Report to
The Vermont Legislature

Sustainability of Tobacco Programs
2016 Report to the Legislature

In Accordance with Act 172 (2016) Section E.300.4
An act relating to making appropriations for the support of government

Submitted to: **Joint Fiscal Committee**

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Introduction

The Vermont State Legislature recognized the urgent need to sustain Vermont's comprehensive Tobacco Control Program in the always-challenging fiscal climate. This urgency is created by the following factors:

- In April 2017, Vermont will receive the last of the ten-year Strategic Contribution Fund payments of approximately $10-12 million annually, reducing the annual Master Settlement Agreement payments from approximately $34 million to $23 million.
- The high rate of smoking among those enrolled in Medicaid accounts for 41% of all smoking-related health care costs in VT.[1]
- Vermonters at or below the federal poverty level smoke at a higher rate (29%) than those above the poverty level.
- Funding for Vermont's Tobacco Control Program has relied on annual appropriations from the Master Settlement Agreement (MSA). In fiscal year 2017, this appropriation was approximately 10% of the MSA compared to the nearly 82% directed to Medicaid. In addition, 0% of the annual tobacco product tax revenue (projected to raise $77 million in fiscal year 2017) is appropriated to the comprehensive Tobacco Control Program.

Legislative Charge

Section E. 300.4.a. of Act 172 (2016), An act relating to making appropriations for the support of government:

"a. The Secretary of Administration or designee, the Secretary of Human Services or designee, the Tobacco Evaluation and Review Board, and participating stakeholders in the implementation of the tobacco control program shall develop an action plan for tobacco program funding at a level necessary to maintain the gains made in preventing and reducing tobacco use that have been accomplished since their inception. In addition, the plan shall consider utilizing a percentage of tobacco revenues and the inclusion of monies that have been withheld by tobacco manufacturers but which may be received by the State of Vermont in future years.

b. The Secretary of Human Services shall present this plan to the Joint Fiscal Committee at its November 2016 meeting."

Burden of Tobacco-Related Disease

Each year, more Vermonters die from chronic diseases than all other causes combined. Three behaviors – tobacco use, physical inactivity and poor diet – are the major drivers of four chronic

[1]RTI International's "Independent Evaluation of the VT Tobacco Control Program: 2015 Annual Report – a Historical Look at Progress Achieved, Successes, and Lessons Learned and RTI Recommendations for Tobacco Control in Vermont for the Years 2015-2020," pg. 2-5 & 2-6)

diseases – cancer, cardiovascular disease, lung disease and diabetes – which result in more than 50% of deaths in Vermont. This is branded in the Health Department initiative: 3-4-50.

The Department of Health is launching this major initiative to educate stakeholders on the impact of chronic disease and engage leaders from multiple sectors to implement key strategies which will help to reduce chronic disease through prevention of physical inactivity, poor diet, and tobacco use.

Currently, there is very limited funding for physical activity and nutrition interventions and obesity prevention programs. Thus, obesity rates continue to trend upwards in both adults and youth.

In contrast, Vermont's tobacco control program historically has had fairly strong investment from both the Centers for Disease Control and Prevention (CDC) and through the Master Settlement Agreement (MSA) funds, although average spending over the past six years has been approximately $1.2 million less per year than the previous 6-year average. This continued investment has led to reductions in tobacco use among adults and youth from a high of 24% for adults and 40% for youth 20 years ago to 17% (adults) and 11% (youth) today. The long history of tobacco control efforts has led to a strong evidence-base that guides the work of the Vermont Tobacco Control Program (VTCP). Continued investment will continue to yield results. However, we are facing more significant challenges with many of the major policy initiatives such as smoke-free indoor air already implemented, and emerging products such as electronic cigarettes attracting new users. This means that continued and enhanced funding and attention will be needed to maintain the progress that has been made and to continue to bend the curve on tobacco use.

Recommendation

Maintain current level of funding for the Vermont Tobacco Control Program (VTCP). The funding is used to implement the following critical strategies:

- Mass reach media aims to increase cessation, decrease initiation, and increase support for environmental change. At the currently funded level ($1.02 million) the program runs three adult cessation media campaigns annually, youth prevention via digital media, and provider education initiatives.

- State and community interventions are focused on prevention to reduce youth access, prevent initiation, and change norms through reduced exposure. At the currently funded level ($1.03 million), the program funds 16 coalitions and supports 19 supervisory unions to achieve the stated outcomes.

- Cessation interventions are focused on increased quit attempts and increased quit rates. At the currently funded level ($.67 million), the VTCP provides all three arms of a quit program: quit online, quit line, quit in person (via Blueprint). Additionally, the program provides 8 weeks of free nicotine replacement therapy for enrolled participants.

- Surveillance and evaluation provide accountability and demonstrate effectiveness. This is a critical infrastructure component of the program that ensures funds are utilized in the most effective way and for the best results. Current expenditure is $393,907.

- Infrastructure ensures the program is sufficiently supported to manage sub-recipient awards and grants, effectively run the programs and respond to CDC and VTERB requirements and requests. Current expenditure is $267,282.

Sustaining Funding for the Comprehensive Tobacco Control Program: A Return on Investment

State Tobacco Control Programs have documented **return on investments** (ROI) of between **2:1** (cardiovascular hospital admissions among Medicaid population in Massachusetts over a 3-year period) and **50:1** (health care costs in California over a 10-year period). Other states have seen the impact of tobacco prevention funding cuts. Oregon charted decreases in tobacco use rates over time which stalled when the program was cut by 60%. When funding was restored, rates began to decline again. Massachusetts saw an increase in adult smoking rates, youth rates stalled and sales to youth increased when funding was cut by 95%.

Vermont has appropriated nearly $73 million to the Tobacco Control Program between 2001 & 2014 and there has been an estimated savings of $1.43 billion in overall smoking-related healthcare costs, including $586 million in Medicaid costs. Additional decreases in tobacco use will result in additional health care savings.[2]

What Works

The Community Guide (a publication of the Community Preventive Services Task Force) has identified several well-evidenced strategies that lower tobacco use and burden. Over the past 16 years since using MSA funds to establish a comprehensive program, the VTCP has employed these strategies to good effect. The combination of tobacco tax increases and second hand smoke interventions along with mass media and cessation services has resulted in a slow but steady decline in tobacco use rates.

Comprehensive tobacco control programs are coordinated efforts to implement population-level interventions to reduce appeal and acceptability of tobacco use, increase tobacco use cessation, reduce secondhand smoke exposure, and prevent initiation of tobacco use among young people. Programs combine and integrate evidence-based educational, clinical, regulatory, economic, and social strategies at local, state, or national levels (Cost-Benefit Ratio: median 12:1).

The components of a comprehensive tobacco control program include:

- Raising the excise taxes for tobacco products has been shown to be singularly effective at reducing initiation of tobacco use among youth and promoting cessation of use among adults. Since 2002, the cigarette tax has increased a total of $1.89 through five increases (from $1.19 in 2002 to $3.08 in 2015). The youth smoking rate is particularly susceptible to price increases, which is seen in the dips in youth rates that followed each tax increase. The Task Force reports that a 20% increase in tobacco unit price would be associated

with 3.6% reduction in adults who smoke and a 7.2% reduction in the proportion among young people.

- Implementing mass-media campaigns that are long-term and high intensity is another recommended strategy. Mass-reach health communication interventions were associated with decreased tobacco use prevalence, increased cessation and use of available cessation services, and decreased initiation of tobacco use among young people (Community Guide Cost-Benefit Ratio: range 7:1 to 74:1).

- Cessation services, including phone-based and in-person support and elimination of copays for effective cessation therapies, are also evidence-based. Quitlines use the telephone to provide evidence-based behavioral counseling and support to help tobacco users who want to quit. Counseling is provided by trained cessation specialists who follow standardized protocols that may include several sessions delivered over one or more months (Cost-Benefit Ratio estimate 2:1 to 5:1, Simpson & Nonnemaker, 2013).

- Protective Policies, such as smoke-free policies, reduce exposure to second-hand smoke, reduce prevalence of use and reduce initiation of tobacco use among young people. State and local ordinances establish smoke-free standards that can impact indoor workplaces, indoor spaces, and outdoor public places. Private-sector smoke-free policies may ban all tobacco use on private property or restrict smoking to designated outdoor locations.

Conclusion

The maintenance of the Vermont Tobacco Control Program is critical to continue the progress made since funding of the comprehensive program began in 2000 to reduce the morbidity, mortality and health care costs associated with the leading preventable cause of death.

Potential Enhancements should Additional Funding Become Available

The Centers for Disease Control and Prevention provides recommended minimum amounts for the components of a comprehensive program. Below are the recommended amounts, what the VTCP would implement with additional funds, and what the anticipated result would be:

- **Media/Counter Marketing**: At the minimum recommended amount ($1.1 million), the program would run an additional 6-8 adult cessation campaigns. The anticipated result of achieving the minimum recommended funding would be lower prevalence from 17% to 15% (Community Guide estimates range of -5.2 to -1.9 percentage points).

- **State and Community Prevention**: At the minimum recommended amount ($2.5 million), the program would provide statewide coverage with more coalitions and Regional Prevention Partners funded at higher amounts. Additionally, more youth groups would be supported for peer education and prevention. The anticipated result would be to reduce youth all-tobacco use from 25% to 20% based on the Community Guide median decrease of 5.8 percentage points.

- **Cessation**: At the minimum recommended amount ($1.7 million), the program would expand the coverage of quit partners to reduce drive times and increase provider engagement for disproportionately impacted populations (Medicaid, low income, lesbian,

gay, bisexual, transgender, and individuals with disabilities). Additional resources and training would be available for medical providers and special interventions would be deployed for Vermonters of low socioeconomic status, with mental health diagnoses, with disabilities and cognitive impairment, and the lesbian, gay, bisexual, and transgender community – all of whom have higher rates of use. The anticipated result of CDC minimum funding would be a median increase of 3.1 percent in tobacco cessation.

- **Surveillance and evaluation**: CDC recommends a minimum of .5 million for Vermont. This would allow for increased evaluation of programs to ensure maximum efficacy.

- **Infrastructure**: CDC recommends a minimum of 0.3 million for Vermont.

Appendix A – Comparison Table

Best Practice Tobacco Control and Prevention Components	**Objective**	**Vermont Program Current Funding Level $3,626,269**	**CDC Minimum Recommended Level $6,100,000**	**Outcomes from CDC Recommended Funding Level**
Mass Reach Media/Counter marketing	Raise awareness of tobacco's harm Drive tobacco users to quit resources Strengthen perception of harm Create strong tobacco-free social norms	*$1.02 million current* Adult Cessation Campaigns CDC Quit Tips from Former Smokers 802Quits for all Vermonters to help quit thru phone, online and in-person supports Provider Education	*$1.1 million recommended* Run 6-8 additional Adult Cessation Campaigns Create more Quit Partner ads to show real Vermonters providing and benefiting from 802Quits	**Run adult cessation mass reach media more frequently throughout the year driving cessation activity and reducing use = lower prevalence from 17% to 15% (keeping the HV2020 goal of 12%).**
Prevention State and Community Interventions	Prevent tobacco initiation among youth Reduce youth access Strengthen perception of harm Create strong tobacco-free social norms	*$1.03 million current* 16 Community Coalitions 19 Supervisory Unions supported for youth prevention Local and State durable change efforts (smoke free parks, beaches, municipalities)	*$2.5 million recommended* Fund more community-based coalitions/orgs & Regional Prevention Partners to work on tobacco prevention & local protective actions e.g. safe buffers around schools	**Fund more coalitions, youth groups OVX and VKAT with Agency of Education, and assist more youth with quitting. Fewer youth smoking and trying tobacco products = lower youth initiation and use.**

	Provide cessation for youth			**Result would be lower prevalence of any tobacco use in past 30 days. Current is 25%. Target by 2020 is 20%.**
Cessation Services	Increase quit attempts Maintain and make accessible a state quitline Work with health systems to provide training & tools for tobacco guideline based care Increase # of smoke and tobacco-free campuses that support cessation outcomes Reduce exposure to secondhand smoke among non-smokers especially children	*$0.67 million current* 802Quits including Quitline available 24/7 and free text Quit Online with free chat Quit Partners in collaboration with Blueprint for Health	*$1.7 million recommended* Increase provider engagement and use of 802Quits This is key to increasing cessation and decreasing use among adults and youth Hold twice as many trainings to create certified treatment specialists who can bill for tobacco treatment and to support providers in treating tobacco use Expand coverage of Quit Partners to shorten drive time in any part of state to less than 30 min for group cessation classes	**Assist more Vermonters who are harder to reach and assist (low-income, low education and poor mental health) and are tobacco users with tobacco treatment & supports. Result = median increase of 3.1 percent in tobacco cessation.** **Result would be lower prevalence among adults with depression to 20% by 2020 (from 27%).**
Surveillance ***Evaluation***	Monitor use and trends in data, share data with public, support a data-informed tobacco program Program and intervention quality improvement Program impact	*$0.36 million current* Conduct, analyze and disseminate data including BRFSS, YRBS, Adult Tobacco Survey, Macro Polls, Claims	*$0.5 million recommended* Enhance and maintain current surveillance and evaluation efforts	**Resources are needed for data analysis and economic cost benefit assessment would place VT along with MA as a leader in treating Medicaid-insured for tobacco dependence.**