**

Restaurants: **Restricted**

Bars: **No provision**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **Restricted**

Recreational/Cultural Facilities: **Restricted**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: NE REV. STAT. §§ 71-5701 et seq.

The **American Lung Association** recognizes Nebraska for passing a strong smokefree law that protects virtually all workers from secondhand smoke.

*On February 26, 2008, Nebraska enacted a law prohibiting smoking in virtually all public places and workplaces. However, the law does not take effect until June 1, 2009 so the state receives a grade of "I" for Incomplete.

Cigarette Tax — D

Tax Rate per pack of 20:	$0.64

Cessation Coverage — C

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT inhaler, NRT lozenge, Chantix and Zyban**

Counseling: **Covers group and individual counseling**

Barriers to Coverage: **Limits on duration, prior authorization required, minimal co-payments required, combination therapy required**

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT inhaler, NRT lozenge, Chantix and Zyban**

Counseling: **No coverage**

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

OTHER PROVISIONS:

State Funding for Quitline: **No**

Private Insurance Mandate: **No**

Citation: See **Nebraska Cessation Coverage 1-pager** for specific sources

The **American Lung Association** recognizes Nebraska for providing coverage for all 7 recommended tobacco cessation medications and both forms of recommended counseling under its state Medicaid program for the first time in 2008.

Behind the Scenes

In Nebraska, the nation's only Unicameral legislature took a major step forward for lung health during the 2008 legislative session by strengthening the 1989 Nebraska Clean Indoor Air Act. In February, the senators passed Legislative bill 395, which was signed by the governor and will give Nebraska a comprehensive smokefree worksite law in June of 2009. The American Lung Association in Nebraska had pressed for a comprehensive bill after a watered down version was advanced during the 2007 legislative session.

The most objectionable portion of that watered-down version was a provision whereby local entities could elect to opt-out of the law, or even opt-down to a weaker version of its own choosing. A massive grassroots campaign by the Lung Association and its partners convinced the senators, and the governor, that a comprehensive law was the only way to effectively protect citizens from secondhand smoke.

There were two other major victories during the session as well.

An additional $500,000 was allocated to comprehensive tobacco control programming from Master Settlement Agreement funds, bringing the total to $3 million annually. That figure is still below what is recommended by the U.S. Centers for Disease Control and Prevention; however, it was a major boost to tobacco control efforts, and a major victory during tight budgetary times.

Also, for the first time, funding was approved for tobacco use cessation services for clients of the state's Medicaid program. $500,000 was provided for that effort. People on Nebraska's Medicaid program smoke at a much higher rate than the general population, making this an important investment.

The towns of Grand Island and Humbolt also passed smokefree ordinances in 2008 which are slightly more strict than the Nebraska Clean Indoor Air Act. The new statewide law does not restrict local communities from passing stronger laws. Also, in May, the Nebraska Supreme Court overturned several exemptions in Omaha's law restricting smoking for bars that don't serve food, for establishments with keno machines and Horsemen's Park, a horse-racing track, saying the law created an unfair benefit for exempted businesses. The ruling took effect in June meaning the biggest city in Nebraska went completely smokefree a year ahead of the state.

Nebraska State Facts

Economic Costs Due to Smoking:	$1,091,897,000
Adult Smoking Rate:	19.9%
High School Smoking Rate:	19.7%
Middle School Smoking Rate:	5.4%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school and middle school smoking rates are taken from the 2006 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/nebraska

Nevada Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding: $4,163,615*

CDC Best Practices State Spending Recommendation: $32,500,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — B

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Restricted***

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

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: NV REV. STAT. ANN. §§ 202.2483, 202.2492 & 202.24025

* Nevada's law prohibits smoking in bars that serve food, but allows smoking in bars that do not serve food.

Cigarette Tax — D

Tax Rate per pack of 20: $0.80

Cessation Coverage — C

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT inhaler, NRT lozenge, Chantix and Zyban**

Counseling: **Coverage provided only under certain conditions**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, prior authorization required, minimal co-payments required**

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT inhaler, NRT lozenge, Chantix and Zyban**

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

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

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Nevada Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Nevada works to stimulate greater awareness of tobacco control issues in Nevada and advocates for tobacco control policy change at the state and local levels. Key activities include protecting and strengthening Nevada's strong smokefree air law, enacting tobacco tax increases, and increasing the small amount of money currently going to Nevada's tobacco prevention and cessation program.

Nevada's legislature meets only once every two years, so there was no legislative session in 2008. Over $3.4 million was provided for state tobacco control initiatives in FY2009 per a law designating how Master Settlement Agreement (MSA) dollars are to be spent, last amended in 2007. The Centers for Disease Control and Prevention (CDC) recommends the state spend $21.5 million on such programs. Given that Nevada received a sizable bump in its MSA payments in April 2008, which will last for the next 10 years, Nevada is spending a relative pittance on these vital programs.

Thanks to the state's voters, Nevada now has a strong smokefree law in place that prohibits smoking in many public places and workplaces, including restaurants and bars that serve food. Preemption of local smokefree laws was also repealed allowing local communities to now pass stronger laws. Although there have been implementation challenges, the majority of affected businesses are respecting the will of the voters. Unfortunately, because the law was passed by ballot initiative, it can't be strengthened to include bars and casinos until 2011.

Nevada provides some of the best coverage of cessation treatments for its state employees in the country covering all seven recommended cessation medications and all recommended forms of counseling with only a few barriers to using the coverage. Medicaid coverage of cessation treatments are somewhat more limited with counseling being covered only under certain circumstances although all seven recommended cessation medications are covered. The Lung Association will encourage the strengthening of Nevada's Medicaid coverage since the Medicaid population smokes at a much higher rate than the general population.

Nevada has one of the lowest smoking rates among high school students in the country at 13.6 percent according to the CDC's 2007 Youth Risk Behavioral Surveillance System. However, the adult rate remains above the nationwide average at 21.5 percent meaning more action is needed to help existing smokers quit.

In 2009, the American Lung Association in Nevada and its public health partners will push to have a cigarette tax increase approved with some of the revenue dedicated to tobacco prevention and cessation programs. We look forward to continuing our work to protect Nevada's citizens from the deadly toll of tobacco use.

Nevada State Facts

Economic Costs Due to Smoking:	$1,611,851,000
Adult Smoking Rate:	21.5%
High School Smoking Rate:	13.6%
Middle School Smoking Rate:	N/A
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 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. **Data on the number of deaths are not comparable by state.** 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
Reno Office:
10615 Double "R" Blvd., Suite 100
Reno, NV 89521
(775) 829-5864
www.lungusa.org/nevada

Las Vegas Office:
3552 W. Cheyenne Ave., Suite 130
North Las Vegas, NV 89032
(702)431-6333
www.lungusa.org/nevada

New Hampshire Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$1,058,560*
CDC Best Practices State Spending Recommendation:	$19,200,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

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**

Bars: **Prohibited (allows for an economic hardship waiver)**

Casinos/Gaming Establishments: **Restricted**

Retail Stores: **Restricted**

Recreation/Cultural: **Restricted**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: NH REV. STAT. §§ 155.64 et seq. & 126-K:7

Cigarette Tax — C

Tax Rate per pack of 20:	$1.33*

The **American Lung Association** recognizes New Hampshire for increasing its cigarette tax by $0.25 to $1.33 per pack.

*On October 15, 2008, the cigarette tax increased from $1.08 to $1.33 per pack.

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Coverage provided only under certain conditions**

Counseling: **Covers individual counseling for all enrollees; covers group counseling for pregnant women only**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, prior authorization required, minimal co-payments required**

STATE EMPLOYEE HEALTH PLAN:

Medications: **No coverage**

Counseling: **Covers group counseling**

Barriers to Coverage: **Limits on duration**

OTHER PROVISIONS:

State Funding for Quitline: **No**

Private Insurance Mandate: **No**

Citation: See **New Hampshire Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in New Hampshire had a few successes during the 2008 legislative session. Small cigars were reclassified as cigarettes (and therefore taxable at the same rate as cigarettes). Small cigars often look identical to cigarettes, but through this loophole had been allowed to be sold at much lower prices. A bill that attempted to tax cigars and snuff for the first time, increase the tax on other tobacco products, including spit tobacco, from 19 percent to 60 percent and to allocate the additional revenue to a tobacco use prevention and cessation program, was held over for interim study between sessions.

A 25-cent cigarette tax hike increasing New Hampshire's tax from $1.08 per pack to $1.33 per pack went into effect October 1. However, this was only because a bad provision in the law that would have canceled the increase if the cigarette tax generated $50 million in revenue between July and September was not met.

Efforts to carve out exemptions to the recently enacted smokefree restaurant and bar law were defeated. These included measures to allow smoking in cigar bars (60% of income derived from cigar sales), to exempt certain restaurants from the smokefree law if their income was more than 50 percent from cigar sales and to add a definition of tavern to the statute, thereby excluding them.

A law was passed establishing more stringent standards and stronger fines for violations of the clean indoor air law ($100 per day for a first offense, $200 day for each subsequent offense), taking effect January 1, 2009.

An effort to eliminate free cigarette samples and vending machine licenses was killed in the House.

The allocations to the tobacco prevention and cessation program created in 2007 and funded with tobacco settlement dollars as a part of the Comprehensive Cancer Plan were tragically significantly reduced in 2008 by the governor. The allocation for the Plan was originally $2 million in fiscal year 2008 and $4 million in fiscal year 2009. This was reduced to $250,000 and $500,000 respectively. Only a portion of the plan funding is allocated to the tobacco prevention and cessation program, so New Hampshire is spending a measly $200,000 on these programs this fiscal year. Also, the Comprehensive Cancer Plan Oversight Board now allocates amounts appropriated to the plan for certain programs, eliminating the two-thirds automatic allocation percentage going to the tobacco prevention and cessation program.

The American Lung Association in New Hampshire will continue to advocate for increased tobacco prevention and cessation funding and for closing loopholes in the statewide smokefree law.

New Hampshire State Facts

Economic Costs Due to Smoking:	$887,508,000
Adult Smoking Rate:	19.3%
High School Smoking Rate:	19.0%
Middle School Smoking Rate:	3.8%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2004 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. **Data on the number of deaths are not comparable by state.** 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
20 Warren Street, Suite 4
Concord, NH 03301
(603) 369-3977
www.lungusa.org/newhampshire

New Jersey Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$10,150,687*
CDC Best Practices State Spending Recommendation:	$119,800,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — A

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited (allowed in cigar bars/ lounges)**

Casinos/Gaming Establishments: **Restricted***

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: NJ STAT. ANN. §§ C.26:3D-55 to C.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 — A

Tax Rate per pack of 20:	$2.575

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **All health plans cover NRT patch; some plans cover NRT Gum, Chantix and Zyban**

Counseling: **All plans cover group and individual counseling**

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

STATE EMPLOYEE HEALTH PLAN:

Medications: **No coverage**

Counseling: **Some health plans cover phone and/or online counseling**

Barriers to Coverage: **N/A**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **Yes**

Citation: See **New Jersey Cessation Coverage 1-pager** for specific sources

* Barriers could include: Limits on duration, annual or lifetime limit on quit attempts, prior authorization required, co-payments required, stepped care required and/or combination therapy required.

Behind the Scenes

The American Lung Association in New Jersey continues to take important steps to make tobacco control issues a public health priority at the state and local level.

In 2006, New Jersey celebrated the significant success of passing a smokefree air law prohibiting smoking in most public places and workplaces, including restaurants and bars, throughout the state. The only exemption was for casino gaming floors. The Senate Health, Human Services and Senior Citizen's Committee held a hearing on a bill to eliminate the casino floor exemption for casinos and simulcasting facilities. The committee sent the bill to the full Senate where it passed unanimously. However, the bill stalled in the state Assembly.

The Lung Association and its partners worked with the Atlantic City Council in 2008 to take action. The Council unanimously passed legislation to eliminate smoking on the gaming floors of casinos and limit smoking in casinos to separately ventilated smoking lounges, provided they were constructed by October 15. If the lounges were not constructed by that date, casinos were required to be 100 percent smokefree in all indoor areas. However, the city council postponed the ordinance from taking effect for one year in October meaning the previous ordinance that restricted smoking to 25 percent of the gaming floors of casinos is in effect currently.

Unfortunately, state funding for the tobacco control and prevention program funding was cut in fiscal year 2009 by $1.9 million to $9.1 million after having been funded at $11 million the past several years. New Jersey securitized most of its annual Master Settlement Agreement payments in 2002, virtually eliminating a potential source of funding. As a condition of securitizing these tobacco settlement payments the governor and legislature had indicated at the time that they would commit a significant amount of money to tobacco control programs. Sadly, but not too surprisingly, this turned out to be a false promise.

The Lung Association also supported a bill approved in 2008 to prohibit smoking on the grounds of state psychiatric hospitals if a cessation program is offered a year prior to the policy taking effect.

In 2009, the American Lung Association in New Jersey will advocate for increased funding in next year's annual budget with the goal of eventually reaching the level of funding ($119.8 million) recommended by the U.S. Centers for Disease Control and Prevention.

New Jersey State Facts

Economic Costs Due to Smoking:	$5,595,317
Adult Smoking Rate:	17.1%
High School Smoking Rate:	15.8%
Middle School Smoking Rate:	3.2%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school and middle school smoking rates are taken from the 2006 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. **Data on the number of deaths are not comparable by state.** 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
1600 Route 22 East
Union, NJ 07083-3410
(908) 687-9340
www.lungusa.org/newjersey

New Mexico Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$10,555,567*
CDC Best Practices State Spending Recommendation:	$23,400,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

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**

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

Casinos/Gaming Establishments: **No provision**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation; NM STAT. ANN. §§ 24-16-1 et seq. & N.M. ADMIN. CODE 6.12.4 et seq.

Cigarette Tax — D

Tax Rate per pack of 20: $0.91

Cessation Coverage — B

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Coverage of medications varies by health plan**

Counseling: **No coverage for individual counseling; coverage for group counseling varies by health plan**

Barriers to Coverage: **All plans have an annual limit on quit attempts; limits on duration and requiring combination therapy vary by health plan**

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT inhaler, NRT lozenge, Chantix and Zyban**

Counseling: **Covers group, individual, phone and online counseling as well as quit kits**

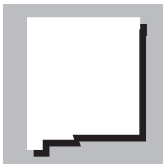
Barriers to Coverage: **Co-payments required**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **Yes**

Citation: See **New Mexico Cessation Coverage 1-pager** for specific sources



Behind the Scenes

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.

The 2008 legislative session once again saw tobacco settlement dollars under intense pressure to be allocated for other purposes. The Lung Association was successful in working with the legislature to protect this critical funding. State funding will remain at $9.6 million for fiscal year 2009; $9.116 million for the state Department of Health's Tobacco Use Prevention and Control Program, and $500,000 for the Indian Affairs Department's tobacco control programs. An increase in funding is needed to move closer to the $23.4 million recommended by the U.S. Center for Disease Control and Prevention (CDC).

The most profound change in tobacco control took place on the local front. The city of Albuquerque was one of the only large cities in New Mexico that had a local ordinance on smoking weaker than the statewide Dee Johnson Clean Indoor Air Act. The Albuquerque smokefree air bill was passed unanimously in June 2008. This new ordinance brings Albuquerque, the biggest city in New Mexico, up to date with the state law and prohibits smoking in all private workplaces, restaurants and bars as well as childcare facilities and the Albuquerque BioPark facility and grounds.

Polls conducted in the state confirm that 90 percent of New Mexicans are aware of the Dee Johnson Clean Indoor Air Act passed during the 2007 legislative session. The poll also found that 52 percent of respondents said they were "more likely" to visit non-smoking restaurants and bars.

Moving forward, increasing tobacco taxes is an effective way to prevent and reduce smoking, especially among teens. That is why increasing the cigarette tax will be a priority for the American Lung Association in New Mexico in future legislative sessions. According to the CDC's 2007 Youth Risk Behavioral Surveillance System, New Mexico high school smoking rates stand at 24.2 percent down from 25.7 percent recorded in 2005. Beginning in July 2008, the Lung Association will implement the Not-On-Tobacco program (N-O-T) to New Mexico high schools statewide. This program will also contribute to the effort in helping teens quit smoking. Another top priority is to work with tribal communities to make Native American owned casinos smokefree.

New Mexico State Facts

Economic Costs Due to Smoking:	$975,711,000
Adult Smoking Rate:	20.8%
High School Smoking Rate:	24.2%
Middle School Smoking Rate:	11.2%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2004 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. **Data on the number of deaths are not comparable by state.** 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
7001 Menaul Blvd. NE, Suite 1A
Albuquerque, NM 87110
(505) 265-0732
www.lungusa.org/newmexico

New York Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding: $81,944,471*

CDC Best Practices State Spending Recommendation: $254,300,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — A

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

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

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

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: NY [PUB. HEALTH] LAW §§ 1399-n et seq.

Cigarette Tax — A

Tax Rate per pack of 20: $2.75*

The **American Lung Association** recognizes New York for increasing its cigarette tax by $1.25 to $2.75 per pack, and now having the highest tax on cigarettes in the U.S.

*On June 3, 2008, the cigarette tax increased from $1.50 to $2.75 per pack.

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT inhaler, Chantix and Zyban**

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

Barriers to Coverage: **All plans have limits on duration and an annual limit on quit attempts; some plans require co-payments**

STATE EMPLOYEE HEALTH PLAN:

Medications: **Coverage for NRT Gum, NRT Patch, NRT nasal spray, NRT inhaler, Chantix and Zyban varies by health plan**

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

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

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **New York Cessation Coverage 1-pager** for specific sources

*Barriers to coverage could include: Limits on duration, annual or lifetime limit on quit attempts, requiring prior authorization, requiring co-payments, requiring stepped care and/or requiring combination therapy.

Behind the Scenes

The American Lung Association in New York has continued to promote tobacco control policies at the state and local levels with the goals of helping people quit smoking, preventing people from starting, and protecting all New Yorkers from the dangers of secondhand smoke. In collaboration with local partner organizations that receive funding and support from the New York State Department of Health, the Lung Association had a very successful legislative session in 2008.

We led efforts to make smoking more expensive and inconvenient by advocating for an increased tobacco tax. The New York state legislature passed, and Gov. David Paterson signed legislation raising the excise tax on cigarettes to $2.75 per pack, the highest in the nation. New York City has its own additional $1.50 local cigarette excise tax, bringing the total tax to $4.25 across the five boroughs, the highest state and local tobacco tax in the nation. This major victory in the 2008 legislative session, which took effect on June 3, makes New York the public health leader in tobacco taxation.

The American Lung Association in New York also worked to expand New York's smokefree laws throughout the state. Legislation was passed that makes all dormitories in public and private colleges and universities in New York state smokefree. In addition, New York issued regulations to become the first state in the nation to require all state-run addiction treatment centers (both inpatient and outpatient) to prohibit smoking in their facilities and on their grounds and offer smoking cessation services to their clients.

At the local level, we have continued our efforts to minimize exposure to secondhand smoke. We have supported efforts in municipalities which limit smoking at various locations including playgrounds, parks, the entranceways to buildings, and beaches.

In 2009, the American Lung Association in New York is well positioned for continued success. We will work tirelessly to increase funding for the state tobacco control program. While the program has been very successful at its current level, we must increase the funding closer to the $254.3 million level recommended by the Centers for Disease Control and Prevention. We will also continue working to prohibit smoking at playgrounds statewide and to pass a ban on the sale and marketing of alcohol and candy-flavored cigarettes.

New York State Facts

Economic Costs Due to Smoking:	$14,164,397,000
Adult Smoking Rate:	18.9%
High School Smoking Rate:	13.8%
Middle School Smoking Rate:	4.1%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2006 New York 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/newyork

North Carolina Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding: $18,478,253*

CDC Best Practices State Spending Recommendation: $106,800,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — F

OVERVIEW OF STATE SMOKING RESTRICTIONS:

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

Private Worksites: **No provision**

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

Child Care Facilities: **No provision**

Restaurants: **No provision**

Bars: **No provision**

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

Retail Stores: **No provision**

Recreational/Cultural Facilities: **No provision**

Penalties: **Yes**

Enforcement: **No**

Preemption: **Yes**

Citation: NC GEN. STAT. §§ 143-595 to 143-601, 130A-491 to 130A-498 & 115c-407

Cigarette Tax — F

Tax Rate per pack of 20: $0.35

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT nasal spray, NRT inhaler, NRT lozenge, Chantix and Zyban**

Counseling: **No coverage**

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

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers NRT patch and Zyban**

Counseling: **Covers individual counseling**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, co-payments required, combination therapy required**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **North Carolina Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in North Carolina has helped bring about important policy changes in clean air and tobacco control that have improved life for the citizens of North Carolina. The Lung Association, in conjunction with other tobacco control advocacy groups, continues to support legislation that will promote lung health and reduce tobacco use in North Carolina.

We have begun to see the results of our 2007 advocacy successes. A law passed in 2007 requiring all schools to be 100 percent tobacco free took effect on August 1, 2008, and now all 115 school districts in North Carolina have a policy prohibiting any tobacco use—by anyone, at any time, anywhere on campus or at off-campus school events such as field trips and football games. North Carolina is one of only a handful of states that requires this by law.

We have successfully continued the public discussion about the dangers of secondhand smoke and maintained legislative momentum around the issue in preparation for advancing a comprehensive statewide smokefree bill in 2009. One law approved in 2008 clarifies the authority of the governing boards of local community colleges to make their community college campuses tobacco-free. Another law requires all vehicles owned, operated and leased by the state be 100 percent smokefree by January 1, 2009 and clarifies that local governments have the authority to do the same.

Senate bill 1686, which was passed by the Senate during the 2008 legislative session, but not acted on by the House would have protected state workers and the public by prohibiting smoking within 25 feet from the entrances, windows and ventilation systems of state government buildings, and would have given local governments authority to establish a smokefree perimeter of up to 50 feet around local government buildings.

To help protect all citizens and workers in North Carolina from secondhand smoke, smokefree public places and workplaces are a top priority for the American Lung Association in North Carolina. Our goal is to ensure that no one is exposed involuntarily to tobacco smoke and to reduce the incidence of youth smoking. Priorities in 2009 will include advancing smokefree public places legislation and supporting legislation that will reduce youth access to tobacco products. The Lung Association will continue to lead the grassroots efforts on smokefree air in our state through advocacy and education.

North Carolina State Facts

Economic Costs Due to Smoking:	$6,281,486,000
Adult Smoking Rate:	22.9%
High School Smoking Rate:	22.5%
Middle School Smoking Rate:	5.8%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2005 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. **Data on the number of deaths are not comparable by state.** 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
3801 Lake Boone Trail, Suite 190
Raleigh, NC 27607
(919) 832-8326
www.lungusa.org/northcarolina

North Dakota Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$4,086,796*
CDC Best Practices State Spending Recommendation:	$9,300,000

The **American Lung Association** recognizes the voters of North Dakota for approving a ballot initiative that will provide significantly more funding for the state tobacco control program next year.

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — C

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Restricted**

Bars: **No provision**

Retail Stores: **Prohibited**

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

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: ND CENT. CODE §§ 23-12-9 et seq. & 50-11.1

Cigarette Tax — F

Tax Rate per pack of 20:	$0.44

Cessation Coverage — B

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Inhaler, Zyban and Chantix**

Counseling: **Covers individual and group counseling**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, minimal co-payments required, prior authorization required for all medications, and combination therapy required**

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers NRT Gum, NRT Patch, NRT nasal spray, NRT inhaler, NRT lozenge, Chantix and Zyban**

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

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

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **Yes**

Citation: See **North Dakota Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in North Dakota has long been a leader in the workings of the Healthy North Dakota Tobacco Policy Committee and now serves in a leadership role in Tobacco Free North Dakota, the state tobacco control coalition. With our partners we continue to support state and local 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, so there was no 2008 legislative session. The 2007 state legislative session saw an attempt to remove the exemptions for stand-alone bars, separately enclosed bars areas of restaurants and hotels, bowling alleys and truck stops from North Dakota's current law that took in effect in August 2005, but that effort was unsuccessful. Tobacco control advocates expect the smokefree law to be reconsidered and potentially strengthened in the 2009 legislative session.

Local tobacco control coalitions continued working on smokefree air ordinances that are stronger than the state law in 2008. In June, Fargo and West Fargo voters approved ballot initiatives eliminating exemptions in their respective local smokefree ordinances. Fargo is the biggest city in North Dakota making this an important victory for gaining momentum on the statewide level.

The American Lung Association of North Dakota was a supporter of an initiated measure that appeared on the November 2008 ballot to allocate all of North Dakota's strategic contribution payments from the Master Settlement Agreement to a Tobacco Prevention Trust Fund. The money will be used to support a comprehensive tobacco control program funded at the $9.3 million per year level recommended by the Centers for Disease Control and Prevention in North Dakota. It was approved by voters 54 percent to 46 percent and took effect in December although funding will not be appropriated until 2009.

North Dakota continues to see progress in reaching the Healthy North Dakota 2010 objective of achieving a smoking rate of less than 19 percent. The percentage of students in grades 9 through 12 who currently smoke cigarettes has declined by almost half from 40.6 percent in 1999 to 21.1 percent in 2007. The percentage of students in grades seven and eight who currently smoke also shows a steady decline from 13.4 percent in 1999 to 6.3 percent in 2007.

North Dakota State Facts

Economic Costs Due to Smoking:	$442,053,000
Adult Smoking Rate:	20.9%
High School Smoking Rate:	21.1%
Middle School Smoking Rate:	6.3%
Smoking Attributable Deaths:	877
Smoking Attributable Lung Cancer Deaths:	259
Smoking Attributable Respiratory Disease Deaths:	245

Adult smoking rate is taken from CDC's Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/northdakota

Ohio Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$7,633,907*
CDC Best Practices State Spending Recommendation:	$145,000,000

*Includes FY 2009 funding from the Centers for Disease Control and Prevention

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: OH REV. CODE ANN. §§ 3794.01 to 3794.09

Cigarette Tax — C

Tax Rate per pack of 20:	$1.25

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT patch, NRT gum, NRT nasal spray, NRT inhaler, NRT lozenge, Zyban and Chantix**

Counseling: **No coverage**

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

STATE EMPLOYEE HEALTH PLAN:

Medications: **Some health plans cover NRT patch, NRT gum, NRT nasal spray, NRT inhaler, NRT lozenge, Zyban and Chantix**

Counseling: **Some health plans cover group counseling**

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

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Ohio Cessation Coverage 1-pager** for specific sources

Behind the Scenes

Since tobacco use is one of the greatest threats to lung health, the American Lung Association in Ohio continues to advocate for public policy that protects people from secondhand smoke, keeps our kids from starting to smoke, and helps smokers quit.

Unfortunately, 2008 brought another move by Ohio's lawmakers which puts Ohio's children at greater risk of smoking and Ohio's adult smokers without the tools they need to quit. The legislature passed and the governor signed legislation to take away the majority of funding from the highly effective Ohio Tobacco Prevention Foundation and use it for a job stimulus plan. In an effort to preserve funding for tobacco prevention and cessation, the board of the Foundation granted most of those funds to the American Legacy Foundation for use in Ohio. The state treasurer refused to release the funds, and a lawsuit ensued. The funds are currently frozen while the lawsuit is being settled.

The legislature transferred the remaining funds to the Department of Health to continue programming on a much smaller scale. Because of the greatly reduced funding, as of June 30, all community coalition, in-school prevention, and adult cessation programs around the state ceased to exist. Some programming was restored later in the year, but at a greatly reduced level.

The Lung Association led a coalition of over 60 organizations working to increase the funding of tobacco prevention and cessation programs while fighting the growing problem of non-cigarette tobacco use. The coalition is asking the legislature to correct the inequity between the "other tobacco products" tax, which covers non-cigarette forms of tobacco, and the cigarette tax, and dedicate the revenue generated to tobacco prevention and cessation. The tax correction would allow all of the cancelled programs to be reinstated and also reduce youth users of these "other tobacco products" by 25 percent.

In the spring, a bill was introduced in the House to correct the tax and fund a Center for Tobacco Use Prevention within the Department of Health. Regrettably, the general assembly did not consider the legislation in 2008. However, the Lung Association and the coalition will pursue the tax correction and funding in 2009.

Members of the legislature also introduced legislation to potentially weaken Ohio's strong smokefree workplace law, but were unsuccessful in getting it passed. We expect the legislation to be reintroduced in 2009.

As we look to 2009, the American Lung Association in Ohio will continue to advocate for full funding of scientifically-based tobacco prevention and cessation programming to protect our children, save lives and lower healthcare costs. We will also continue to be a leader in protecting our strong smokefree public places law.

Ohio State Facts

Economic Costs Due to Smoking:	$9,174,669,000
Adult Smoking Rate:	23.1%
High School Smoking Rate:	21.6%
Middle School Smoking Rate:	7.2%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2006 Ohio 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/ohio

Oklahoma Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding: $19,093,550*

CDC Best Practices State Spending Recommendation: $45,000,000

The **American Lung Association** recognizes Oklahoma for continuing to gradually increase funding for its state tobacco control program.

*Includes FY2009 funding from the Centers for Disease Control and Prevention

Smokefree Air — D

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Restricted**

Private Worksites: **Restricted**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Restricted**

Bars: **No provision**

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

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: OK STAT. ANN. tit. 63 §§ 1-1521 et seq. & tit. 21 § 1247

Cigarette Tax — D

Tax Rate per pack of 20: $1.03

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT patch, NRT gum, NRT nasal spray, NRT inhaler, NRT lozenge, Zyban and Chantix**

Counseling: **Covers individual counseling**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, prior authorization required for second quit attempt, minimal co-payments required, combination therapy required for second quit attempt**

STATE EMPLOYEE HEALTH COVERAGE:

Medications: **Some health plans cover NRT patch, NRT gum, NRT Nasal spray, NRT inhaler, NRT lozenge, Zyban and Chantix**

Counseling: **Covers phone counseling**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Oklahoma Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Oklahoma's goal is to spearhead and support efforts to keep Oklahoma's air healthy and its residents' tobacco free. Together with our volunteers, e-advocates and partner health organizations, we are working toward reducing the burden that tobacco use has on Oklahomans.

Several amendments to bills regarding tobacco control issues were carried over to the 2009 Oklahoma legislative session in 2008. These include prohibiting smoking in public places and workplaces, repealing state preemption of local tobacco ordinances, improving tobacco cessation coverage in the state health insurance plan, and tobacco tax enforcement. The Lung Association will continue to advocate for these bills that would repeal most of the exemptions in the statewide law on smoking to protect all Oklahoma workers from secondhand smoke, and help Oklahoma smokers quit.

While some states have failed to keep their promise to use tobacco settlement funds for tobacco prevention and other programs to improve health, Oklahoma has created a constitutionally-protected endowment to assure that funds will be available for these purposes for generations to come. In 2000, Oklahoma voters approved a constitutional amendment dedicating most of the state's annual Master Settlement Agreement (MSA) payments to the Tobacco Settlement Endowment Trust (TSET). The endowment trust fund received an increasing share of the MSA payment each year until fiscal year 2008 when the percentage reached 75 percent, where it will remain each year thereafter.

Thanks to the dedication and commitment of the Oklahoma TSET Board of Directors, all of the earnings generated by the endowment trust fund to date have been spent exclusively on tobacco control programs. This unique approach, combined with other state funding, has resulted in $18 million in state money being available for tobacco control programs in fiscal year 2009.

Unfortunately, Oklahoma has some of the highest smoking rates among both adults and high school students in the country. In an effort to help more Oklahomans stop smoking, the Oklahoma State Department of Health and partner agencies continue providing smoking cessation services free for those Oklahomans calling the state Helpline, 1-800-QUIT-NOW (1-800-784-8669.) Additionally, a statewide media campaign "Tobacco Stops with Me" was launched which provides information on how to quit, how to support someone who is trying to quit and what each of us can do to make Oklahoma a healthier place to live.

The American Lung Association in Oklahoma working with other coalition members seeks to create a social climate conducive to tobacco control policy change. The ultimate goal is a smokefree Oklahoma. The Lung Association will continue to lead the public discussion on smokefree air and build capacity for comprehensive smokefree policies throughout the state.

Oklahoma State Facts

Economic Costs Due to Smoking:	$2,816,758,000
Adult Smoking Rate:	25.8%
High School Smoking Rate:	23.2%
Middle School Smoking Rate:	7.5%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 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. **Data on the number of deaths are not comparable by state.** 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
1010 East 8th Street
Tulsa, OK 74120
(918) 747-3441
www.lungusa.org/oklahoma

Oregon Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding: $8,801,930*

CDC Best Practices State Spending Recommendation: $43,000,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention

Smokefree Air — A

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibits**

Private Worksites: **Prohibits**

Schools: **Prohibits**

Child Care Facilities: **Prohibits**

Restaurants: **Prohibits**

Bars: **Prohibits (allowed in cigar bars)**

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

Retail Stores: **Prohibits**

Recreational/Cultural Facilities: **Prohibits**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: OR REV. STAT. §§ 433.835 to 433.870, 433.990, 441.815, 441.990 & OR ADMIN. RULES 581-021-0110

The **American Lung Association** recognizes Oregon for its strong smokefree law that took effect January 1, 2009 protecting virtually all workers from secondhand smoke.

Cigarette Tax — D

Tax Rate per pack of 20: $1.18

Cessation Coverage — B

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT patch, NRT gum, NRT nasal spray, NRT inhaler, NRT lozenge, Zyban and Chantix**

Counseling: **Covers group and individual counseling**

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

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers NRT gum, NRT patch, Zyban and Chantix**

Counseling: **Covers phone counseling**

Barriers to Coverage: **Co-payments and combination therapy required**

OTHER PROVISIONS:

State Funding for Quitlines: **Yes**

Private Insurance Mandate: **No**

Citation: See **Oregon Cessation Coverage 1-pager** for specific sources

Behind the Scenes

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 federal, state and local policy efforts that prevent youth from using tobacco products, protects all Oregonians from secondhand smoke and helps people who want to quit.

Oregon is one of the few states whose legislature meets biennially, so there was no legislative session in 2008. The 2007 session was very successful with the legislature passing a smokefree workplace law that will become effective on January 1, 2009. A law that requires fire-safety standards for cigarettes was implemented on July 1. The 2009 session holds great promise for tobacco control in Oregon with an ambitious agenda that will include legislation to increase the current $1.18 per pack cigarette tax with funds allocated to the state Tobacco Prevention and Education Program. The agenda also includes policies that would require all landlords to disclose the smoking status of rental properties to potential renters, a tobacco sampling law and legislation to close a loophole in the current vending machine law.

The Lung Association continues to lead the Portland-Vancouver Metro Area Smokefree Housing Project, and partners with four county health departments to achieve the project's mission: to reduce renters' exposure to secondhand smoke by increasing the number of properties with a no-smoking policy.

The smokefree housing project components include: landlord and tenant education about the benefits of no-smoking policies, print materials, a website and advocacy at landlord trade shows and one-on-one meetings with property managers. There are approximately 14,000 rental units in Oregon & Southwest Washington that are covered by a no-smoking policy, approximately 15 percent of total units.

The Lung Association also coordinates a statewide initiative for community colleges to adopt tobacco-free campus policies. In June 2008, Portland Community College (Oregon's largest post-secondary institution serving 86,000 students) announced it will be 100 percent tobacco-free by fall 2009. Several other Oregon community colleges are expected to follow.

The Lung Association has worked in collaboration with the Oregon Head Start Association and the Oregon Department of Education to develop new tobacco-free standards for Oregon Head Start Pre-Kindergarten programs. Under a new rule that is scheduled to take effect January 1, each program is required to adopt a policy prohibiting tobacco use on its premises and prohibiting the smell of tobacco on staff or volunteer clothes to protect children from this asthma trigger.

The final Lung Association component of facilitating tobacco free school campuses is the K-12 project. Of the 200 school districts in Oregon, 90 percent have adopted and implemented policies that make all schools tobacco-free at all times.

Oregon State Facts

Economic Costs Due to Smoking:	$2,174,506,000
Adult Smoking Rate:	16.9%
High School Smoking Rate:	19.4%
Middle School Smoking Rate:	9.1%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school and middle school (8th grade only) smoking rates are taken from the 2007 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/oregon

Pennsylvania Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$33,116,934*
CDC Best Practices State Spending Recommendation:	$155,500,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — C

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Restricted**

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

Bars: **Restricted**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: S.B. 246 enacted 6/13/08 and effective 9/11/08 & 35 PA. STAT. § 1223.5

Cigarette Tax — C

Tax Rate per pack of 20:	$1.35

Cessation Coverage — C

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT patch, NRT gum, NRT nasal spray, NRT inhaler, NRT lozenge, Zyban and Chantix**

Counseling: **Covers group and individual counseling**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, minimal co-payments required; some health plans allowed to require prior authorization**

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers NRT gum and NRT patch**

Counseling: **Covers phone counseling**

Barriers to Coverage: **Combination therapy required**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Pennsylvania Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Pennsylvania continued its efforts to enhance tobacco control efforts in the Commonwealth during the 2008 legislative session.

Pennsylvania's legislators passed a bill strengthening Pennsylvania's very weak smoking restrictions in June. The new law eliminates smoking in most restaurants, nightclubs and many workplaces. However, the law is riddled with exemptions, including: up to 50 percent of casino floors, some restaurants and bars, private clubs, truck stops, tobacco-related businesses and promotional events, residential adult care facilities (such as nursing homes and rehabilitation centers), non-profit fundraisers, cigar bars and outdoor recreational facilities, such as arenas.

The Lung Association was disappointed the law was not more inclusive, and feels Pennsylvania missed an opportunity to take a big step forward by protecting all workers from secondhand smoke. The bill took effect on September 11, 2008. Philadelphia's slightly stronger law on smoking in indoor public places will stand, but the city will not be able to strengthen it in the future. All other local communities continue to be preempted from protecting their citizens from secondhand smoke as well. Implementation of the new law has been a challenge also, with the many exemptions creating confusion about what businesses are covered.

Funds allocated to Pennsylvania's tobacco prevention and cessation program total about $32 million in fiscal year 2009. All of the money from the tobacco settlement is to be used for uncompensated care, smoking cessation and prevention, research and healthcare assistance. While 12 percent of the funds coming into Pennsylvania are allocated towards tobacco prevention and cessation, the past three years the legislature has decreased the amount by 25 percent as a result of temporary changes to the state fiscal code through separate legislation. The Lung Association continues to advocate for raising this amount to the level recommended by the U.S. Centers for Disease Control and Prevention.

In 2009, the American Lung Association in Pennsylvania will continue to lead the fight to protect people from the dangers of secondhand smoke, prevent kids from starting to smoke and motivate adults to quit.

Pennsylvania State Facts

Economic Costs Due to Smoking:	$9,423,966,000
Adult Smoking Rate:	21.0%
High School Smoking Rate:	17.5%
Middle School Smoking Rate:	4.1%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school and middle school smoking rates are taken from the 2006 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/pennsylvania

Rhode Island Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$1,875,392*
CDC Best Practices State Spending Recommendation:	$15,200,000

*Includes FY 2009 funding from the Centers for Disease Control and Prevention

Smokefree Air — A

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

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

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

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: RI GEN. LAWS §§ 23-20.10-1 et seq.; 23-20.9-1 et seq. & 23-28.15

Cigarette Tax — A

Tax Rate per pack of 20:	$2.46

Cessation Coverage — B

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT gum, NRT patch, NRT inhaler, NRT nasal spray, NRT lozenge, Zyban* and Chantix***

Counseling: **Covers individual and group counseling**

Barriers to Coverage: **Limits on duration, combination therapy required; some health plans require co-payments and prior authorization**

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers NRT patch, NRT gum, NRT inhaler, NRT nasal spray, NRT lozenge**

Counseling: **Covers group counseling**

Barriers to Coverage: **Limits on duration, annual limits on quit attempts, co-payments required**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **Yes**

Citation: See **Rhode Island Cessation Coverage 1-pager** for specific sources

*Coverage for Zyban and Chantix varies by managed care organization.

Behind the Scenes

The American Lung Association in Rhode Island works with its partners on tobacco control throughout the state to enact and defend strong regulations and 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, comprehensive tobacco control program in Rhode Island.

A major coalition focus in 2008 was taxing little cigars like cigarettes to make them a less attractive alternative for youth and others with less disposable income. This was successful as little cigar buyers will soon pay the same $2.46 per pack tax as cigarettes. However, the coalition was unable to prevent an extension of a 50-cent cap on the tax on other cigars, and could not achieve an increase in taxes on other tobacco products.

Several proposals to weaken or gut the smokefree workplace and public places law that went into effect in March 2005 were defeated, though hopes to apply the smokefree law fully to the state's two gaming facilities were also unsuccessful. Proposals by several legislators to prohibit smoking in vehicles while children six or younger are present also did not reach a floor vote.

In the face of a major state budget deficit, funding for tobacco control stayed at a bare bones level. The Department of Health did continue to fund some tobacco dependence treatment services for the uninsured and worked to enforce the existing requirement that private insurers must provide some coverage of smoking cessation services. The department also funded five comprehensive tobacco control initiatives through community-based (geographic or minority population) organizations which did major organizing work in their communities. A major and ongoing project by the five funded organizations involves surveying actual tobacco retail sales locations, advertising and the promotions offered, and mapping the findings in relationship to schools, demographics of the communities, and other factors which clearly demonstrate targeting to the populations most at risk when compared to other communities.

The findings from the survey mapping will be used to strengthen the campaign to revamp the license system for retail sales of tobacco products. This will be a major focus for advocacy activity in 2009, including raising the license fee, improving enforcement of licensing laws, closing a major loophole in the law affecting retailers who sell to minors, and banning promotional offers. The American Lung Association in Rhode Island will also continue working for adequate funding and other resources for comprehensive tobacco control and, as part of an overall Healthy Air agenda, expand protection from secondhand smoke exposure while defending the current law.

Rhode Island State Facts

Economic Costs Due to Smoking:	$869,938,000
Adult Smoking Rate:	17.0%
High School Smoking Rate:	15.1%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2005 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/rhodeisland

South Carolina Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$1,003,690*
CDC Best Practices State Spending Recommendation:	$62,200,000

*FY2009 funding from the Centers for Disease Control and Prevention is the sole source of funding.

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: SC CODE OF LAWS §§ 44-95-10 et seq.

*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:	$0.07

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT gum, NRT patch, NRT inhaler, NRT nasal spray, NRT lozenge, Chantix and Zyban**

Counseling: **No coverage**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, minimal co-payments required, stepped care therapy required, prior authorization required on some medications, and combination therapy not allowed**

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers NRT gum, NRT patch, NRT lozenge, Zyban and Chantix**

Counseling: **Covers phone counseling**

Barriers to Coverage: **Annual limit on quit attempts, co-payments required for some medications, combination therapy required**

OTHER PROVISIONS:

State Funding for Quitline: **No**

Private Insurance Mandate: **No**

Citation: See **South Carolina Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in South Carolina is strongly committed to laws and regulations that reduce tobacco use and prevent exposure to secondhand smoke in worksites and places of employment. Volunteers and staff have worked diligently for an increase in the state's lowest-in-the-nation cigarette tax, funding for South Carolina's tobacco use prevention program and local smokefree air ordinances.

Tobacco control advocates saw stunning victories and crushing disappointments in 2008. Smokefree air got a big boost when the State Supreme Court ruled that South Carolina's constitution allowed for passage of local smokefree ordinances that were stronger than state law. The ruling unleashed South Carolina's cities and counties, and local comprehensive smokefree air ordinances are becoming law throughout the state. Prior to the court decision, hospitality industry inspired smokefree air amendments aimed at creating a weak statewide smokefree air law were proposed in the House Judiciary Committee. That legislation died in committee.

2008 was a carryover year for state legislation. The quest to raise the state's seven cent cigarette tax resumed with state Senate passage of a 50-cent increase. Senators' Leatherman, Land and Alexander led a three-day, bipartisan battle resulting in a 33-11 victory. Bill revenues were directed toward tobacco use prevention programs and expanded health coverage. The House approved the Senate version with minor changes and this landmark legislation was on its way to the Governor.

Messages of support for the cigarette tax increase poured in to the Governor's office from all over the state. However, the governor chose to veto the bill. House supporters, led by Representatives' Rice, Ott, Scott and Cobb-Hunter worked tirelessly to override the veto. Despite support from the public and editorial boards of every daily paper in the state, House leaders flexed enough muscle to sustain the Governor's veto and kill the legislation. Funding for state tobacco use prevention programs in fiscal year 2009 died with the bill, making the defeat doubly disappointing.

House bill 3567 could have significantly reduced tobacco use in South Carolina. While final action killed the bill, it did not kill the issue. The American Lung Association in South Carolina is grateful for the leadership and support so many gave to this legislation.

We pledge to continue our work until a cigarette tax increase is a reality for South Carolina.

South Carolina State Facts

Economic Costs Due to Smoking:	$3,275,713,000
Adult Smoking Rate:	21.9%
High School Smoking Rate:	17.8%
Middle School Smoking Rate:	8.7%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 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. **Data on the number of deaths are not comparable by state.** 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
1817 Gadsden Street
Columbia, SC 29201-2392
(803) 779-5864
www.lungusa.org/southcarolina

South Dakota Report Card

Grades:

Tobacco Prevention and Control Spending — D

FY2009 Tobacco Control Program Funding:	$5,793,727*
CDC Best Practices State Spending Recommendation:	$11,300,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — F

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Restricted**

Bars: **No provision**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **No provision**

Preemption: **Yes**

Citation: SD COD. LAWS §§ 22-36-2 & 10-50-64

Cigarette Tax — C

Tax Rate per pack of 20: $1.53

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers Zyban and Chantix**

Counseling: **No coverage**

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

STATE EMPLOYEE HEALTH PLAN:

Medications: **No coverage**

Counseling: **No coverage**

Barriers to Coverage: **N/A**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **South Dakota Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in South Dakota through its involvement with local and statewide coalitions, has helped bring important policy changes on tobacco control for the people of South Dakota. As a member of the South Dakota Tobacco Free Kids Network, the Lung Association supported the passage of the state's first clean indoor air law in 2002. The South Dakota Tobacco-Free Kids Network is a statewide alliance of health, medical, education and other individual and civic organizations advocating for laws, policies and funding for effective programs that will result in significant reductions in tobacco use and addiction.

After passage of a $1.00 increase for the cigarette tax at the ballot in November 2006, members of the South Dakota Tobacco-Free Kids Network came together and developed policy statements around reducing exposure to secondhand smoke in worksites and public places as well as giving authority to local governments to regulate tobacco products and protect their citizens from tobacco use (overturning preemption). During the 2008 legislative session the focus was on building capacity at the local level and a strong show at the capitol during the session to show support for a smokefree South Dakota.

An advocacy day was held on February 11, 2008 at the state capital, which was a significant advocacy event for smokefree efforts in South Dakota. Over 200 local supporters and coalition members from around the state converged on the state capital, Pierre, with scheduled activities during committee meetings and legislative visits with their representatives.

A bill was passed in 2008 that contained a provision requiring restaurants with a certain type of liquor license to prohibit smoking covering some establishments that serve alcohol that were previously exempt from the statewide clean indoor air law.

The 2009 legislative session provides an excellent opportunity to achieve a smokefree South Dakota. Polling will be done in fall 2008 to measure support, messaging and next steps for the session. All 105 legislative seats are up for election in November 2008. Term limits will result in a new leadership in both the majority and minority parties in the House and could change the majority party in the Senate.

The American Lung Association in South Dakota will work to educate these new legislators on the value of a comprehensive statewide smokefree law to protect all workers from secondhand smoke, and other policies that can reduce tobacco use in South Dakota.

South Dakota State Facts

Economic Costs Due to Smoking:	$509,230,000
Adult Smoking Rate:	19.8%
High School Smoking Rate:	24.7%
Middle School Smoking Rate:	7.7%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2005 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/southdakota

Tennessee Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding: $6,056,098*

CDC Best Practices State Spending Recommendation: $71,700,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — C

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

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

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Restricted***

Bars: **Restricted***

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

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: TN CODE ANN. §§ 39-17-1801 to 39-17-1810 & 4-4-121

* 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: $0.62

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **No coverage**

Counseling: **No coverage**

Barriers to Coverage: **N/A**

STATE EMPLOYEE HEALTH COVERAGE:

Medications: **Covers NRT gum, NRT patch, NRT inhaler, NRT nasal spray, NRT lozenge, Chantix, Zyban**

Counseling: **No coverage**

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

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Tennessee Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Tennessee along with its partners in the Campaign for a Healthy and Responsible Tennessee (CHART) worked to protect and build on the historic legislative successes on tobacco control achieved in 2007.

Following the three major tobacco control victories won in 2007: a 42-cent increase in the cigarette tax, a strong statewide smokefree workplace law and $10 million in funding for tobacco control programs, legislative activity around tobacco control initiatives was slower during the 2008 legislative session. However, two major accomplishments were achieved.

Though many bills were filed that would have weakened the smokefree workplace law, all were stopped in committee and the integrity of the law was preserved. A small amendment was approved exempting places of worship from the sign-posting requirement in the law.

Additionally, in spite of a crippling budget deficit, the legislature prudently appropriated $5 million for tobacco prevention and cessation programs to build on the success of the implementation of these programs across the state in 2007/2008. Although the cut from $10 million in funding from the previous year was disappointing, the Lung Association was happy that funding for these vital, public health programs was not eliminated completely.

Other tobacco control-related measures that were approved in 2008 included a law requiring all cigarettes sold in the state to meet specific fire-safety standards effective on January 1, 2010, a measure virtually prohibiting the sale of novelty lighters in the state, and a bill making some changes to licensing requirements for businesses that sell or handle tobacco products.

The American Lung Association in Tennessee applauds the 105th Tennessee General Assembly for its support and commitment to the new smokefree law, and will work to defend and strengthen the law in future legislative sessions. The Lung Association will also continue to defend and increase Tennessee's existing allocation to tobacco prevention and cessation programs.

Tennessee State Facts

Economic Costs Due to Smoking:	$5,135,105,000
Adult Smoking Rate:	24.3%
High School Smoking Rate:	25.5%
Middle School Smoking Rate:	9.7%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavior Survey. Middle school smoking rate is taken from the 2004 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. **Data on the number of deaths are not comparable by state.** 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 B-130
Nashville, TN 37228
(615) 329-1151
www.lungusa.org/tennessee

Texas Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$13,851,736*
CDC Best Practices State Spending Recommendation:	$266,300,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

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: TX PENAL CODE § 48.01; TX EDUC CODE § 154.504 21.927; TX ADMIN. CODE tit. 40, Part 19, Subchapter S, Division 1 § 746.3703(d); & § 747.3503(d).

*The Smokefree Air grade only examines state 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 — C

Tax Rate per pack of 20:	$1.41

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT Inhaler, Chantix, Zyban**

Counseling: **Coverage varies by individual health plan**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts; some individual health plans have other barriers***

STATE EMPLOYEE HEALTH PLAN:

Medications: **No coverage**

Counseling: **Online counseling varies by health plan**

Barriers to Coverage: **N/A**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Texas Cessation Coverage 1-pager** for specific sources

* Medicaid barriers that vary by health plan: co-payments required, stepped care required, combination therapy required.

Behind the Scenes

The American Lung Association in Texas volunteers and staff continue to partner with a coalition of health advocates seeking to make Texas smokefree through the passage of a comprehensive law prohibiting smoking in public places and workplaces.

The Texas legislature meets bi-annually, so there was no 2008 legislative session in Texas. Although the legislature failed to pass a smokefree workplace law during the 2007 legislative session, there were significant accomplishments. Over 80 statewide and local organizations endorsed the proposed law. The Texas Restaurant Association endorsed the bill. Over 8,000 voters in targeted districts sent in cards of support, which were hand delivered to their respective House and Senate members.

This issue had strong endorsements from major daily papers across Texas, including the Dallas Morning News, Houston Chronicle and the Austin American Statesman.

Both the speaker of the House and the lieutenant governor established smokefree legislation as a priority. The lieutenant governor even testified before the Senate committee in support of the bill, a rare occurrence. There were over 55 House sponsors of the bill. However, several damaging amendments were added toward the end of the legislative session, which ultimately caused the Lung Association to drop its support of the bill.

In 2008, we are continuing to educate legislators, legislative staff and the general public about the importance of a strong smokefree law for Texas in preparation for the 2009 legislative session. Smoke-Free Texas, a coalition consisting of the American Lung Association, American Cancer Society, American Heart Association and other health advocates will lead this effort. Voters overwhelmingly want a comprehensive smokefree law for public places and workplaces. Sixty-six percent of Texans polled favored making all the state's workplaces, restaurants and bars smokefree, according to a survey of 803 Texas adults conducted in January 2007.

In addition, in December, the Dallas city council voted to amend its current smokefree ordinance to include all private worksites and bars, a major victory that should be influential for the statewide effort. To date, 18 Texas communities besides Dallas, including Austin, El Paso and Houston, have comprehensive smokefree ordinances, up from 14 in 2007.

As for tobacco prevention and cessation programs, Texas appropriated approximately $13.8 million in funding for fiscal year 2009, well below the $266 million recommended by the U.S. Centers for Disease Control and Prevention.

The American Lung Association in Texas is well positioned in the 2009 legislative session to push for a smokefree Texas, and help protect all Texans from secondhand smoke.

Texas State Facts

Economic Costs Due to Smoking:	$13,044,600,000
Adult Smoking Rate:	19.3%
High School Smoking Rate:	21.1%
Middle School Smoking Rate:	9.5%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavior Survey. Middle school smoking rate is taken from the 2006 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. **Data on the number of deaths are not comparable by state.** 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
8150 Brookriver Drive, Suite 101
Dallas, TX 75247
(214) 631-5864
www.lungusa.org/texas

Utah Report Card

Grades:

Tobacco Prevention and Control Spending	**F**

FY2009 Tobacco Control Program Funding: $8,157,438*

CDC Best Practices State Spending Recommendation: $23,600,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air	**A**

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

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

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: UT CODE ANN. §§ 26-38-1 et seq.

The **American Lung Association** recognizes Utah for its strong smokefree law that took effect January 1, 2009 protecting virtually all workers from secondhand smoke.

Cigarette Tax	**D**

Tax Rate per pack of 20: $0.695

Cessation Coverage	**F**

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers Chantix, Zyban; other medications covered under certain conditions**

Counseling: **Covers Group and individual counseling (pregnant women only)**

Barriers to Coverage: **Limits on duration, lifetime limit on quit attempts, prior authorization required, minimal co-payments required**

STATE EMPLOYEE HEALTH COVERAGE:

Medications: **Covers NRT patch, Chantix, Zyban**

Counseling: **No coverage**

Barriers to Coverage: **Limits on duration, prior authorization required, co-payments required**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Utah Cessation Coverage 1-pager** for specific sources

Behind the Scenes

Utah continues to have the lowest smoking rates in the nation for both adults (11.7%) and high school students (7.9%). Even though the rates are low, smoking still significantly impacts the physical and financial health of all Utahans. Also, the adult smoking rate increased from 9.8 percent in 2006, which is a bit troubling. For many years, state and local health departments and organizations, including the American Lung Association in Utah, have joined forces in the Coalition for Tobacco Free Utah (CTFU) to fight the ongoing tobacco epidemic.

During the 2008 legislative session, a measure was introduced in the state House of Representatives to increase Utah's cigarette tax by 50 cents to $1.195 per pack. Despite earning 84 percent support from Utah voters in a poll released in February 2008, the increase was not approved. However, this effort will help lay the groundwork for a proposal to raise the cigarette tax to $2.00 per pack in the 2009 legislative session.

Sadly, a damaging change to tobacco tax law in Utah was approved, changing Utah's tax on spit tobacco to a weight-based tax of 75 cents per ounce from 35 percent of the manufacturer's selling price previously. This will effectively reduce the tax rate on premium spit tobacco products, which are the most popular with youth, and ensure low tax rates on new lightweight spit tobacco products entering the market.

On January 1, changes to Utah's smokefree law took effect prohibiting smoking in bars and private clubs, finally protecting workers in these places from secondhand smoke, and giving Utah a comprehensive law prohibiting smoking in virtually all public places and workplaces.

Tobacco control efforts in Utah have been bolstered by dedicated revenue from Master Settlement Agreement payments and cigarette taxes going to Utah's tobacco prevention and cessation program. These funds have allowed the state to implement programs in every county and greatly increase public awareness of the negative impact of smoking and to promote the development of tobacco-free policies.

However, funding for tobacco prevention and cessation programs has remained at about $8.5 million when federal dollars from the U.S. Centers for Disease Control and Prevention (CDC) are counted for the past few years. In updated recommendations issued in 2007, the CDC now recommends that Utah spend $23.6 million on tobacco prevention and cessation programs.

The American Lung Association in Utah will continue to play a leading role in protecting Utahans from the death and disease caused by tobacco use and addiction.

Utah State Facts

Economic Costs Due to Smoking:	$662,595,000
Adult Smoking Rate:	11.7%
High School Smoking Rate:	7.9%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/utah

Vermont Report Card

Grades:

Tobacco Prevention and Control Spending — D

FY2009 Tobacco Control Program Funding:	$6,164,694*
CDC Best Practices State Spending Recommendation:	$10,400,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Cigarette Tax — B

Tax Rate per pack of 20: $1.99*

The **American Lung Association** recognizes Vermont for increasing its cigarette tax by $0.20 to $1.99 per pack.

*On July 1, 2008, the cigarette tax increased from $1.79 to $1.99 per pack.

Smokefree Air — A

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Restricted**

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

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

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

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: VT STAT. ANN. tit. 18, §§ 37-1741 et seq.; 28-1421 et seq.; 3-124; 3-130; 3-131; & tit. 16 § 1-140

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT nasal spray, NRT inhaler, NRT lozenge, Chantix, Zyban**

Counseling: **No coverage**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, minimal co-payments required, combination therapy required**

STATE EMPLOYEE HEALTH PLAN:

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

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

Barriers to Coverage: **Combination therapy required**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Vermont Cessation Coverage 1-pager** for specific sources

Behind the Scenes

For more than a decade, the American Lung Association in Vermont with its partners in the Coalition for a Tobacco Free Vermont, has worked to increase funding for, and ensure sustainability of, the state's comprehensive tobacco control program.

Despite a challenging budget year for Vermont lawmakers, the state tobacco control program was level-funded at about $5.2 million. Though the coalition advocated for an increase of $3.2 million, the Lung Association was pleased that the current level of funding was maintained given the number of competing requests and programs in a tough economic year.

Unfortunately, the Tobacco Trust Fund, created to provide a stable, long-term source of funding for the tobacco control program from annual tobacco settlement payments, was tapped for other programs this year. Approximately $3.2 million in interest earned from the trust fund was used for fiscal year 2009 appropriations. Of greater concern, $650,000 of the fund principal was allocated to Catamount Health, a state health insurance program. In a plan developed after the legislature adjourned, the Joint Fiscal Committee diverted nearly $3 million from the trust fund to help address a projected $30 million state budget deficit as well. Chipping away at the trust fund puts future funding of the tobacco control program at tremendous risk.

In a great win for tobacco control advocates, effective July 1, 2008, cigarettes, roll-your-own tobacco, little cigars and snuff can no longer be sold to Vermont consumers by mail, phone or the Internet. This legislation will help to deter the illegal sale of tobacco to underage youth as well as reduce tobacco excise tax evasion.

The excise tax on cigarettes, little cigars, roll-your-own tobacco and snuff increased on July 1, 2008 as a result of legislation passed in 2006. The cigarette excise tax is now $1.99 per pack and the excise tax on snuff increased equivalently.

In 2009, the American Lung Association in Vermont will continue to advocate for increased funding for the tobacco control program and protection of the Tobacco Trust Fund. In addition, the Lung Association will work with its partners to close a loophole in the 1987 smoking in the workplace law that allows smoking in the workplace under certain conditions.

Vermont State Facts

Economic Costs Due to Smoking:	$434,237,000
Adult Smoking Rate:	17.6%
High School Smoking Rate:	18.2%
Middle School Smoking Rate:	4.0%
Smoking Attributable Deaths:	830
Smoking Attributable Lung Cancer Deaths:	264
Smoking Attributable Respiratory Disease Deaths:	248

Adult smoking rate is taken from CDC's Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2006 Vermont 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/vermont

Virginia Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$13,579,582*
CDC Best Practices State Spending Recommendation:	$103,200,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — F

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Restricted**

Private Worksites: **No provision**

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

Childcare Facilities: **Prohibited (excludes home-based child care)**

Restaurants: **Restricted**

Bars: **No provision**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **Restricted**

Recreational/Cultural Facilities: **Restricted**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: VA CODE ANN. §§ 15.2-2801 et seq.

Cigarette Tax — F

Tax Rate per pack of 20:	$0.30

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, NRT Nasal spray, NRT inhaler, NRT lozenge, Chantix and Zyban**

Counseling: **Covers group counseling (pregnant women only)**

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

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers NRT Gum, NRT Patch, NRT inhaler, Chantix, and Zyban**

Counseling: **Covers phone counseling**

Barriers to Coverage: **Limits on duration, co-payments required, combination therapy required**

OTHER PROVISIONS:

State Funding for Quitline: **No**

Private Insurance Mandate: **No**

Citation: See **Virginia Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Virginia remains a leader in tobacco control in the state. We continue to advocate for smokefree workplaces and promote tobacco cessation and prevention programs. We have ensured tobacco control remains a priority for our policy makers as an active steering committee member of Virginians for a Healthy Future, a statewide tobacco control coalition formed to reduce the use of tobacco products in Virginia.

During the 2008 legislative session, the Lung Association helped pass comprehensive smokefree legislation as well as legislation prohibiting smoking in just restaurants and bars through the state Senate for the second year in a row. Similar bills were introduced in the House of Delegates, but these bills along with the Senate-passed bills were referred to an unfriendly subcommittee in the House where a vote on them was never held. This was despite a January 2008 poll showing that 75 percent of Virginia's voters support a law that would make all workplaces smokefree.

Newspapers across the Commonwealth came out in favor of smokefree legislation and highlighted the blocking of this important public health issue by leadership in the House of Delegates. In 2008, Gov. Tim Kaine not only supported smokefree legislation but also asked legislators to submit bills on his behalf.

Continued funding of tobacco use prevention and cessation programs from the state's allocation of Master Settlement Agreement dollars is an annual battle with the budget committees. The tobacco settlement allocation for fiscal year 2008 included a bonus payment of $6.25 million, and we fought to have 100 percent of that money go to tobacco prevention and cessation services instead of allowing the current formula dictate that only 10 percent be allocated for these efforts. However, in a tight budget year, the $6.25 million was directed toward other health-related expenditures.

In preparation for 2009, the Lung Association and state coalition members will continue to lead the grassroots efforts on smokefree air in our state. Regional coalition meetings have been held in five key areas of the state, and a postcard campaign is in full swing to put pressure on the House of Delegates to allow the smokefree legislation to come to a vote. A part-time coalition organizer has been hired to bring grassroots efforts to a new level. We are planning our 2009 Lobby Day and building on last year's success of doubling volunteer participation.

The American Lung Association in Virginia will continue its effort to protect all Virginians, including the most vulnerable populations—children, pregnant women and those with chronic lung disease—from the hazards of secondhand smoke.

Virginia State Facts

Economic Costs Due to Smoking:	$4,737,271,000
Adult Smoking Rate:	18.5%
High School Smoking Rate:	21.7%
Middle School Smoking Rate:	7.6%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school and middle school smoking rates are taken from the 2005 Virginia 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. **Data on the number of deaths are not comparable by state.** 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
9221 Forest Hill Avenue
Richmond, VA 23235
(804) 267-1900
www.lungusa.org/virginia

Washington Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$28,354,230*
CDC Best Practices State Spending Recommendation:	$67,300,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — A

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Prohibited**

Bars: **Prohibited**

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

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: WA. REV. CODE §§ 70.160.010 et seq. & 28A.210.310

Cigarette Tax — B

Tax Rate per pack of 20: $2.025

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT Patch, Chantix and Zyban**

Counseling: **Covers individual counseling**

Barriers to Coverage: **Prior authorization required**

STATE EMPLOYEE HEALTH PLAN:

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

Counseling: **Covers phone and online counseling**

Barriers to Coverage: **Prior authorization required, combination therapy required**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Washington Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Washington provides leadership in convening partners and guiding policy efforts to continue the state's success in reducing the impact of tobacco among Washingtonians. Together with partners, the Lung Association works to ensure tobacco control and prevention remains a priority for state legislators and local decision makers.

The priority issue for the Lung Association during the 2008 legislative session was to pass legislation authorizing the state Medicaid program to provide tobacco cessation services to its clients, and appropriate money for the effort. The Lung Association was successful on both counts. The coverage is not comprehensive as some cessation medications and forms of counseling are excluded, and a few barriers to obtaining the coverage exist. However, it is a good first step that will help the state's Medicaid population, which has a much higher rate of smoking than the general population, have the tools they need to quit.

A law was also approved during the 2008 session to require cigarettes sold in Washington to self-extinguish when not being smoked to help prevent cigarette-caused fires.

Washington's comprehensive smokefree law saw no legislative challenges in 2008 perhaps indicating an acceptance that the law is here to stay. In September 2008, the Washington Supreme Court ruled that private clubs are covered by the law in response to a lawsuit filed by an American Legion post. Data was also released by the Washington Department of Revenue that showed business in bars was up 20 percent in 2007 after a very small increase of 0.3 percent in 2006. This data shows that the smokefree law has had no long-term effect on business while protecting all workers from secondhand smoke.

Since the initiation of Washington's tobacco prevention and cessation program in 2000, smoking among Washington's youth has dropped by 50 percent and is now at an all time low of 14.9 percent. Washington's adult smoking rates have also dropped substantially since 2000 and stood at 16.8 percent in 2007, one of the lowest in the country.

In 2009, the American Lung Association in Washington will continue to be a leader in advocating for policies to reduce the impact of tobacco use on our state. The 2009 legislative session may see several attempts to weaken our strong smokefree air law. The Lung Association will continue to ward off these attempts to weaken the law and will continue the search to identify and secure sustainable funding for our successful tobacco prevention and control program.

Washington State Facts

Economic Costs Due to Smoking:	$3,763,962,000
Adult Smoking Rate:	16.8%
High School Smoking Rate:	14.9%
Middle School Smoking Rate:	6.4%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school (10th grade only) and middle school (8th grade only) smoking rates are taken from the 2006 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. **Data on the number of deaths are not comparable by state.** 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
(800) LUNG-USA
www.lungusa.org

West Virginia Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$6,643,796*
CDC Best Practices State Spending Recommendation:	$27,800,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

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**

Bars: **No provision**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **No provision**

Recreational/Cultural Facilities: **No provision**

Penalties: **Yes**

Enforcement: **No**

Preemption: **No**

Citation: WV CODE §§ 16-9A-4 et seq. & 31-20-5b; WV CSR §§ 126-66-1 et seq.; 64-21-10; 64-21-20; WV Div. of Personnel Policy, Smoking Restrictions in the Workplace.

*The Smokefree Air grade only examines state tobacco control law and does not reflect local smokefree ordinances. All 55 counties in West Virginia have county board of health regulations of varying strength regulating secondhand smoke exposure.

Cigarette Tax — F

Tax Rate per pack of 20:	$0.55

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **No coverage for Chantix, coverage for NRT Gum, NRT Patch, NRT Nasal spray, NRT Inhaler, NRT Lozenge and Zyban varies by health plan**

Counseling: **No coverage for individual counseling, group counseling coverage varies by health plan**

Barriers to Coverage: **Limits on duration, prior authorization required for all medications, combination therapy required**

STATE EMPLOYEE HEALTH PLAN:

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

Counseling: **Covers Individual counseling**

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

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **West Virginia Cessation Coverage 1-pager** for specific sources

Behind the Scenes

Over the past several years, tobacco control in West Virginia has been making steady progress through the use of funding for tobacco prevention and cessation programs, and the enactment of county-level clean indoor air regulations.

During 2007, the West Virginia Legislature passed a bill to securitize future Master Settlement Agreement payments. As a result of this legislation passing, and the potential destruction securitization could have to state tobacco prevention and cessation programming, the American Lung Association in West Virginia worked hard to maintain the $5.7 million for tobacco cessation and education programming that was put into the budget. The Lung Association was successful in keeping these funds at the $5.7 million level in fiscal year 2009. These funds come from state general revenue. The Lung Association continues to receive a strong commitment from the governor of his intention to continue funding tobacco prevention programming from general revenue funds in future years.

Once again an attempt at the state level to preempt the authority of local boards of health to enact and enforce clean indoor air regulations was defeated. West Virginia has been very successful in creating county-level clean indoor air regulations, with virtually all counties having ordinances on smoking of varying strength.

In 2008, a number of county boards of health strengthened or are working on strengthening their regulations to completely protect workers in all public places and workplaces. This included Kanawha County, which includes the state capitol Charleston, where the regulation was strengthened to prohibit smoking in all workplaces, including all restaurants, bars and gaming establishments. As more counties adopt these stringent requirements for clean indoor air, the hospitality and tobacco industries continue to unsuccessfully push legislators to remove authority for clean indoor air regulation from the control of local boards of health.

In 2009, the American Lung Association in West Virginia will continue to lead the fight to protect people from the dangers of secondhand smoke, prevent kids from starting to smoke and motivate adults to quit.

West Virginia State Facts

Economic Costs Due to Smoking:	$1,727,637,000
Adult Smoking Rate:	26.9%
High School Smoking Rate:	27.6%
Middle School Smoking Rate:	11.1%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 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. **Data on the number of deaths are not comparable by state.** 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.lungusa.org/westvirginia

Wisconsin Report Card

Grades:

Tobacco Prevention and Control Spending — F

FY2009 Tobacco Control Program Funding:	$16,231,707*
CDC Best Practices State Spending Recommendation:	$64,300,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — F

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Restricted**

Private Worksites: **Restricted**

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

Child Care Facilities: **Prohibited**

Restaurants: **Restricted**

Bars: **No provision**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **Restricted**

Recreational/Cultural Facilities: **Restricted**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **No**

Citation: WI STAT. ANN. §§ 101.123; & 120.12(20)

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

Cigarette Tax — C

Tax Rate per pack of 20: $1.77

Cessation Coverage — B

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **Covers NRT Gum, NRT patch, NRT nasal spray, NRT inhaler, Chantix and Zyban**

Counseling: **Covers individual and group (under certain conditions) counseling**

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

STATE EMPLOYEE HEALTH PLAN:

Medications: **Covers NRT patch, NRT nasal spray, NRT inhaler, Chantix and Zyban**

Counseling: **Covers individual counseling**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, co-payments required**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Wisconsin Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Wisconsin works as a leading member of the statewide coalition to reduce tobacco use by Wisconsin residents and protect non-smokers from involuntary exposure to secondhand smoke. We do so by advocating for high prices for tobacco products through increased excise taxes, aggressively working toward achieving the level of funding recommended by the U.S. Centers for Disease Control and Prevention for the state tobacco control and prevention program, and promoting and advancing smokefree air policies in workplaces and public places.

Wisconsin has found strong leadership for these efforts in Gov. Jim Doyle, who during the 2007 legislative session called for a three-pronged approach to reducing tobacco use: increasing the cigarette tax and funding for prevention and cessation programs, and enacting a comprehensive statewide smokefree air bill. Of those three, the legislature concurred on two—in the fiscal year 2008/2009 two-year budget passed in 2007 they increased the cigarette tax from 77 cents to $1.77 per pack, giving Wisconsin the highest tax in the Upper Midwest region, and increased tobacco control program funding by 50 percent from $10 million per year to $15 million.

The Breathe Free Wisconsin Act which would have prohibited smoking in all workplaces and public places, including restaurants and taverns, passed out of committee in both houses but was blocked by leadership who would not allow it to come to the floor for a full vote in 2008. Regardless, the bill enjoyed wide bipartisan support.

Public support for the policy also remains strong, and in fact, continues to grow. In a poll conducted in spring 2008, 69 percent of respondents said they favor a law that prohibits smoking in all public places, including restaurants and taverns; only 28 percent remain opposed. Respondents also reported that despite their own personal preferences, 78 percent believe that it is likely that Wisconsin will pass a comprehensive smokefree air law within the next two years.

In 2009, Wisconsin will again introduce comprehensive statewide smokefree air legislation in both houses. While the tobacco industry and Wisconsin Tavern League continue to fight these bills on all fronts, their opposition is weakening as more local communities pass comprehensive ordinances, creating an unlevel playing field. Tavern owners in those communities are speaking out in favor of a statewide bill, saying it is the only option that is fair to all.

Wisconsin State Facts

Economic Costs Due to Smoking:	$3,657,509,000
Adult Smoking Rate:	19.6%
High School Smoking Rate:	20.5%
Middle School Smoking Rate:	5.8%
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 Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2006 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. **Data on the number of deaths are not comparable by state.** 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
13100 West Lisbon Road, Suite 700
Brookfield, WI 53005-2508
(262) 703-4200
www.lungusa.org/wisconsin

Wyoming Report Card

Grades:

Tobacco Prevention and Control Spending — B

FY2009 Tobacco Control Program Funding:	$6,875,598*
CDC Best Practices State Spending Recommendation:	$9,000,000

*Includes FY2009 funding from the Centers for Disease Control and Prevention.

Smokefree Air — F

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Restricted**

Private Worksites: **No provision**

Schools: **No provision**

Child Care Facilities: **No provision**

Restaurants: **No provision**

Bars: **No provision**

Casinos/Gaming Establishments: **No provision**

Retail Stores: **No provision**

Recreational/Cultural Facilities: **No provision**

Penalties: **No**

Enforcement: **No**

Preemption: **No**

Citation: WY State Government Non-smoking Policy, 1989

Cigarette Tax — D

Tax Rate per pack of 20: $0.60

Cessation Coverage — F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

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

Counseling: **Covers individual counseling**

Barriers to Coverage: **Limits on duration, annual limit on quit attempts, minimal co-payments required**

STATE EMPLOYEE HEALTH PLAN:

Medications: **No coverage**

Counseling: **No coverage**

Barriers to Coverage: **N/A**

OTHER PROVISIONS:

State Funding for Quitline: **Yes**

Private Insurance Mandate: **No**

Citation: See **Wyoming Cessation Coverage 1-pager** for specific sources

Behind the Scenes

The American Lung Association in Wyoming is working with local and statewide tobacco coalitions to bring about significant policy changes to benefit the health of the people of Wyoming. Ongoing partnerships have the mission of decreasing tobacco consumption through the proven three-pronged approach of high tobacco tax rates, state and local smokefree policies and well-funded tobacco prevention programs.

Funded at their highest level in history, the tobacco control program needs only another $2 million per year to meet the new recommendations for Wyoming from the Centers for Disease Control Prevention. During the 2009 General legislative session, members will consider interim budget requests and advocates are working to ensure that a portion of the approximately $6 million per year increase in tobacco Master Settlement funds are spent on tobacco control programs first.

The interim session has included several study topics on tobacco. Primarily at the request of U.S. Smokeless Tobacco, the Joint Revenue Committee agreed to review "other tobacco products" taxation. UST currently has 85 percent of the smokeless business in Wyoming, but they are pushing to change the way that spit tobacco is taxed, moving to a weight-based tax. This will decrease the cost of premium spit tobacco products, which they sell and are the most popular with youth. Because spit tobacco use in Wyoming is among the highest in the country for both adult and youth, advocates are asking the Joint Revenue Committee to increase all tobacco taxes.

Advocates are also working to make Wyoming smokefree. A second interim study being considered by the Joint Labor Health and Social Services Committee is their possible sponsorship of a statewide smokefree bill. Because bars in both Montana and Utah will go smokefree in 2009 along with the entire state of Oregon, the time is right for the people of Wyoming to have the same health protections and pass a smokefree law in 2009.

The Lung Association believes that all employees and patrons deserve smokefree workplaces, restaurants, and bars. The tobacco industry, using the Wyoming Liquor Dealers as their front, continues to fight comprehensive laws. There are now four Wyoming municipalities that have comprehensive smokefree laws including the newest, Burlington, a small town in northwest Wyoming. Several other towns have passed and enacted weaker ordinances, which highlights the importance of our work to makes sure that all workplaces, including bars, truck stops and private clubs are smokefree.

Other efforts include building a grassroots base in each legislative district to support both community and statewide smokefree policy change. The Wyoming Healthcare Commission recently wrote and signed a resolution in favor of a statewide law, and the American Lung Association in Wyoming is part of a growing coalition of state and national organizations working to pass a strong bill.

Wyoming State Facts

Economic Costs Due to Smoking:	$315,154
Adult Smoking Rate:	22.1%
High School Smoking Rate:	20.8%
Middle School Smoking Rate:	7.8%
Smoking Attributable Deaths:	700
Smoking Attributable Lung Cancer Deaths:	190
Smoking Attributable Respiratory Disease Deaths:	250

Adult smoking rate is taken from CDC's Behavioral Risk Factor Surveillance System, 2007 Prevalence Data. High school smoking rate is taken from the 2007 Youth Risk Behavioral Surveillance System. Middle school smoking rate is taken from the 2007 Wyoming Youth Risk Behavior 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. **Data on the number of deaths are not comparable by state.** 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
301 Thelma Drive, #264
Casper, WY 82690-2325
(307) 251-2687
www.lungusa.org/wyoming

We will breathe easier when the air over every
American city is clean and pure.
We will breathe easier when the air in our public spaces,
workplaces and children's homes is free of secondhand smoke.
We will breathe easier when Americans are free from the addictive grip
of cigarettes and the debilitating effects of lung disease.
We will breathe easier when our nation's children no longer battle
airborne poisons or the fear of an asthma attack.
Until then, we are fighting for air.

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