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American Legacy Foundation. Saving Lives, Saving Money: Why States Should Invest in a Tobacco-Free Future.

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SAVING LIVES, SAVING MONEY.

Why States Should Invest in a Tobacco-Free Future




Legacy

American Legacy Foundation®

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Overview

Tobacco use remains the leading preventable cause of death and disease in the United States, responsible for more than 400,000 premature deaths each year.[i] Given current trends, more than five million children alive today will ultimately die prematurely from smoking.[ii] Despite this staggering toll, the movement to reduce the death and disease caused by tobacco products finds itself at a crossroads. The dilemma, indeed the tragedy, is that at a time when proven tobacco control, prevention and treatment programs exist, we lack the political will to make the required investment in these efforts.

This lack of political will is even more tragic because each state has readily available funds – received each year from U.S. cigarette companies – that could be invested in new efforts to protect families from the horrors of tobacco-related disease. In 1997 and 1998, Mississippi, Texas, Florida and Minnesota settled their lawsuits against the major U.S. cigarette companies through individual agreements scheduled to bring those states annual payments that total more than $40 billion through 2025. Then, in November 1998, the rest of the states jointly entered into the Master Settlement Agreement (MSA) to settle their lawsuits against the tobacco companies in return for annual base payments to each state that total more than $206 billion through 2025.

The states filed their lawsuits during the 1990's to obtain reimbursement for the expenses they had incurred because of wrongful acts by the tobacco industry that increased tobacco use, related disease and costs. It was understood that some of the MSA money would be invested in programs to prevent children from starting to smoke, and to treat those already addicted to tobacco products or already suffering from tobacco-related disease. But today, less than four years later, 45 states and the District of Columbia have failed to make even the minimal investment in comprehensive tobacco control efforts recommended by the Centers for Disease Control and Prevention (CDC).[iii] Moreover, of the five states that are spending the CDC minimum or more — Arizona, Maine, Massachusetts, Mississippi, and Minnesota — serious efforts underway in at least three would substantially reduce their current allocations of funds to tobacco-prevention programs well below the CDC minimum. Other states are also considering cuts to their tobacco-control programs because of budget difficulties. Even without these cuts, just five percent of the tobacco settlement funds received by the states are actually being used to prevent and reduce tobacco use in the current fiscal year.[iv]

By contrast, the total annual costs to society to treat the illnesses caused by tobacco — estimated to be approximately $85 billion for 2001— are extraordinary. State and local governments alone pay roughly $12 billion each year just in Medicaid costs attributable to tobacco use.

The good news is that investing in tobacco control efforts is remarkably cost-effective. **Part One** of this report highlights four successful state efforts: California, Massachusetts, Maine and Florida. California estimates that every dollar dedicated to tobacco control yields more than three dollars in health care cost savings. Massachusetts is saving more than two dollars for every dollar it spends on its tobacco-prevention program.[v]

If we know what it takes to get the job done, then why do we find ourselves at a crossroads in this effort?

One key problem is that growing budget deficits are pressuring states to use tobacco-settlement dollars for deficit reduction. However appealing this approach may be in the short term, it does not constitute sound fiscal or public health policy over the long term. **Part Two** of this report shows that a sustained minimal investment in comprehensive tobacco control will actually save state and local governments an enormous amount of money by preventing tobacco-related illnesses and thereby avoiding related treatment costs. Using well established econometric modeling techniques, this report provides state-by-state estimates of the health care cost savings that

could be realized if each of the states invested the amounts recommended by CDC to prevent and reduce tobacco use.

The savings identified in this report — the state and local share of Medicaid costs — are only a portion of the overall health care costs associated with treating tobacco-related illnesses. In reality, the actual savings to taxpayers from reductions in tobacco use are much larger. For example, the savings calculated here do not include the money taxpayers would save from reductions in their contribution to the federal share of tobacco-related Medicaid payments.

This report is required reading for policy makers at the state level who will be making difficult funding decisions this year. The recent economic downturn has saddled the states with real budget deficits. But just as real are the deaths, disease, and resulting health care costs caused by tobacco use that each state could begin avoiding with relatively small investments in tobacco-prevention efforts. Diverting tobacco-settlement dollars to deficit reduction may be penny-wise, but it is pound-foolish.

Case Studies

CALIFORNIA

In 1988, California voters approved Proposition 99. This ballot initiative increased state cigarette taxes by 25 cents per pack, with 20 percent of the new revenues (over $100 million per year) earmarked for health education against tobacco use. The California Department of Health Services introduced a variety of innovative approaches to reduce tobacco use. In the spring of 1990, California launched its new Tobacco Control Program, which included a statewide media campaign, tobacco control programs in local health departments, competitively selected state, regional, and community-based projects, as well as an extensive evaluation of the entire tobacco education campaign. The program's main goals are to counter the tobacco industry's aggressive marketing and promotion, promote and support clean indoor air policies, and reduce illegal sales of and access to tobacco products. California's media campaign targets both adults and youth, with a focus on countering pro-tobacco influences, reducing exposure to secondhand smoke, reducing the appeal and availability of tobacco to youth, and supporting the Smokers' Helpline, which provides one-on-one counseling in multiple languages for smokers who want to quit. To reach California's diverse communities and cultures, the campaign supplements the general market advertising with linguistically and culturally relevant advertising for Hispanic/Latinos, Asians and Pacific Islanders, American Indians, and African Americans.

Since the passage of Proposition 99, cigarette consumption in California has declined by 57 percent, compared to just 27 percent for the country as a whole, excluding California. It has gone from 114 packs per capita annually before the program (1983-1988) to 49.2 packs per capita recently (1998-1999).[vi] Despite the tobacco industry's successful efforts to reduce the state's tobacco prevention funding throughout the 1990s, cigarette consumption still declined more in California than in the rest of the country.[vii]

- From 1988 to 2000, adult smoking prevalence in California decreased 25 percent (from 22.8 percent to 17.1 percent), resulting in over one million fewer smokers. [viii]

- Because of these smoking declines, between 1990 and 1998 the California Tobacco Control Program saved the state an estimated $8.4 billion in overall smoking-

caused costs and more than $3 billion in smoking-caused health care costs.[ix] Put another way, the program saves $3 in direct health care costs for every dollar it spends.

• In the first seven years of the program, the smoking reductions saved California $390 million in direct medical costs just from fewer smoking-caused heart attacks and strokes.[x] There are substantial benefits that could be expected in any state within only a few years of reduced adult smoking prevalence if sustained tobacco control programs were funded. The California Tobacco Control Program has been credited with preventing 33,300 deaths from heart disease between 1989 and 1997.[xi]

• By reducing smoking among pregnant women, California's program reduced the number of low birth weight babies with a subsequent reduction of $107 million in related health care costs over the past seven years.[xii] This reduction is a predictable, short-term benefit of sustained tobacco control funding at the state level.

• Since 1988 (the year before the California tobacco-prevention began), the rates of lung and bronchus cancer in California have declined more than five times as fast as they did in a sample of other areas of the United States (-14.0% vs. -2.7%). This decline is not only saving thousands of lives but also saving the state millions of dollars in medical costs. Projected future savings are in the billions.[xiii]

MASSACHUSETTS

In 1992, Massachusetts voters approved a referendum that increased the state cigarette tax by 25 cents per pack. Part of the new tax revenues was used to fund the Massachusetts Tobacco Control Program (MTCP), which began in 1993. The goals of the Massachusetts Tobacco Control Program included preventing young people from starting to use tobacco, reducing youth access to tobacco products, persuading and helping both adult and younger smokers to quit smoking, and protecting non-smokers by reducing their exposure to secondhand smoke. To accomplish these goals, the MTCP funds a comprehensive statewide, regional and community-based program that includes policy promotion and enforcement, targeted community smoking intervention programs, school-based programs, statewide support services such as quit lines, a materials clearinghouse, media campaigns, and program evaluation.

• Massachusetts' cigarette consumption declined by 32 percent between 1992 and 1999 (from 118 packs per capita to 80 packs per capita), compared to a decrease of just 8 percent in the rest of the country (excluding California and Massachusetts).[xiv]

• From 1995 to 2001, current smoking among Massachusetts high school students was reduced by 25 percent (from 34.8% to 26%). [xv]

• Between 1993 and 1999, adult smoking prevalence dropped 7.5 percent (from 22.6 percent to 20.9 percent), resulting in 80,000 fewer smokers. [xvi]

• A 2000 study found that the Massachusetts' comprehensive tobacco-control program reduces total health care spending in the state by $85 million per year — which means the state is now saving well over two dollars in reduced smoking-caused health care costs annually for every single dollar it spends on its comprehensive tobacco prevention and control efforts.[xvii]

MAINE

In 1997, Maine increased its cigarette excise tax and used a portion of those funds to establish a comprehensive tobacco prevention program known as the Partnership for a Tobacco-Free Maine. Maine has subsequently augmented its program with proceeds from the 1998 state tobacco settlement, which also resulted in a further increase in cigarette prices. The state also raised cigarette taxes again

in 2001, to $1.00 per pack. The statewide program focuses primarily on population-based strategies to effect policy and environmental change. The main objectives of the program are to prevent initiation of tobacco use by youth, encourage and assist tobacco users to quit, reduce exposure to secondhand smoke, and identify and eliminate disparities related to tobacco use among population groups. Maine's comprehensive program includes a statewide multi-media and public awareness campaign, treatment services including a toll-free help-line, a statewide youth advocacy network, local youth advocacy programs, increased enforcement and education on Maine's youth access laws, and program monitoring, surveillance, and evaluation of the comprehensive program. Maine is currently one of only five states that funds tobacco prevention programs at levels recommended by the CDC.

• Smoking among Maine's high school students has declined a dramatic 36 percent since 1997, falling from 39.2 percent to 25 percent,[xviii] compared to a 23-percent decline nationwide.[xix]

• Maine's program is also encouraging young smokers to quit. Between 1997 and 2001, the percentage of youth tobacco users who have tried to quit increased from 33 percent to 57 percent.[xx]

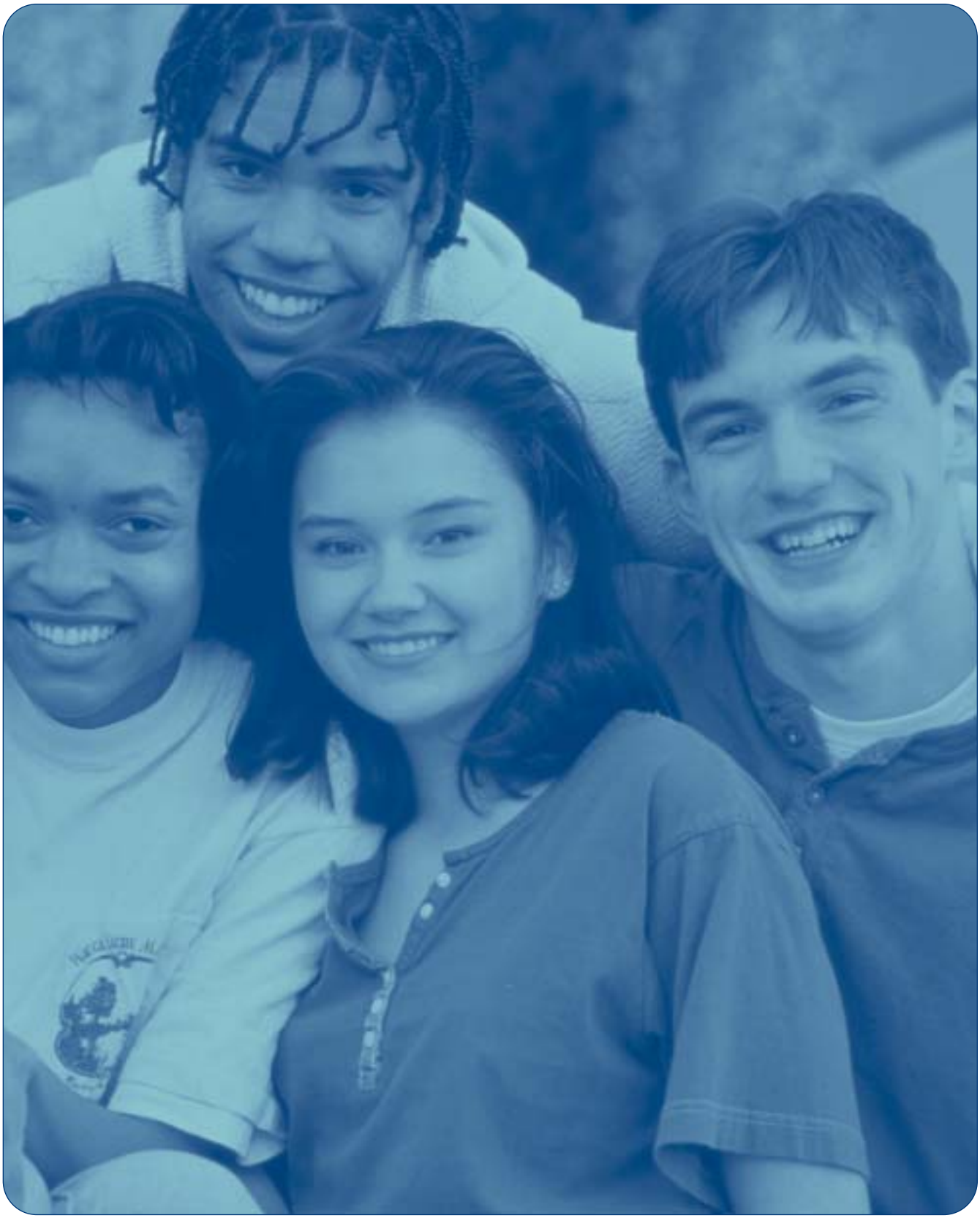
• On September 18, 1999, the *Act To Protect Citizens From the Detrimental Effects of Tobacco Smoke* went into effect. This act made all restaurants in Maine smoke-free.[xxi]

FLORIDA

With funding from its 1997 settlement with the tobacco industry, Florida funded a tobacco prevention program aimed exclusively at preventing and reducing youth tobacco use. The Florida program employs counter-marketing and communications, education and training, youth and community partnerships, enforcement, and evaluation and research to achieve this goal. Another element of Florida's tobacco control program is the Florida Leadership Council for Tobacco Control. It works not only to prevent and reduce youth tobacco use but also to reduce adult tobacco use and exposure to environmental tobacco smoke.

• In the three years since the Florida program started in March of 1998, current smoking has declined by 47 percent (from 18.5 percent to 9.8 percent) among middle school students and by 30 percent (from 27.4 percent to 19.0 percent) among high school students. These declines resulted in almost 75,000 fewer youth smokers in 2001.[xxii] The comparable declines nationwide were 36 and 19 percent, respectively.[xxiii] Although the state is already benefiting from some cost savings from these youth smoking reductions, much larger savings will accrue in the decades to come when these lower youth smoking rates translate to fewer adult smokers and less smoking-caused disability and disease.

• Although the Florida program has served as a model for prevention among youth, recent funding cuts have stalled some of the state's impressive reductions in youth smoking, especially among middle schoolers and those in the lower grades.[xxiv] To maximize results, including cost savings, the Florida program could benefit from using tobacco settlement funds both to restore and expand its existing program to provide a more comprehensive approach.



Estimating Cost Savings to the States

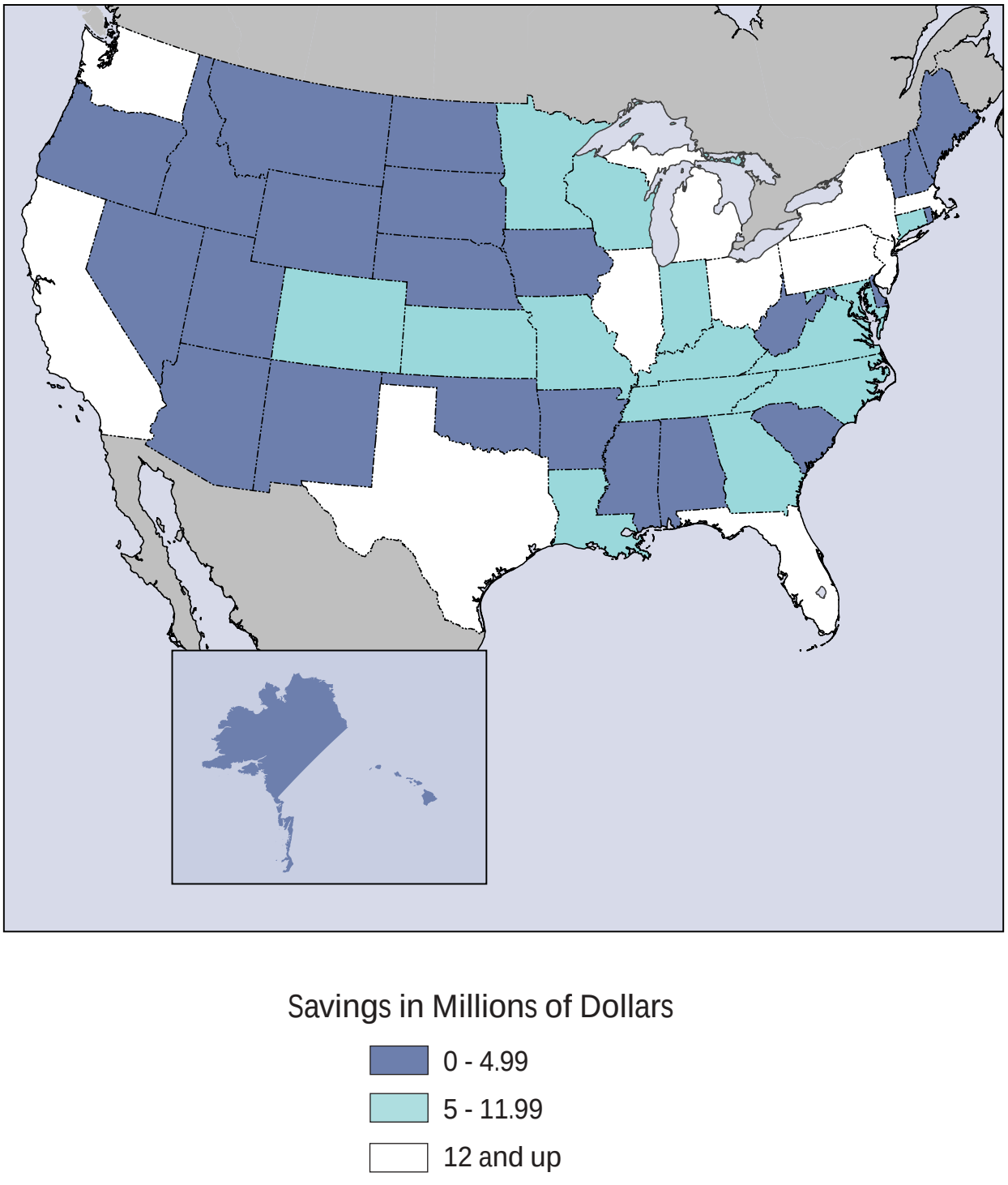
Changes in the prevalence of smoking translate to health care cost savings for states and individuals. Miller and colleagues developed a statistical model that identified Medicaid health care expenditures that were due to or attributable to smoking in 1993.[xxv] The current report presents 2001 estimates of the Medicaid costs attributable to smoking and the potential savings from reducing the prevalence of smoking by investing in tobacco control programs.

The model from Miller et al. used data from the 1987-1988 National Medical Expenditure Survey (NMES) that questioned 35,000 adults about their medical care utilization and their smoking and health history repeatedly over a 14-month period. Actual cost data for health care was separately obtained from providers and payers. The statistical model in Miller et al. explained differences in medical care utilization from person to person as a function of smoking status, health status, and other factors (e.g., socioeconomic status, insurance status, and other risk factors). From this model, it is possible to predict health care expenditures that are related to smoking behavior. The results of this model were then applied to state-specific estimates of smoking prevalence (and other variables in the model) to estimate the fraction of costs attributable to smoking for the 1993 Medicaid population.

To estimate the smoking attributable Medicaid costs borne by states in 2001, several calculations were performed. The 1993 estimates of the fraction of Medicaid costs attributable to smoking were applied to 1998 Medicaid personal health care expenditure data (the most recent available). These estimates were then inflated to derive 2001 costs (using the Medical Care Inflation Index provided by the Bureau of Labor Statistics).[xxvi] Next, the fraction of costs attributable to smoking was adjusted by varying degrees of reductions in smoking prevalence for each state, using revised econometric models based on the Miller et al. study. These sets of calculations then suggest the level of savings that each state might obtain at different levels of program success (reductions of adult smoking prevalence) over several years. Importantly, these calculations do not include savings that will be experienced by taxpayers from reductions in the federal share of tobacco-related Medicaid payments.

The map on the following page provides a graphic representation of the savings that each state will experience in its Medicaid program with a 25-percent reduction in adult smoking. More specific state-by-state estimates are contained in the chart that follows.

Projected State-by-State Medicaid Adult Health Care Cost Savings Based on a 25% Reduction in Smoking Prevalence



The first column of the table shows total Medicaid costs. The second column shows the costs attributable to smoking that are currently borne by state Medicaid programs in 2001. The total Medicaid costs paid by states are estimated at roughly $12 billion, ranging from $12 million in Wyoming to $2.4 billion in New York.

The next four columns illustrate the annual cost savings to states for a 5-, 10-, 25-, and 50-percent reduction in adult current smoking prevalence. The overall cost savings for all states from a 5- and 50-percent reduction, respectively, range from $110 million to $1.1 billion.

The likelihood of these kinds of declines is suggested by the fact that between 1988 and 2000, the prevalence of smoking decreased by 25 percent in California in large part due to its strong commitment to tobacco control. This decrease occurred even though California's actual tobacco-prevention expenditures never quite reached the CDC's minimum recommended level for tobacco control funding in the state. Accordingly, other states should be able to achieve similar reductions in their adult smoking rates in response to a commitment to comprehensive tobacco control sustained over several years. Indeed, other states could do even better if they were to surpass California and invest the CDC minimum or more. The Medicaid cost savings alone to states for a 25-percent reduction in smoking totals $550 million, or $11 million per state, on average, per year.

Furthermore, the estimates in this report do not include total savings that the citizens of each state will enjoy in other cost areas, such as private insurance, out-of-pocket medical expenditures, costs of buying cigarettes, cigarette fire damages, cleaning costs, and lost productivity due to illnesses caused by cigarettes. These savings will directly improve the economies of the states because money not spent by citizens on health care, cigarettes, and other costs of smoking will be spent on other commodities. A new report by the Centers for Disease Control and Prevention[xxvii] indicates that in 1998, total medical costs attributable to smoking totaled over $75 billion. Adjusting for medical care inflation, this translates to $85 billion for 2001 or $167 million per state annually.

One illustrative example of the medical costs borne by state residents not included in these estimates is the cost associated with treating low birth weight babies resulting from the mothers' smoking during pregnancy. One study estimated that a 1-percentage-point decline in the prevalence of smoking during pregnancy each year for 7 years would prevent 57,200 low birth weight live births and save $572 million in direct medical costs (1995 dollars).[xxviii] The decrease in smoking during pregnancy and its costs savings documented by this study mirror the prevalence decline experienced by the overall population in California in response to the state's tobacco control program. Nationwide, updating the cost savings to 2001 using medical inflation factors leads to a current estimate of low birth weight medical cost savings of $708 million. States would experience these savings and related savings from reductions in certain other illnesses, such as heart disease, very shortly after achieving the designated drops in tobacco use.

Roughly half of all smoking-caused health care costs are covered by federal, state, and local government expenditures, with the remainder paid through private insurers, HMOs, or directly by state residents.[xxix] A 25-percent reduction in smoking would reduce these costs substantially. Quantifying the non-health care costs from tobacco use – and the potential savings – is more difficult and less precise. A report by the U.S. Department of the Treasury, however, estimated that non-health costs, including lost productivity, totaled at least $40 billion per year.[xxx] These costs would also fall, along with state smoking rate declines.

State-Specific Estimated Medicaid Cost Savings for Progressive Reductions in Adult Smoking Prevalence

State	Total Estimated Medicaid Expenditures (2001)*	Total Estimated Smoking – Attributable Medicaid Expenditures paid by States (2001)	State Medicaid Savings from a 5% Reduction	State Medicaid Savings from a 10% Reduction	State Medicaid Savings from a 25% Reduction	State Medicaid Savings from a 50% Reduction
ALABAMA	$2,319,368,660	$62,795,134	$389,330	$778,660	$1,934,090	$3,874,460
ALASKA	$402,879,175	$31,735,175	$469,681	$936,188	$2,345,229	$4,690,459
ARIZONA	$1,947,999,588	$97,287,443	$642,097	$1,274,466	$3,191,028	$6,372,328
ARKANSAS	$1,564,251,546	$57,427,163	$470,903	$941,805	$2,348,771	$4,703,285
CALIFORNIA	$16,025,138,144	$1,273,795,918	$9,680,849	$19,234,318	$48,149,486	$96,298,971
COLORADO	$1,693,668,041	$140,107,423	$1,246,956	$2,493,912	$6,234,780	$12,455,550
CONNECTICUT	$3,006,964,124	$189,060,619	$1,247,800	$2,514,506	$6,276,813	$12,572,531
DELAWARE	$444,517,526	$34,886,186	$380,259	$760,519	$1,901,297	$3,802,594
D.C.	$801,256,907	$20,594,103	$137,980	$275,961	$689,902	$1,381,864
FLORIDA	$7,058,263,093	$483,274,95	$3,866,200	$7,732,399	$19,282,671	$38,613,669
GEORGIA	$3,676,553,814	$193,325,736	$1,256,617	$2,513,235	$6,283,086	$12,585,505
HAWAII	$716,854,845	$45,059,447	$378,499	$756,999	$1,901,509	$3,798,511
IDAHO	$508,663,093	$21,213,052	$201,524	$405,169	$1,013,984	$2,027,968
ILLINOIS	$7,611,940,619	$689,846,186	$8,140,185	$16,280,370	$40,631,940	$81,194,896
INDIANA	$2,832,533,196	$162,502,103	$1,690,022	$3,380,044	$8,450,109	$16,883,969
IOWA	$1,864,722,887	$97,850,124	$958,931	$1,908,077	$4,775,086	$9,550,172
KANSAS	$1,187,255,670	$68,872,082	$1,019,307	$2,031,726	$5,082,760	$10,165,519
KENTUCKY	$2,774,014,433	$128,291,134	$1,449,690	$2,886,551	$7,209,962	$14,432,753
LOUISIANA	$3,519,003,299	$174,881,072	$1,381,560	$2,763,121	$6,890,314	$13,798,117
MAINE	$1,191,757,113	$62,761,373	$935,144	$1,870,289	$4,669,446	$9,345,168
MARYLAND	$2,831,407,835	$209,317,113	$1,444,288	$2,888,576	$7,242,372	$14,505,676
MASSACHUSETTS	$6,415,682,062	$459,709,897	$3,907,534	$7,861,039	$19,675,584	$39,305,196
MICHIGAN	$6,031,934,021	$436,234,870	$4,536,843	$9,117,309	$22,771,460	$45,586,544
MINNESOTA	$3,266,922,474	$204,252,990	$1,838,277	$3,676,554	$9,170,959	$18,341,918
MISSISSIPPI	$1,703,796,289	$55,637,839	$372,774	$745,547	$1,863,868	$3,733,299
MISSOURI	$3,306,310,103	$182,139,649	$1,730,327	$3,478,867	$8,669,847	$17,357,909
MONTANA	$453,520,412	$15,800,066	$191,181	$382,362	$955,904	$1,910,228
NEBRASKA	$976,813,196	$47,265,155	$378,121	$756,242	$1,890,606	$3,776,486
NEVADA	$560,429,691	$54,017,320	$621,199	$1,242,398	$3,116,799	$6,228,197
NEW HAMPSHIRE	$797,880,825	$50,641,237	$450,707	$906,478	$2,268,727	$4,537,455
NEW JERSEY	$5,378,099,381	$424,823,711	$4,545,614	$9,133,710	$22,813,033	$45,583,584
NEW MEXICO	$1,108,480,412	$43,754,029	$345,657	$691,314	$1,723,909	$3,452,193
NEW YORK	$30,361,109,691	$2,403,208,041	$21,869,193	$43,738,386	$109,345,966	$218,691,932
NORTH CAROLINA	$5,084,380,206	$263,334,433	$2,291,010	$4,582,019	$11,455,048	$22,883,762
NORTH DAKOTA	$385,998,763	$12,491,505	$84,942	$169,884	$425,960	$853,170
OHIO	$7,392,495,258	$513,535,905	$6,213,784	$12,376,215	$30,966,215	$61,932,430
OKLAHOMA	$1,506,858,144	$57,393,402	$516,541	$1,033,081	$2,582,703	$5,159,667
OREGON	$1,883,854,021	$103,353,138	$981,855	$1,974,045	$4,919,609	$9,839,219
PENNSYLVANIA	$9,180,693,608	$676,060,515	$7,774,696	$15,616,998	$38,941,086	$77,949,777
RHODE ISLAND	$1,081,471,753	$75,624,247	$695,743	$1,383,924	$3,456,028	$6,919,619
SOUTH CAROLINA	$2,535,437,938	$107,100,590	$803,254	$1,606,509	$4,016,272	$8,021,834
SOUTH DAKOTA	$406,255,258	$17,218,021	$156,684	$315,090	$786,864	$1,573,727
TENNESSEE	$4,037,794,639	$215,123,975	$2,387,876	$4,775,752	$11,939,381	$23,857,249
TEXAS	$9,455,281,649	$569,432,577	$3,644,368	$7,231,794	$18,107,956	$36,215,912
UTAH	$760,743,918	$27,346,268	$333,624	$667,249	$1,668,122	$3,336,245
VERMONT	$436,640,000	$23,317,476	$282,141	$564,283	$1,408,376	$2,816,751
VIRGINIA	$2,485,922,062	$172,596,590	$1,311,734	$2,640,728	$6,593,190	$13,169,120
WASHINGTON	$3,510,000,412	$285,841,649	$2,715,496	$5,459,576	$13,634,647	$27,269,293
WEST VIRGINIA	$1,428,082,887	$50,359,897	$518,707	$1,037,414	$2,593,535	$5,187,069
WISCONSIN	$3,030,596,701	$173,024,227	$1,505,311	$3,010,622	$7,509,251	$15,035,805
WYOMING	$226,197,526	$12,401,476	$116,574	$234,388	$584,110	$1,169,459
United States	$179,168,696,907	$11,977,924,235	$110,124,154	$220,265,794	$550,444,901	$1,100,913,299

*Note: Total Medicaid health care expenditures were obtained from the Centers for Medicare and Medicaid Services (CMS) for 1998 and adjusted for medical care inflation data obtained from the Bureau of Labor Statistics

Conclusion



Decisionmakers at the state level face very difficult fiscal challenges this year – and almost every year. The temptation to divert funds flowing from the tobacco settlements to address pressing budget shortfalls is understandable. Any diversion of funds from tobacco control, however, is inconsistent with the spirit of the settlement and undercuts the long-term public good that could be achieved through sustained, adequately funded, state tobacco-control programs. Clearly, the economic benefits from these programs will be apparent both in the near-term and over the long run, just as they have been already for California and Massachusetts. But this issue is not just about cost-effectiveness; it is about saving lives and reducing needless human suffering. It is a question of political commitment and public responsibility.

We must remember that the citizens in each state did not choose to incur the tobacco-related health care costs paid through state funds. As Miller and colleagues have written, "Although the tobacco industry often argues that smoking cigarettes is a matter of individual choice…this harmful product imposes significant economic burdens on state taxpayers, who have no choice but to bear them."[xxxi]

This report shows that it makes good, sound fiscal sense for the states to use the unprecedented opportunity provided by their tobacco-settlement funds to invest in comprehensive tobacco control and prevention and protect their citizens from the deadly effects of tobacco use. This report makes clear that by investing in tobacco control today, states can save a substantial amount tomorrow in avoided future health care costs. The public health stakes in this debate are enormously high. Addiction to nicotine-containing tobacco products among children leads to tobacco-related illness and disability in adulthood, and, ultimately, shorter, less productive and less enjoyable adult lives.

There is also an important personal and family dimension to the tobacco problem that we should not forget. The extraordinary health care costs to treat these avoidable illnesses – as high as they are – do not begin to capture the devastation that these diseases wreak on families and society. It is our mothers and fathers, sisters and brothers, and aunts and uncles, who are dying prematurely from tobacco, and our families who suffer this unnecessary loss. This is not only an economic insult, it is an avoidable human tragedy.

It is up to the states to act now and do the right thing.

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