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SAVING LIVES, SAVING MONEY II:

Tobacco-Free States Spend Less on Medicaid

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THIS STUDY PRESENTS ESTIMATES of the reduction in state Medicaid expenditures that would result from reducing or eradicating smoking through effective cessation and prevention programs. Two types of estimates are provided: cross-sectional estimates show how much less Medicaid spending would be in a given state five years after a proportion of current smokers successfully quit, and life-cycle estimates project how much state Medicaid programs would save over the course of a cohort of young smokers' lives if none of them had ever smoked.

Cross-sectional Results. The cross-sectional component of this study shows that, on average, state Medicaid expenditures would be 5.6% lower five years after all beneficiaries successfully quit smoking. The proportion of Medicaid spending directly attributable to current smoking ranges from 2.8% to 8.2% across states. This translates into expenditures ranging from \$15 million (Wyoming) to \$1.5 billion (New York) (see Table 1). Summed across states, U.S. Medicaid expenditure would be \$9.7 billion lower if all current smokers in the Medicaid system successfully quit. This table also shows how much lower Medicaid expenditures would be five years after a 5%, 10%, 25% or 50% reduction in the state smoking rate.

Life-cycle Results. The life-cycle component of this study shows that, on average, state Medicaid expenditures attributable to smoking for a 24-year-old male smoker will be \$353 over the course of his lifetime. Because the average 24-year-old male smoker is estimated to pay \$347 through income taxes over his lifetime to finance smoking-attributable Medicaid expenditures, the net cost of smoking to Medicaid over the lifetime of a male smoker is about \$6. The figures for female smokers are starkly different. On average, state Medicaid expenditures attributable to smoking for a 24-year-old female smoker will be \$1,581 over the course of her lifetime. Because the average 24-year-old female smoker is estimated to pay only \$209 through income taxes over her lifetime to finance smoking-attributable Medicaid expenditures, the net cost of smoking to Medicaid over the lifetime of a female smoker is about \$1,372. If states could prevent all smoking among 24-year-olds, reductions in Medicaid expenditures over the course of their lifetimes would be between \$1.4 million (Alaska and Vermont) and \$125 million (Texas) in current dollars (see Table 2). Summed across states, the total lifetime costs of smoking to Medicaid in the U.S. for the current cohort of 24-year-old smokers is nearly \$1 billion.

Conclusions. These results suggest that states can realize dramatic reductions in Medicaid expenditures by implementing strong smoking cessation and prevention programs. It is our hope that states will view these estimates as practical tools which can be used to set both short and long-term goals for reductions in Medicaid expenditures associated with tobacco use. These estimates can be used in conjunction with the ever-expanding literature on effective, population-based tobacco control strategies to help states identify suitable programs and determine appropriate levels of funding for their particular needs and goals.

IN 2002, THE AMERICAN LEGACY FOUNDATION published “*Saving Lives, Saving Money: Why States Should Invest in a Tobacco-Free Future*,” a report that presented estimated savings to state Medicaid programs associated with reductions in adult smoking prevalence. That study represented the first estimates of the cost of smoking to state Medicaid programs since Miller and colleagues published their findings on this topic in 1998 (Miller et al., 1998).

This report updates the 2002 Legacy study, using new data and an improved methodology to estimate the impact of effective smoking cessation programs on state Medicaid programs. This analysis takes into account changes in Medicaid and the medical care market over the past decade. In addition, this report presents a powerful new analysis that departs from those previously published by both Miller et al. and Legacy: an examination of the costs of smoking to state Medicaid programs over the course of the lives of a cohort of young smokers. Because the methodology used in this study differs from that used in 2002, the two studies are not comparable.

TABLE 1 OF THIS REPORT presents estimates of how much less Medicaid spending would be in a given year if all current smokers successfully quit, and how much lower Medicaid expenditures would be five years after a 5%, 10%, 25% or 50% reduction in the state smoking rate. Like most other previously published cross-sectional estimates of the cost of smoking, including Miller et al. and the Legacy 2002 study, the estimates in Table 1 assume that the benefits of smoking reduction accrue in the relative short term; in this case, beginning five years after cessation.

Table 2 of this report presents the costs of smoking to state Medicaid programs over the course of the lives of a cohort of young smokers. These life-cycle estimates project how much state Medicaid programs would save over the course of the lives of young people in their state if they had never begun smoking. Life-cycle estimates are useful for gauging the long-term impact on state Medicaid programs of smoking prevention in youth (Manning et al., 1989; Warner, Hodgson, and Carroll, 1999; Sloan et al., 2004). Life-cycle estimates differ from cross-sectional estimates in that they account for the differences in life expectancy for smokers compared with nonsmokers and for payments into the Medicaid system by smokers. Smokers have shorter life expectancy than nonsmokers and therefore may rely on public insurance programs for a shorter period of time than nonsmokers. However, as a result of smoking-related health complications, smokers may use the medical system more intensively during their time on public insurance, leaving the net impact uncertain. In addition, over their lifetime, smokers will pay taxes that finance public insurance. Unlike cross-sectional cost estimates, life-cycle estimates account for the fact that smokers help to finance some of their own medical expenditures. The methods and analyses used to derive both the cross-sectional and life-cycle estimates are described below.

Overview of the Analytic Model

In order to calculate the net lifetime costs of a smoker to a state Medicaid program, it is necessary to predict Medicaid expenditures, weighted by the probability of being covered by Medicaid, and tax payments for Medicaid at each age and for each smoking status. The net costs to Medicaid at each age are then discounted and adjusted for survival to each age and quit rates at each age. Therefore, the life-cycle estimates are derived using a five-part model: the effect of smoking on (1) Medicaid expenditures, (2) Medicaid coverage, (3) tax burden, and (4) life expectancy as well as (5) smoking quit rates. The cross-sectional estimates are calculated using only the first two components of this model.

Data Sources

Both models draw on data from a variety of sources. The effect of smoking on Medicaid expenditures is estimated using pooled data from the 2000 through 2004 Medical Expenditure Panel Surveys (MEPS) Consolidated Data Files, a nationally representative survey of the civilian noninstitutionalized population, linked to the 1998 through 2003 National Health Interview Survey (NHIS) Adult Sample to define smoking status using smoking histories. The effect of smoking on Medicaid coverage and income is estimated using pooled data from the 1998 through 2005 NHIS Adult Sample. Annual income tax burden at the federal and state levels is predicted by using predicted income in the National Bureau of Economic Research's (NBER's) TaxSim software. TaxSim software incorporates federal and state tax policy through 2005. Finally, the life tables by smoking status, sex, and age and the estimated quit rates by sex and age were published in Sloan et al. (2004).

Definitions

Current smokers have smoked at least 100 cigarettes in their lifetime and are still smoking or quit smoking within the past five years. Former smokers have smoked at least 100 cigarettes in their lifetime but quit smoking more than five years ago. Never smokers have not smoked 100 cigarettes in their lifetime. Individuals who quit smoking within the past five years were classified as current smokers because of the likelihood that they will relapse, and because smokers often quit smoking in response to adverse health events (Moore and Hughes, 2001; Taylor et al., 2002). Because the medical costs associated with such health events should be attributed to the recent current smoking of the individual, classifying them as former smokers would bias the data in such a way that it may appear as though former smokers placed a greater burden on Medicaid programs than current smokers. In fact, research shows that cessation programs can generate health benefits and cost savings even in the short term (Lightwood and Glantz, 1997).

The Cross-sectional Analysis

The parameters from the national Medicaid expenditure model are used to predict annual Medicaid expenditures for each person by state using the 2005 Behavioral Risk Factor Surveillance System (BRFSS), the most recent data available. However, since BRFSS has not included questions on Medicaid coverage since 2000, parameters from the national Medicaid coverage model are used to predict the probability of each person in a state being covered by Medicaid. Predicted Medicaid expenditures are then weighted by the probability of being covered by Medicaid to calculate expected Medicaid expenditures for each person in a state. Medicaid expenditures attributable to smoking are calculated as follows. Expected Medicaid expenditures are re-predicted for each person in the state, treating current smokers as former smokers but holding all other variables constant. Because many smokers relapse within a few years of quitting, this analysis defines "successful quitting" as having quit at least five years previously. The smoking-

attributable fraction (SAF) of Medicaid expenditures is calculated by summing this difference for each person in the state and dividing by total predicted Medicaid expenditures. Smoking-attributable expenditures (SAE) for each state's Medicaid program apply the SAF to total adult Medicaid expenditures as reported in the Medicaid Statistical Information System (MSIS) State Summary Fiscal Year 2003 and inflated to 2005 dollars using the Medical Care Consumer Price Index.

The Life-cycle Analysis

Estimates from the analytic model are used to calculate the present value of net Medicaid expenditures attributable to smoking over the lifetime of a typical 24-year-old smoker (Sloan et al., 2004). The analysis begins with young people age 24 because nearly all smokers begin smoking before age 24, whereas younger smokers might still be experimenting off and on with cigarettes. The parameters from the models and published data are used to predict Medicaid expenditures, Medicaid coverage, income tax, probability of being alive, and probability of quitting smoking by state, smoking status, sex, and age, using mean values by state and sex from the 2005 BRFSS for explanatory variables other than smoking status and age. The Medicaid expenditure per person in each state is then calculated by summing, by smoking status, discounted, survival-adjusted and quit-adjusted expected Medicaid expenditure at every age from 24 to 85, the highest age recorded in our estimation sample. The difference between the total Medicaid expenditure for a smoker beginning at age 24 and a never smoker beginning at age 24 is the smoking-attributable Medicaid expenditure per smoker over the lifetime.

The present value of income taxes per person in each state is calculated by summing, by smoking status, the discounted, survival-adjusted and quit-adjusted expected income taxes at every age from 24 to 85. The share of taxes going to Medicaid for each sex and smoking status is then calculated. The net cost of smoking to Medicaid is the difference between the lifetime smoking-attributable Medicaid expenditures and the lifetime Medicaid tax burden.

Data Analysis

All regressions control for age, ethnicity, education, marital status, body weight, alcohol consumption, and year. All analyses are conducted separately for males and females and are representative of the sampled population (i.e., nation or state).

Results of the Cross-sectional Analysis

This counterfactual simulation shows how much lower Medicaid expenditures would be if the cohort of current smokers were instead former smokers who had quit more than five years previously. Smoking-attributable fractions (SAFs) range from 2.8% of Medicaid expenditures in California to 8.2% in New Hampshire. The average SAF across states is 5.6%. This means that, on average, states' Medicaid expenditures would be 5.6% lower if all current smokers among beneficiaries quit. When the SAFs are applied to total Medicaid expenditures reported by the Centers for Medicare & Medicaid Services (CMS), the estimates of smoking-attributable expenditures (SAEs)- that is, expenditures directly attributable to current smoking- range from \$15 million in Wyoming to \$1.5 billion in New York (Table 1). Summed across states, U.S. Medicaid expenditure would be \$9.7 billion lower if all current smokers in Medicaid were instead former smokers. Table 1 also shows how much lower Medicaid expenditures would be five years after a 5%, 10%, 25% or 50% reduction in the state smoking rate.

Results of the Life-cycle Analysis

The present value of lifetime Medicaid expenditures net of taxes paid into the Medicaid system is reported for typical male and female 24-year-old smokers in each state in Table 2. For males, the net costs to Medicaid per smoker range from -\$418 in West Virginia to \$288 in Utah. Negative values mean that male smokers pay more into the Medicaid system over their lifetime than they consume in Medicaid services. Averaged across states, a 24-year-old male smoker is estimated to have \$353 in Medicaid expenditures attributable to smoking over his lifetime (not shown). The same 24-year-old male smoker is also estimated to pay \$347 over his lifetime to finance smoking-attributable Medicaid expenditures, for a net cost of smoking to Medicaid of \$6 over the lifetime of a male smoker. For females, the net costs to Medicaid per smoker range from \$782 in New Hampshire to \$2,958 in Mississippi. Averaged across states, a 24-year-old female smoker is estimated to have \$1,581 in Medicaid expenditures attributable to smoking over her lifetime (not shown). The same 24-year-old female smoker is estimated to pay \$209 over her lifetime to finance smoking-attributable Medicaid expenditures, for a net cost of smoking to Medicaid of \$1,372 over the lifetime of a female smoker.


The last column of Table 2 shows the present value of smoking-attributable Medicaid costs over the lifetime of the current cohort of 24-year-old smokers by state. This column shows that, for example, if California could prevent all smoking among 24-year-olds in the state, the reductions in Medicaid expenditures over their lifetimes would be worth \$93 million in current dollars. The estimates of total lifetime costs of smoking to Medicaid range from \$1.4 million in Alaska and Vermont to \$125 million in Texas. Summed across states, the total lifetime costs of smoking to Medicaid in the U.S. for the current cohort of 24-year-old smokers is nearly \$1 billion.

Relation to Prior Estimates

The cross-sectional smoking-attributable fractions (SAFs) reported here are smaller than those previously reported in Miller et al. (1998). This difference is primarily due to the fact that Miller et al. (1998) constructed SAFs by comparing ever smokers with never smokers, whereas this report compares current smokers with former smokers. When we constructed SAFs by comparing both current and former smokers to never smokers (to mimic the methods used by Miller et al.), controlling for other differences between the groups, the average SAF across the states was 19%, compared with 15% reported by Miller et al. (1998). The difference in estimates could be due to a number of factors. The studies use different regression models. In addition, unlike NHIS, many of the key smoking variables in the data used by Miller et al. were imputed. The smoking histories used to define smoking status in the NHIS might have captured more historical smokers than in the previous study. Lastly, over the past 20 years, smoking prevalence has not declined as much among low-income groups as it has in higher income groups (CDC, 2004). It could be that the remaining smokers in Medicaid are more addicted and are manifesting more smoking-related health problems than in previous Medicaid cohorts.

Although the methodology for the first report on this topic, *Saving Lives, Saving Money*, differs from the current report, the cross-sectional SAFs are similar to those reported in the first American Legacy Foundation report. In that report, the total estimated smoking-attributable Medicaid expenditures paid by states were, on average, 5.7% of the total estimated Medicaid expenditures. The average SAF across states in this report is 5.6%.

The lifetime costs of smoking to Medicaid are similar to those reported at the national level by Sloan et al. (2004). Sloan et al. report smoking-attributable Medicaid expenditures of \$1,308 per female smoker and \$306 per male smoker in 2000 dollars. Inflating to 2005 dollars, these numbers are \$1,621 and \$379 for females and males, respectively. The averages across states from this report are \$1,581 for females and \$353 for males. In 2005 dollars, the net cost of smoking to Medicaid per smoker reported by Sloan et al. is \$1,174 for females and -\$76 for males. The averages across states of the net lifetime cost of smoking to Medicaid in this report are \$1,372 for females and \$6 for males.

A photograph of a diverse group of young adults, including men and women of various ethnicities, engaged in conversation outdoors. The image is overlaid with a blue tint. The group is positioned in the upper half of the page, with a dark blue box containing the word 'DISCUSSION' centered above them.

THIS REPORT IMPROVES ON EXISTING ESTIMATES of the cost of smoking to Medicaid in two ways. First, it is based on the most current data on Medicaid expenditures: five years of MEPS data through 2004. Second, it provides two types of cost estimates, each of which is suited to inform particular smoking policies. The cross-sectional analysis provides estimates of reductions in state Medicaid expenditures in an ideal scenario in which all current smokers successfully quit and the health benefits of their quitting were observed immediately; it also shows expected reductions in expenditures associated with stepped declines in the state smoking rate. These estimates suggest that states can realize dramatic reductions in Medicaid expenditures by implementing strong smoking cessation programs.

The lifetime analysis presents estimates of the long-term cost of young adult smoking to state Medicaid programs. This analysis takes into account changes in health and life expectancy that result from smoking, as well as the fact that smokers finance some of their own Medicaid expenditures through taxes. Male smokers place only a modest burden on the system because they tend to pay into Medicaid through taxes about as much as the extra expenditures they incur as a result of their smoking. Young female smokers, on the other hand, place an additional \$1,300 burden on the Medicaid system, on average, over their lifetime. This suggests that smoking-attributable Medicaid expenditures can be reduced most markedly through public health policies and programs that influence the smoking behavior of low-income females.

The total lifetime costs of young smokers presented in Table 2 are for one cohort of 24-year-olds. Every year a new group of young people will turn 24. Policy that focuses on preventing smoking among young people by age 24 will generate reductions in lifetime Medicaid expenditures for each age cohort. These estimates are useful for gauging the long-term impact of youth smoking prevention programs on state Medicaid expenditures. Since nearly all individuals begin smoking in adolescence, states can dramatically reduce future Medicaid expenditures by implementing youth smoking prevention programs today.

Limitations

All numbers reported in the tables are estimates that involve an amount of uncertainty. The combination of so many data sources and statistical models precludes the straightforward calculation of standard errors or confidence intervals for the cost estimates. Readers are reminded that the estimated costs might differ from the true costs of smoking to Medicaid.

The life-cycle estimates are based on estimates from the current cohort of adults. New cohorts of young adults might experience different smoking-related patterns over their lifetime than the current group of adults (e.g., quit patterns of current 24-year-old smokers could be different from those experienced by smokers in previous generations).

This report focuses on the costs of smoking to Medicaid. Many of the other costs of smoking to society are not included in the analysis, including medical costs to other payers (e.g., Medicare, private insurance, out-of-pocket payments), productivity losses, the effects of secondhand smoke and smoking during pregnancy, and valuations of changes in mortality and morbidity. The effect of policy at the state level on these other factors should also be considered.



Table 1. Cross-sectional Analysis. Potential Annual Reductions in Medicaid Expenditures Associated with Smokers Quitting: Savings to States Beginning Five Years After a Decrease in the Smoking Rate.

State	Total Annual Estimated Medicaid Expenditures (millions) 2005 \$	State Reductions in Medicaid Expenditures Five Years After All Current Smokers Quitting (millions 2005 \$)	State Reductions in Medicaid Expenditures Five Years After 5% of Current Smokers Quitting (millions 2005 \$)	State Reductions in Medicaid Expenditures Five Years After 10% of Current Smokers Quitting (millions 2005 \$)	State Reductions in Medicaid Expenditures Five Years After 25% of Current Smokers Quitting (millions 2005 \$)	State Reductions in Medicaid Expenditures Five Years After 50% of Current Smokers Quitting (millions 2005 \$)
Alabama	2,132	104	5	10	26	52
Alaska	531	31	2	3	8	16
Arizona	2,158	129	6	13	32	65
Arkansas	1,542	94	5	9	24	47
California	21,094	591	30	59	148	296
Colorado	1,797	102	5	10	26	51
Connecticut	3,120	181	9	18	45	91
Delaware	591	37	2	4	9	19
District of Columbia	896	50	3	5	13	25
Florida	8,436	346	17	35	87	173
Georgia	3,800	190	10	19	48	95
Hawaii	632	30	2	3	8	15
Idaho	672	35	2	4	9	18
Illinois	6,586	349	17	35	87	175
Indiana	3,222	248	12	25	62	124
Iowa	1,658	106	5	11	27	53
Kansas	1,322	63	3	6	16	32
Kentucky	2,761	182	9	18	46	91
Louisiana	2,793	131	7	13	33	66
Maine	1,635	93	5	9	23	47
Maryland	3,538	223	11	22	56	112
Massachusetts	5,820	291	15	29	73	146
Michigan	5,016	276	14	28	69	138
Minnesota	3,862	224	11	22	56	112
Mississippi	2,107	103	5	10	26	52
Missouri	3,662	227	11	23	57	114
Montana	411	19	1	2	5	10
Nebraska	912	50	3	5	13	25
Nevada	627	39	2	4	10	20
New Hampshire	653	54	3	5	14	27
New Jersey	5,252	273	14	27	68	137
New Mexico	1,330	62	3	6	16	31
New York	32,184	1,480	74	148	370	740
North Carolina	5,258	294	15	29	74	147
North Dakota	402	22	1	2	6	11
Ohio	9,173	550	28	55	138	275
Oklahoma	1,606	103	5	10	26	52
Oregon	1,718	82	4	8	21	41
Pennsylvania	7,699	470	24	47	118	235
Rhode Island	1,122	56	3	6	14	28
South Carolina	2,255	135	7	14	34	68
South Dakota	410	22	1	2	6	11
Tennessee	4,887	357	18	36	89	179
Texas	8,895	498	25	50	125	249
Utah	659	24	1	2	6	12
Vermont	490	28	1	3	7	14
Virginia	2,617	162	8	16	41	81
Washington	2,644	130	7	13	33	65
West Virginia	1,389	101	5	10	25	51
Wisconsin	3,545	245	12	25	61	123
Wyoming	258	15	1	2	4	8
U.S.	--	9,711	486	971	2,428	4,856

Notes: Smoking-attributable fractions are based on parameter estimates from Medicaid-eligible sample from 2000 to 2004 Medical Expenditure Panel Survey (MEPS) data merged to 1998 to 2003 National Health Interview Survey (NHIS) Adult Sample. Smoking-attributable Medicaid expenditures apply the smoking-attributable fraction to total adult Medicaid expenditures as reported in the Medicaid Statistical Information System (MSIS) State Summary Fiscal Year 2003 and inflated to 2005 dollars using the Medical Care Consumer Price Index. All counterfactual "nonsmoking" simulations conducted using populations from the 2005 Behavioral Risk Factor Surveillance System (BRFSS). "Assuming All Current Smokers Quit": these estimates indicate how much lower Medicaid expenditures would be if all current smokers were former smokers who had quit more than five years previously.

Table 2. Lifetime Analysis. Net Lifetime Medicaid Costs over the Lives of a Cohort of 24-Year-Old Smokers

State	Annual Net Medicaid Costs Costs Per Smoker* (2005 \$)		Total Number of 24-Year- Old Smokers by State		Total Net Lifetime Costs for the Cohort** (millions 2005 \$)		
	Male	Female	Male	Female	Male	Female	Total
Alabama	-71	2,104	12,128	8,645	-0.9	18.2	17.3
Alaska	105	1,122	1,500	1,134	0.2	1.3	1.4
Arizona	70	1,280	22,295	12,094	1.6	15.5	17.0
Arkansas	-204	1,643	10,305	11,945	-2.1	19.6	17.5
California	255	1,951	93,710	35,545	23.9	69.3	93.3
Colorado	7	855	12,444	11,260	0.1	9.6	9.7
Connecticut	62	784	10,686	4,612	0.7	3.6	4.3
Delaware	-170	812	1,280	2,857	-0.2	2.3	2.1
District of Columbia	68	1,634	1,501	1,948	0.1	3.2	3.3
Florida	101	1,411	27,707	27,667	2.8	39.0	41.9
Georgia	68	1,679	24,029	15,154	1.6	25.4	27.1
Hawaii	60	1,375	2,281	1,815	0.1	2.5	2.6
Idaho	221	1,474	3,112	1,744	0.7	2.6	3.3
Illinois	136	1,314	47,674	30,403	6.5	39.9	46.4
Indiana	-213	1,203	22,424	28,659	-4.8	34.5	29.7
Iowa	28	1,146	9,029	5,664	0.3	6.5	6.7
Kansas	64	1,267	5,345	6,202	0.3	7.9	8.2
Kentucky	-113	1,815	11,623	11,152	-1.3	20.2	18.9
Louisiana	-52	2,001	7,432	10,403	-0.4	20.8	20.4
Maine	-48	1,242	1,726	3,376	-0.1	4.2	4.1
Maryland	28	1,047	8,957	9,025	0.2	9.4	9.7
Massachusetts	61	955	12,421	12,942	0.8	12.4	13.1
Michigan	20	1,157	19,937	20,773	0.4	24.0	24.4
Minnesota	-27	848	8,655	21,260	-0.2	18.0	17.8
Mississippi	119	2,958	10,490	5,135	1.2	15.2	16.4
Missouri	-24	1,391	7,432	16,375	-0.2	22.8	22.6
Montana	137	1,242	2,310	2,171	0.3	2.7	3.0
Nebraska	-29	1,157	4,473	4,647	-0.1	5.4	5.2
Nevada	-26	1,397	4,720	4,652	-0.1	6.5	6.4
New Hampshire	-86	782	4,998	4,584	-0.4	3.6	3.2
New Jersey	28	1,052	19,912	19,718	0.6	20.7	21.3
New Mexico	69	1,899	6,193	3,455	0.4	6.6	7.0
New York	61	1,478	28,348	45,454	1.7	67.2	68.9
North Carolina	-23	1,636	27,410	22,819	-0.6	37.3	36.7
North Dakota	42	1,087	1,661	1,840	0.1	2.0	2.1
Ohio	-22	1,237	37,429	23,421	-0.8	29.0	28.2
Oklahoma	-151	1,896	5,564	8,875	-0.8	16.8	16.0
Oregon	102	1,326	6,102	6,862	0.6	9.1	9.7
Pennsylvania	1	1,304	37,699	31,394	0.1	40.9	41.0
Rhode Island	-47	1,054	1,492	3,806	-0.1	4.0	3.9
South Carolina	-185	1,802	17,915	16,425	-3.3	29.6	26.3
South Dakota	92	1,153	1,997	2,397	0.2	2.8	2.9
Tennessee	-155	1,670	29,494	25,042	-4.6	41.8	37.2
Texas	-39	1,741	49,751	72,912	-1.9	127.0	125.0
Utah	288	1,624	3,214	2,556	0.9	4.2	5.1
Vermont	115	994	1,198	1,248	0.1	1.2	1.4
Virginia	0	943	28,835	22,551	0.0	21.3	21.3
Washington	136	1,080	13,128	10,948	1.8	11.8	13.6
West Virginia	-418	1,952	7,114	8,996	-3.0	17.6	14.6
Wisconsin	-182	877	11,794	21,576	-2.2	18.9	16.8
Wyoming	30	1,097	1,768	1,805	0.1	2.0	2.0
U.S.	--	--	--	--	20.2	978.0	998.2

Notes: **Annual Net Medicaid Costs Per Smoker” is the present value of lifetime Medicaid expenditures per smoker net of taxes paid for Medicaid. ** “Total Net Lifetime Costs for the Cohort” is the present value of lifetime Medicaid expenditures for the cohort, net of taxes paid for Medicaid. A discount rate of 3% was used in the present value calculations. This table is based on estimates from 2000 to 2004 Medical Expenditure Panel Survey (MEPS), 1998 to 2005 National Health Interview Survey (NHIS) Adult Sample, 2005 Behavioral Risk Factor Surveillance System (BRFSS), and Sloan et al. (2004).

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This study was conducted for American Legacy Foundation by Justin Trogdon and Joanne Pais of RTI International, June 2007. Additional information including technical notes and appendices are available on the Legacy website, at: www.americanlegacy.org.

