Over the past several decades, California has emerged as a leader in tobacco control. Currently, it enjoys the second lowest state smoking prevalence (10.5%), trailing only Utah’s 8.8%. And if adjusted for the (presumably) non-smoking Mormon population that accounts for half of Utah’s residents, California would be the unquestioned leader. California has achieved this through a combination of state and local tobacco control policy initiatives, though—perhaps surprisingly—it has not been a leader in state tobacco taxation. Indeed, it was not an early state to tax tobacco products, passing its first such tax in 1959. It ranked only 33rd in the nation in the size of its tobacco tax until the 2016 enactment of a $2 tax, which raised the state tax from $0.87 to the current $2.87, placing it now ninth overall.

There are many examples of California’s pioneering tobacco control efforts:

- In 1989 it created the first statewide comprehensive control program and infrastructure.
- In 1993 it created the first toll-free state quitline.
- In 1994 it enacted the first statewide clean indoor air law.
- In 2007, the City of Belmont adopted a groundbreaking law prohibiting smoking in all multi-unit housing. Over the next decade, 51 additional jurisdictions adopted that practice.
- In 2008, San Francisco successfully banned tobacco sales in its pharmacies, withstanding a legal challenge to invalidate that action.
- Systemwide tobacco-free bans occurred in higher education, initially at state universities (2014) and subsequently at state colleges (2017) and community colleges (2018).
- In 2015, San Francisco banned tobacco product use in baseball parks, and this was later extended to all state baseball parks.
- In 2016, it became the second state (after Hawaii) to limit tobacco sales to those older than age 21 years.
- In 2017, several cities restricted or banned the sale of menthol-flavored tobacco products.
- In 2017, several municipalities banned smoking on public beaches.
- In 2017, San Francisco followed two other counties in banning all flavored-tobacco products, including those with menthol. That decision, originally made by the Board of Supervisors, was overwhelmingly confirmed in a 2018 public referendum.

Yet, despite its low smoking prevalence, the enactment of many strong tobacco control policies, and the creation of a culture that de-normalized tobacco use, California still has a long way to go before smoking disappears as a health problem. With its 3.2 million adult smokers, it has the largest such population in the country, reflecting California’s huge population of almost 40 million people. An additional challenge is that over time, smoking has become increasingly concentrated among vulnerable populations who are disproportionately represented in the state Medicaid program, known as Medi-Cal. Because California is one of 34 states (including the District of Columbia) that expanded Medicaid eligibility under the 2010 Affordable Care Act, the population of Medi-Cal smokers also increased. As Zhu et al. explain, the estimated number of California smokers covered by Medi-Cal rose from 738,000 in 2011–2012 to 1,448,000 by 2016, raising the proportion of state smokers covered by Medi-Cal from 19.3% to 41.5%.

This special issue of the American Journal of Preventive Medicine features 11 papers describing various components of California’s Medi-Cal Incentives to Quit Smoking (MIQS) program, a project that ran from 2011 to 2015. The design, financing, and results of MIQS are...
MIQS resulted from the California Department of Health Care Services’ Strategy for Quality Improvement in Health Care effort, and was conducted in partnership with the California Tobacco Control Program. Funded through the 2010 Affordable Care Act and the Centers for Medicare and Medicaid Services Innovation Center, MIQS employed several interventions—mailings that included inserts, selective marketing through targeted ethnic and linguistic outreach channels, modest financial incentives, and free provision of nicotine patches—as a way to stimulate quit attempts. A major focus was to drive Medi-Cal smokers to the state quitline. This strategy was based on evidence showing that quitlines do improve the chances of quitting, and that Medicaid smokers are motivated to quit, although their quit rates are somewhat lower than the general population. Outcome measurements included quit attempts and self-reported abstinence at various time points. The papers in this special issue present the results according to overall impact, responses to the various interventions, and differences by racial and ethnic status and maternal and child health.

What were the findings? In general, there were impressive increases in the desired process measures and modest but significant increases in both quit attempts and successful quits. For example, there was a 70% increase in quitline calls by Medi-Cal smokers, achieving a reach of 4.5%, which far exceeds the national quitline reach of only 1% of smokers. Comparing the various incentives, smokers assigned to nicotine patch plus financial incentives were more likely to make a quit attempt than those in usual care (68% vs 54%) and also more likely to report 6-month prolonged abstinence (13% vs 9%). Engagement of various ethnic groups in California’s multi-ethnic population was achieved. There was a modest increase in reaching pregnant women (from 2.1% to 3.3%). Mass mailings containing either a free nicotine patch or a $20 gift card quadrupled the odds of smokers calling the quitline, although the initial baseline was low. For example, the highest rate of calling quitlines resulting from this wide distribution, low individual cost intervention, was only 0.2%. Calculating benefit cost from the perspective of the state Medi-Cal program over 10 years showed benefit–cost ratios of 1.30 to 1.90, depending on the interventions applied.

What lessons can other states learn from the MIQS project? First of all, the target population—people covered by Medicaid—should be a major focus of state tobacco control efforts because smokers are increasingly concentrated among low-income individuals, especially those with behavioral health conditions. One potential intervention would be that all Medicaid programs—including managed care plans—could require Healthcare Effectiveness Data and Information Set cessation indicator tracking and public reporting. Second, as is true with tobacco control in general, there is no single magic bullet to reduce the burden of smoking. Rather, improvement results from the application of policy and clinical interventions that have been previously demonstrated to succeed. Third, although the results of individual efforts, such as general or targeted mailings, free nicotine replacement therapy, referral to telephone quitlines, and financial incentives (all used in MIQS), as well as taxation, smoke-free legislation, and counter-marketing (all occurring in California as a backdrop to MIQS) may be relatively modest, each contributes to driving down smoking rates. In the case of California, even a small percentage drop in smoking, when applied to 1.5 million smokers, could save thousands of lives.

California is fortunate to have a culture and governmental infrastructure seriously devoted to tobacco control. Indeed, it followed up MIQS with a set of other projects, including UC (University of California) Quits—a coalition to promote bidirectional electronic referral from the states’ five academic medical centers to the quitline. Second, there is the project CA Quits, a statewide learning and technical assistance learning collaborative to integrate smoking-cessation services into health systems. Finally, the California Behavioral Health and Wellness Initiative that is aimed at helping mental health and substance use disorder treatment centers go tobacco-free and encourage smoking cessation adds to the projects following MIQS. Other states, especially those that have not (yet) accepted the expansion of Medicaid enrollment, will have limited opportunity to launch programs such as MIQS. Nevertheless, the experience of the Smoking Cessation Leadership Center has demonstrated that “Tobacco Nation” states, such as Kentucky, North Carolina, Arkansas, Oklahoma, Mississippi, and South Carolina, are home to devoted tobacco control advocates capable of good work even in the face of constrained resources and a culture less invested in public health. Such efforts need to be encouraged in all states in order to reduce the toll from tobacco use, which, despite being at a modern low, is still responsible for the premature deaths of 500,000 people in the U.S. alone, plus an additional 14 million who are disabled from smoking.

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REFERENCES