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Curbing the Costs of Tobacco Use

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The societal costs of tobacco use go beyond direct medical expenditures.

The societal costs of tobacco use go beyond direct medical expenditures, which total more than $75 billion per year. Another $80 billion per year accounts for indirect costs, including lost productivity. As states struggle to curb Medicaid costs, it is important to note that about 14 percent of all Medicaid expenditures are related to smoking. The public health community is asking states to control these costs by using proven ways to reduce the burden of tobacco use both on the lives of citizens and the economies of states.

To reduce tobacco use and exposure, states can increase the unit price of tobacco products and place smoking bans and restrictions.

Reducing Tobacco Use. States can dramatically reduce the health and economic burden of tobacco use. Comprehensive programs, using economic, clinical, regulatory and educational approaches, to further reduce the prevalence of smoking have proved effective, according to the CDC. The independent, nongovernmental Task Force on Community Preventive Services (www.thecommunityguide.org) has two key policy recommendations on how to prevent use, encourage cessation and reduce the health effects associated with tobacco. The first is to increase the unit price of tobacco products. The second is to use smoking bans and restrictions to limit exposure to environmental tobacco smoke, a preventable cause of illness and death, according to the CDC. Policies that increase cigarette prices and reduce smoking indoors can reduce the number of cigarettes smoked each day and help increase the number of smokers who quit. When increases in the unit price of tobacco products and broad-based clean indoor air strategies are a part of a comprehensive program, the effects on tobacco use are even more dramatic.

The challenge in these economic times is to adequately fund these programs. Despite budgetary pressures, Indiana did not cut funding for its new tobacco prevention program. The state also increased its cigarette tax by 40 cents a pack. Only six states (Hawaii, Maine, Maryland, Minnesota, Mississippi and Ohio) however, meet the funding levels for comprehensive programs outlined in CDC's "Best Practices for Comprehensive Tobacco Control Programs." The programs outlined in this document are designed to help prevent use of tobacco among youth and encourage people to quit. (Massachusetts and Arizona had not finalized budgets when the CDC report was published.)

State Action

Nineteen states avoided some budget cuts by increasing cigarette excise taxes in 2002.

States are helping decrease tobacco consumption by enacting cigarette excise taxes and clean indoor air legislation. Nineteen states and Puerto Rico avoided some budget cuts by increasing cigarette excise taxes in 2002. For example, New Jersey passed a 70-cent excise tax and is the only state to earmark tax dollars that increased the funding level for its tobacco control program.

States are making efforts to control environmental tobacco smoke as well. Delaware joined California in 2002 by passing a statewide smoking ban that includes most indoor public places, including restaurants, bars and casinos. A recent study by the California Board of Equalization found that

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Smoking-Attributable Medicaid Costs per Recipient, 1998

Alabama	$352.36
Alaska	804.31
Arizona	485.57
Arkansas	445.13
California	326.14
Colorado	722.84
Connecticut	880.85
Delaware	609.71
District of Columbia	367.58
Florida	512.30
Georgia	343.28
Hawaii	493.42
Idaho	527.33
Illinois	899.06
Indiana	625.31
Iowa	745.39
Kansas	632.56
Kentucky	589.46
Louisiana	719.08
Maine	996.71
Maryland	663.31
Massachusetts	899.73
Michigan	646.11
Minnesota	675.57
Mississippi	424.29
Missouri	565.59
Montana	514.32
Nebraska	499.41
Nevada	748.56
New Hampshire	958.66
New Jersey	928.76
New Mexico	436.51
New York	1,389.77
North Carolina	513.30
North Dakota	604.68
Ohio	862.47
Oklahoma	498.01
Oregon	438.97
Pennsylvania	876.33
Rhode Island	912.01
South Carolina	516.11
South Dakota	504.20
Tennessee	288.17
Texas	543.17
Utah	373.05
Vermont	451.52
Virginia	479.69
Washington	359.58
West Virginia	520.55
Wisconsin	722.80
Wyoming	626.16

www.cdc.gov/tobacco/statehi/html_2002/medicaid.htm

overall sales in eating and drinking establishments rose 9.3 percent in the year after the state implemented a comprehensive smoking ban. Oklahoma's governor issued an emergency order that will force restaurants, bars, taverns, and pool and billiard halls with a seating capacity of 50 or more to be entirely smoke-free or only allow smoking in designated enclosed and properly ventilated rooms. Florida has an initiative on the November ballot for similar smoking bans across the state.

States also are addressing the need for smoking cessation services. Currently, 33 states have "quitlines," toll-free telephone support programs offering state-of-the-art smoking cessation counseling and self-help materials. Illinois passed legislation in 2002 to cover the costs of "stop smoking" prescription drugs and medical devices approved by the Food and Drug Administration for people covered under the state medical assistance program. Alaska, Maryland, Maine, New Hampshire and Oklahoma also have policies that address cessation, outreach and education.

Thirty-three states have toll-free telephone support programs offering smoking cessation counseling and materials.

Within any one state, smoking-attributable costs will be related to directions it takes to prevent and control tobacco use. With comprehensive, sustained efforts to reduce rates of use, health care costs related to tobacco will decrease.

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