TOBACCO CONTROL NETWORK

2016 Policy Recommendations Guide

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Executive Summary

The 2014 publication *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General* summarized both the tremendous gains that the United States has made against tobacco use and the work that is still needed to end the tobacco epidemic. The report noted that although this epidemic is increasingly concentrated among specific vulnerable populations, there are effective interventions that, if uniformly applied, could substantially prevent and reduce tobacco use among all groups.

The Tobacco Control Network (TCN) has been engaged in these efforts since its formation in 1994. Initially created to facilitate information sharing between the National Cancer Institute-funded ASSIST Program, the CDC-funded IMPACT Program, and other national partners, TCN's mission is to improve the public's health by providing education and state-based expertise for tobacco prevention and control at the state and territorial and national levels. Comprised of tobacco control program managers and staff from each state and territorial health agency, TCN is dedicated to raising the primacy of tobacco control in all state health agencies and fostering collaboration and communication across state programs (see Appendix A for a roster of the TCN Executive Committee). The 2016 TCN Policy Recommendations Guide articulates the network's vision for reducing tobacco use, exposure to secondhand smoke and the secondhand aerosols emitted by electronic cigarettes, and tobacco related disparities. It seeks to raise awareness about the need for a comprehensive strategy to address the growth in electronic smoking device usage, particularly among teens and young adults. Additionally, it urges proactive consideration to manage the public health intersection between tobacco use, electronic smoking devices, and legalized retail marijuana sales and use.

The policy recommendations in this document are based on evidence presented in both the 2014 surgeon's general report and in CDC's *Best Practices for Comprehensive Tobacco Control Programs—2014*. This report also draws on state tobacco control practitioners and managers' expertise; in a May 2015 TCN survey, TCN members rated 31 policy and system changes by: (1) the strength of evidence base from sources such as the Surgeon General's Report, CDC's *Best Practices for Comprehensive Tobacco Control Programs—2014*, and The Guide to Community Preventive Services that the policy or system change would reduce tobacco use, secondhand smoke exposure, or nicotine addiction at a population level, and (2) the likelihood that the policy or system change would reduce tobacco-related health disparities. The TCN Executive Committee used the survey results to select and refine the strategies included in this report, and presented a draft strategy list to TCN's membership for their review in August 2015.

This report is not intended to be a prescription for change; instead, TCN recommends that tobacco control program managers use this document to educate their local and state partners, stakeholders, and policy leaders about the public health cost of tobacco use, share tobacco control best practices, and help set public health priorities to address the leading cause of preventable disease and death.

Smoking is an enormous cost driver within state Medicaid programs, but comprehensive tobacco control efforts can help provide cost-effective solutions. TCN and its individual program managers can mobilize their considerable expertise to protect youth, promote the health of our communities, and drive down tobacco-related healthcare costs. The United States cannot afford to be complacent if it is to end the tobacco epidemic, and committed leaders, community engagement, human and financial resources, and political will are crucial to accelerating this work.

Tobacco Control Network Recommendations for Policy and System Change Strategies

Below is a summary of the 2016 TCN Policy Recommendations.[i] The right column lists the percentage of TCN respondents who believed that the recommended strategy was highly likely to reduce tobacco-related disparities. (Percentages are shown only where greater than 50 percent of respondents agreed that the strategy was highly likely to reduce tobacco-related disparities.) Each strategy description also notes whether or not the strategy is a best practice or a promising practice.

Policy or System Change Strategy	Rated Highly Likely to Reduce Tobacco-Related Disparities
Price of Tobacco Products	
1. **Enact a cigarette excise tax** that is at least $2.00 per pack of cigarettes, with an equivalent tax increase on other tobacco products. Designate a portion of the revenue for a comprehensive tobacco control program to prevent and reduce tobacco use, particularly among groups disproportionately impacted by tobacco use and secondhand smoke. Consider indexing the excise tax rate to inflation to reduce erosion of the tax over time. Alternatively, use an ad valorem tax, which automatically increases with inflation as a percentage of the overall price. **BEST PRACTICE**.	Yes (64%)
2. **Apply an excise tax to electronic smoking devices and e-cigarette liquids** to discourage their use, particularly among youth, and create tax parity with other tobacco products. ***PROMISING PRACTICE***.	
3. **Enact tobacco product price promotion restrictions** to minimize erosion of the public health benefits accruing from tobacco tax increases. These may include restricting or minimizing coupon redemption and multi-pack discount offers, requiring minimum pack sizes for other tobacco products, and using minimum price policy approaches. **BEST PRACTICE**.	
4. **Fund sustainable, comprehensive tobacco control programs** consistent with CDC's *Best Practices for Comprehensive Tobacco Control Programs—2014*, designating a portion of the tobacco excise taxes, tobacco industry settlement payments, or other state funds for a comprehensive tobacco control program. **BEST PRACTICE**.	Yes (62%)
5. **Enact 100 percent clean air laws**, inclusive of electronic smoking devices, in all enclosed workplaces and public places, including all restaurants, bars, gaming facilities, and other hospitality venues. **BEST PRACTICE**.	Yes (86%)

[i] Note: Although child-resistant packaging for electronic smoking devices and liquids is urgently needed, it is not included in this document because TCN felt that childhood injury prevention advocates should take the lead on this policy strategy. However, TCN supports addressing this important public health problem.

Policy or System Change Strategy – *continued*	Rated Highly Likely to Reduce Tobacco-Related Disparities
Secondhand Smoke and Aerosol	
6. **Adopt smoke-free multi-unit housing policies** that prohibit smoking and electronic smoking device use in all units and attached balconies and patios. **BEST PRACTICE**.	Yes (86%)
7. **Adopt and enforce 100 percent tobacco-free K-12 school policies** that prohibit the use of tobacco products and electronic smoking devices by students, staff, and visitors on school property, in school vehicles, and at school-sponsored functions away from school property. **BEST PRACTICE**.	Yes (67%)
8. **Adopt tobacco-free college and trade school campus policies** to prohibit the use of all tobacco products, including electronic smoking devices, on all facilities and grounds by students, faculty, staff, and visitors. **BEST PRACTICE**.	
9. **Adopt tobacco-free healthcare and behavioral health treatment campus policies** to prohibit the use of all tobacco products, including electronic smoking devices, on all facilities and grounds, including in long-term housing or inpatient care. **BEST PRACTICE**.	Yes (75%)
10. **Adopt smoke-free car policies** that include electronic smoking devices in order to protect children under the age of 18 from exposure to secondhand smoke and aerosols. **BEST PRACTICE**.	
11. **Adopt tobacco-free outdoor policies** that include electronic smoking devices in order to denormalize tobacco use (particularly in youth-sensitive areas) and protect the public from secondhand smoke exposure, fire hazards, and environmental harms resulting from toxic tobacco waste. ***PROMISING PRACTICE***.	
Availability of Tobacco Products	
12. **Adopt a policy to prohibit the sale of menthol and other flavored tobacco products, including e-liquids**, to reduce tobacco-related disparities and to prevent youth uptake of tobacco products and electronic smoking devices. ***PROMISING PRACTICE***.	Yes (90%)
13. **Enact retail licensing for the sale of tobacco products and electronic smoking devices** with fees earmarked for enforcement to address tax evasion, sales to minors, and other provisions that will reduce accessibility to tobacco products and electronic smoking devices. **BEST PRACTICE**.	Yes (60%)
14. **Promote local tobacco retailer, density, and zoning restrictions** to control the number, type, location, and density of tobacco retailers and vape shops, particularly in youth-sensitive areas and vulnerable neighborhoods with high rates of tobacco-related disparities. **BEST PRACTICE**.	Yes (55%)

Policy or System Change Strategy – *continued*	Rated Highly Likely to Reduce Tobacco-Related Disparities
Availability of Tobacco Products – *continued*	
15. Raise the minimum legal sale age for tobacco and electronic smoking devices to 21 to prevent youth uptake of tobacco products. ***PROMISING PRACTICE***.	Yes (58%)
16. Extend tobacco-related availability restrictions (e.g., on age of sale, self-service display bans, vending machine sales, and free samples) to electronic smoking devices to prevent youth uptake of these products. ***PROMISING PRACTICE***.	
Tobacco Marketing and Advertising	
17. Promote adoption of voluntary policies to restrict the marketing and advertising of electronic smoking devices, such as agreements prohibiting placement of electronic smoking device ads on television and radio, or outdoor and transit ads; prohibiting brand name sponsorship of electronic smoking devices at sporting and cultural events; prohibiting the use of cartoons to market electronic smoking devices; prohibiting use of brand names on merchandise; and prohibiting gifts with the purchase of electronic smoking devices. ***PROMISING PRACTICE***.	Yes (61%)
Tobacco Cessation	
18. Establish a uniform cessation benefit across payer types, including Medicaid, state health insurance exchanges, government employee health plans, and non-government employee health plans, that at a minimum provides the following coverage with no copay or cost sharing or deductible requirement: • Routinely screen for tobacco use • Allow a minimum of two cessation treatments per year consisting of: a. Four cessation counseling sessions, which the beneficiary may attend in person or by telephone and individually or in a group, as she or he prefers. b. A 90-day treatment regimen of any FDA approved tobacco cessation drug without a prior authorization requirement. **BEST PRACTICE**.	Yes (90%)
19. Support cessation treatment system change within healthcare and behavioral treatment systems. Encourage and support healthcare systems and behavioral treatment systems to systematically implement tobacco user identification systems and to be reimbursed for the provision of comprehensive tobacco dependence treatment as the standard of care. **BEST PRACTICE**.	Yes (76%)

Policy or System Change Strategy – *continued*	Rated Highly Likely to Reduce Tobacco-Related Disparities
Emerging Tobacco Control Issues	
20. **Expand the definition of tobacco products to include electronic smoking devices**, but ensure that the definition for these devices is sufficiently flexible to capture the fact that they are used for other substances which may have public health implications that extend beyond tobacco control goals. ***PROMISING PRACTICE***.	
21. **Convene a tobacco control and medical-recreational marijuana task force** to address regulating marijuana and (1) its impact on tobacco control efforts, (2) areas of alignment, and (3) potentially translating tobacco-related policies to marijuana, including taxation, packaging and labeling, sale and distribution, licensing manufacturers, wholesalers, and retailers, advertising and marketing, and clean air. ***PROMISING PRACTICE***.	

Introduction

Purpose

The Tobacco Control Network (TCN) 2016 Policy Recommendations articulates the network's vision for reducing tobacco use, exposure to secondhand smoke and the toxins emitted by electronic smoking devices, and tobacco-related disparities by implementing evidenced-based policy and system changes.[ii] This document was developed to help guide priorities and help tobacco control programs educate their partners and stakeholders. It reflects TCN's mission to implement evidence based comprehensive tobacco control programs, promote information and strategy sharing, advocate for evidence-based and promising program and policy strategies, and increase collaboration among its members and national partners.

Call to Action

The 2014 publication of the Surgeon General's Report, *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General* acknowledged the great strides that the United States has made to reduce disability, disease, and death resulting from tobacco use. However, it also underscored that although public health leaders know how to end the tobacco epidemic, doing so will require stakeholders to redouble their efforts and engage non-governmental partners and society as a whole.[1] With this call to action in mind, this report emphasizes policy strategies that are known to reduce tobacco use while recommending promising practices that are supported by a growing body of evidence. Furthermore, this document endorses applying the precautionary principle to regulating electronic smoking devices, supporting government intervention to avoid possible public health risks.

[ii] Throughout this document, the term "electronic smoking device" is used to refer to electronic cigarettes, hookah pens, tanks, and mods, among other related devices that may be used to heat flavored nicotine and other products. Because these devices are used with a variety of substances, including nicotine, marijuana oil, and illicit substances, references to such products need to be flexible and avoid focusing exclusively on devices that use nicotine.

Finally, this guide anticipates that states across the nation will soon legalize retail marijuana sales, as Colorado, Washington state, and Oregon have already done. TCN therefore encourages stakeholders to thoughtfully examine the intersection between tobacco products, electronic smoking devices, and marijuana, identifying how retail marijuana legalization will impact tobacco control laws and potentially re-normalize smoking behavior, and how states can apply tobacco control best practices to this issue to protect and promote the public's health.

Using this Guide

This document identifies 21 priority policy and system changes to improve the tobacco epidemic. The recommendations are not meant to be prescriptive; rather stakeholders should use them to proactively engage in dialogue with partners, identify opportunities for collective action, and build momentum for ending the tobacco epidemic.

TCN's 2013 Policy Readiness and Stage of Change Assessment notes that a "one size fits all" approach may not be the best way to advance tobacco control and build capacity for change across the nation.[2] The assessment found that in some cases, TCN member jurisdictions were not able to pursue highly impactful policies like tobacco taxes and statewide clean indoor air policies, but were able to work on less impactful strategies like tobacco-free school campus policies. TCN concluded that it may be best for states to work on strategies that are more likely to succeed, even if they have a potentially smaller population-level impact on tobacco use.[3]

Prior experience suggests that incremental steps can build momentum toward more impactful tobacco control policies, especially in rural areas where residents may be more resistant to these changes. Studies examining policy adoption have found that policy success builds momentum and normalizes tobacco control issues for policymakers, which may help facilitate future policy adoption.[4,5]

TCN strongly supports a coordinated application of these strategies and working with external partners to stimulate public and decision-maker support for strong policies and systems changes. TCN encourages its members and their partners to be vigilant against attempts to preempt local authority to enact strong public health measures, and recommends strongly opposing policy exemptions that promote and exacerbate health disparities.

TCN recommends that stakeholders use this document to:

- Develop a short-term and long-term tobacco policy agenda in their states or territories in collaboration with external partners.
- Educate state and local policymakers, opinion leaders, and partners to build awareness and support for specific policy and system changes.
- Plan data collection and surveillance efforts (e.g., regarding tobacco use, observation and attitudes toward tobacco use and policies, policy polls) to demonstrate the need for policy initiatives and evaluate policies post-implementation.
- Plan and implement training and technical assistance to build capacity among partners.
- Justify and enhance credibility for work on specific policy and system changes.
- Reach out to and cultivate new partners.
- Advance health equity and optimal health for all.

The Problem

Conventional Tobacco Products

The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General, 2014 confirmed that tobacco use is the single most preventable cause of death and disease in the United States.[6] An estimated 42 million Americans (18% of all adults) currently smoke cigarettes.[7] Cigarette smoking causes 480,000 deaths each year, accounting for one of every five deaths in the United States (including 50,000 deaths from secondhand smoke).[8] Adults who smoke cigarettes die an average of 10 years earlier than nonsmokers.[9] Smokeless tobacco products also pose a significant health risk, and are not a safe substitute for cigarettes.[10]

The United States has made significant progress in reducing tobacco use since the release of the first Surgeon General's Report on Smoking and Health in 1964; however, large disparities in smoking prevalence and tobacco-related diseases exist among groups differentiated by race and ethnicity, socioeconomic status, educational attainment, mental health, sexual orientation, occupation, and geography.[11,12,13,14] To eliminate these disparities and achieve health equity, it is critical to implement strategies at an intensity that will accelerate the rate of change among these groups, sufficient to create population level declines in tobacco use.[15] Strategic tobacco control policy directly impacts health inequities by addressing use rates and exposure levels, and therefore disease prevalence, among populations disproportionately affected by tobacco use.

Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General, 2012 stated that "preventing smoking and smokeless tobacco use among young people is critical to ending the epidemic of tobacco use."[16] More than 80 percent of adult smokers begin smoking by age 18, and 98 percent begin smoking by age 26.[17] The 50th anniversary surgeon general's report noted that the United States needs more aggressive prevention efforts, since the number of youth and young adults who annually initiate smoking was significantly higher in 2012 than in 2002.[18]

The 2006 document *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General* concluded that there is no risk-free level of exposure to secondhand smoke.[19] Exposure to secondhand smoke has been linked to adverse health effects that harm fetuses, infants, children, and adults.[20] According to this report, secondhand smoke is proven to cause lung cancer, heart disease, serious respiratory illnesses such as bronchitis and asthma, low birth weight, and sudden infant death syndrome.[21] Despite the serious health risks associated with exposure to secondhand smoke, wide disparities continue to persist in laws to protect nonsmokers from exposure to secondhand smoke by geography, occupation, and demographics.[22,23,24,25] Non-Hispanic whites and blacks, and individuals living in southern states are the least likely to be protected by comprehensive clean indoor air laws.[26,27]

Tobacco use also exacts a huge economic toll on the U.S. economy. Smoking-related illness in the United States costs more than $300 billion each year, including nearly $170 billion for direct medical care for adults, and more than $156 billion in lost productivity, including $5.6 billion

due to secondhand smoke exposure. In recent years, smoking accounted for 7-9 percent of all annual healthcare spending in the United States.[28] Annual smoking-caused healthcare costs are $39.6 billion for Medicaid, $45 billion for Medicare, and $23.8 billion for other federal government health programs (e.g., the U.S. Department of Veterans Affairs).[29]

Marketing exerts a powerful influence on tobacco use and undermines the effectiveness of comprehensive tobacco control programs. In 2012, cigarette and smokeless tobacco companies spent more than $9.6 billion, or $26 million per day, on advertising and promotional expenses in the United States.[30,31,32] Of this amount, companies spent approximately $9.17 billion on cigarette advertising and promotion and $435.7 million on smokeless tobacco advertising and promotion.[33,34,35] Much of this marketing targets specific racial or ethnic groups or youth and young adults.[36] Numerous studies demonstrate that exposure to tobacco advertising and promotions influences the uptake of tobacco use by youth and young adults.[37]

Electronic Smoking Devices

Electronic smoking devices (e.g., e-cigarettes, vape pens, e-hookah, and tank systems) were first sold in the United States in 2007. These products quickly diversified and became very popular among youth and young adults, presenting new challenges for public health organizations. Unlike conventional cigarettes, where the tobacco leaf is burned, electronic smoking devices heat a liquid that generally contains nicotine, flavorings, propylene glycol, or vegetable glycerin as a carrying agent. At the time of this publication, FDA recently finalized its deeming rule to regulate all tobacco products, including electronic smoking devices. Once the rule goes into effect, FDA will require companies to disclose the ingredients in their products, allowing FDA to evaluate the chemical contents.

The heated e-liquid in e-cigarettes forms an aerosol that contains particulate matter. Electronic nicotine delivery systems (ENDS) aerosol is not harmless “water vapor,” and not as safe as clean air. ENDS generally emit lower levels of dangerous toxins than combusted cigarettes, but in addition to nicotine, ENDS aerosols can contain heavy metals, ultrafine particulate, and cancer-causing agents like acrolein.[38] ENDS aerosols also contain propylene glycol or glycerin and flavorings. Some ENDS manufacturers claim that propylene glycol, glycerin, and food flavorings are safe because they meet the FDA definition of “generally recognized as safe.” However, this status applies to additives for use in foods, not for inhalation. In addition, recent research indicates that some flavored e-cigarettes may contain a chemical flavoring called diacetyl, which has been linked to severe lung disease. Therefore, inhaling e-cigarette aerosol directly from the device or from secondhand aerosol that is exhaled by users is potentially harmful to health.[39]

Electronic smoking devices vary considerably in appearance and go by other names, such as e-cigs, e-hookahs, hookah pens, vapes, vape pens, or mods. Some devices are disposable, while others are refillable with either a cartridge or by refilling a tank that holds a larger amount of e-liquid. E-liquids are available in thousands of candy, fruit, and liquor flavors. These flavors are known to be appealing to youth and young adults and the flavors themselves may present health risks to the user.[40,41,42]

In 2014, for the first time, the Monitoring the Future Study, led by the University of Michigan's Institute for Social Research, reported that more teens were using e-cigarette than were using conventional cigarettes.[43] The 2011-2014 National Youth Tobacco Survey also found that electronic smoking devices are the most common tobacco product used by youth, and that use among high school students tripled in a single year (from 4.5% in 2013 to 13.4% in 2014).[44] Adolescence is a critical period for brain growth and development, making teenagers especially vulnerable to the toxic effects of nicotine, which may harm brain development and promote future tobacco use.[45,46]

Nationally, 8.5 percent of adults have tried e-cigarettes, and 2.6 percent were current users in 2013.[47] However, national data do not provide a true picture of what is happening within individual states and territories. For example, in California between 2012 and 2013, adult e-cigarette use doubled (from 1.8% to 3.5%), but use among young adults aged 18 to 29 tripled (from 2.3% to 7.6%). One particularly troubling finding noted that 20 percent of young adult e-cigarette users in California had never smoked conventional cigarettes.[48]

Increases in youth and adult use have been accompanied by a spike in calls to poison control centers as a result of exposure to nicotine containing e-liquids and accidental e-cigarette poisonings. Nationally, the number of calls to poison centers involving e-cigarette liquids containing nicotine rose from one per month in September 2010 to 215 per month in February 2014, with more than half (51.1%) of the calls involving children under age 5.[49]

In 2010, the U.S. Court of Appeals for the D.C. Circuit determined that e-cigarettes and other products made or derived from tobacco can be regulated by FDA as tobacco products under the Family Smoking and Prevention Tobacco Control Act of 2009 (the Tobacco Control Act), and that they are not drugs or devices unless they are marketed for therapeutic purposes, for example, as smoking cessation aids.

In 2014, FDA released its proposed regulation for selling and distributing all unregulated tobacco products (including e-cigarettes, hookah, cigars, dissolvables, and gels) as tobacco products.[50] The proposed rule was limited in scope and reflected public health and safety gaps related to areas that FDA does not oversee, including taxation, clean indoor air, raising the minimum age of sale, an outright ban on selling tobacco products, occupational health and safety, and hazardous waste.[51,52,53,54,55,56,57,58,59,60,61,62]

The final rule was issued in May 2016 and will go into effect in August 2016.[63] The rule restricts the age of sale to 18, requires age identification prior to a sale, restricts vending machines to adult-only facilities, prohibits free samples, requires a nicotine health warning statement on

packaging and in advertisements, requires manufacturers to register their electronic smoking devices products and disclose their product ingredients to FDA, allows FDA to review any new or changed products before sale, and requires manufacturers to show scientific evidence to support claims that electronic smoking devices are less harmful.[64] Though the final rule maintains gaps of the proposed rule, state and local governments and private entities have substantial authority to address these gaps and other matters covered by, but not preempted by the Tobacco Control Act.[65] States and local jurisdictions have taken action to extend public health protection by passing policies such as raising the minimum age of tobacco sale to 21 and restricting electronic smoking device use and sale in order to protect youth.

Interventions that increase the price of tobacco products and establish smoke-free environments, in combination with active enforcement for laws prohibiting tobacco sales to minors, are among the most effective strategies for preventing and reducing tobacco use.[66,67,68] Based on evidence that these products are addicting a new generation of young people to nicotine and mounting indications about potential harm from use of these products, numerous health organizations have called for the extension of these policies to electronic smoking devices.[70,71,72,73,74,75,76,77,78,79,80,81,82,83,84] In the absence of long-term causal health findings, the precautionary principle provides a basis to regulate electronic smoking devices. This principle supports government intervention to avoid possible health risks when the potential risks are substantiated by scientific evidence.[85,86,87]

Policy or System Change Strategies

Price of Tobacco Products

"The single most direct and reliable method for reducing consumption is to increase the price of tobacco products, thus encouraging the cessation and reducing the level of initiation of tobacco use." –*Taking Action to Reduce Tobacco Use,* Institute of Medicine, 1998

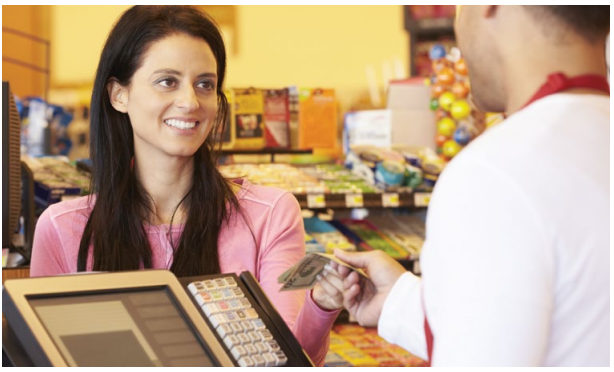
Strong evidence from numerous studies demonstrates that increasing the price of tobacco products:

- Reduces the total amount of tobacco consumed.
- Reduces the prevalence of tobacco use.
- Increases the number of tobacco users who quit.
- Reduces initiation of tobacco use among young people.
- Reduces tobacco-related morbidity and mortality.[88]

A Community Preventive Services Task Force systematic review concluded that increasing the unit price for tobacco products by 20 percent would reduce overall tobacco product consumption by 10.4 percent, reduce adult tobacco use prevalence by 3.6 percent, and lower tobacco use initiation by young people by 8.6 percent. The task force also concluded that interventions that raise the price of tobacco products reduce tobacco-related disparities among different socioeconomic groups and may reduce disparities by race and ethnicity.[89]

Strategies for Increasing the Cost of Tobacco Products

States can use many promising strategies besides tobacco excise taxes to raise prices on tobacco products. These largely focus on the retail environment, an important space for tobacco companies to promote their products, segment the market, and target tobacco users who are



contemplating quitting or who have recently quit. Cigarette companies spend more than 85 percent of their advertising and promotional dollars at the point of sale, which pays for advertising, payments to retailers to obtain prime locations for their products and advertising, and a variety of price discounting tools.[90] Non-tax pricing policies include restricting or minimizing coupon redemption and multi-pack discount offers, designating a minimum pack size for other tobacco products, and designating a minimum price for tobacco products.

Point-of-sale tobacco promotions, particularly price promotions, influence impulse tobacco purchases and undermine quitting by making tobacco products more affordable. Twenty-five percent of smokers report impulse buying, and one-third of recent ex-smokers report urges to start smoking after seeing tobacco displays.[91] Urban-dwellers, ethnic minorities, and low socio-economic status communities are often disproportionately exposed to tobacco products and advertising in retail settings. Storefront tobacco advertising is more prevalent in predominately low-income, racial and ethnic minority communities, and mentholated cigarette brands are also marketed more frequently in these communities.[92] In Minneapolis neighborhoods with large minority populations, the price of a menthol brand of cigarettes popular with African Americans was lower than in non-minority areas.[93,94]

TOBACCO PRODUCT PRICE POLICY RECOMMENDATIONS

1. **Enact a cigarette excise tax** that is at least $2.00 per pack of cigarettes, with an equivalent tax increase on other tobacco products. Designate a portion of the revenue for a comprehensive tobacco control program to prevent and reduce tobacco use, particularly among groups disproportionately impacted by tobacco use and secondhand smoke. Consider indexing the excise tax rate to inflation to reduce erosion of the tax over time. Alternatively, use an ad valorem tax, which automatically increases with inflation as a percentage of the overall price. **BEST PRACTICE**.[iii]
2. **Apply an excise tax to electronic smoking devices and e-cigarette liquids** to discourage their use, particularly among youth, and create tax parity with other tobacco products. ***PROMISING PRACTICE***.
3. **Enact tobacco product price promotion restrictions** to minimize erosion of the public health benefits accruing from tobacco tax increases. These may include restricting or minimizing coupon redemption and multi-pack discount offers, requiring minimum pack sizes for other tobacco products, and using minimum price policy approaches. **BEST PRACTICE**.

Comprehensive Tobacco Control Programs

Comprehensive tobacco control programs are population-level interventions that reduce tobacco's appeal and acceptability, encourage tobacco cessation, reduce secondhand smoke exposure, and prevent young adults from beginning to use tobacco. Such programs comprise evidence-based educational, clinical, regulatory, economic, and social strategies.[95]

[iii] States may need to determine if indexing their tobacco excise tax is appropriate to their situation. Although taxes erode over time due to inflation and indexing the tax to inflation helps preserve the value of the tax, if states only approve a small tobacco excise tax, decision-makers may believe that no further tobacco tax increases are necessary because the tax was previously indexed to inflation.

Every scientific authority that has studied this issue, including the Institute of Medicine (IOM), the President's Cancer Panel, the National Cancer Institute, CDC, and the U.S. surgeon general, has concluded that when properly funded, implemented and sustained, comprehensive tobacco control programs reduce smoking among both youth and adults. The Community Preventive Services Task Force concluded that comprehensive tobacco control programs reduce the prevalence of tobacco use among adults and young people, reduce tobacco product consumption, increase quitting, and contribute to reductions in tobacco-related diseases and deaths. Furthermore, it found that increases in program funding are associated with increases in program effectiveness.[96]

States and Localities' Tobacco Control Programs

In fiscal year 2014, state governments collected $25 billion from the 1998 Tobacco Master Settlement Agreement and tobacco taxes, but spent only 1.9 percent of it — $481.2 million — on tobacco prevention and cessation programs. This means that states spend less than two cents of every dollar in tobacco revenue to prevent and reduce tobacco use. North Dakota and Alaska are the only states that fund tobacco prevention programs at CDC-recommended levels.[97]

Tobacco prevention and cessation programs reduce smoking, save lives and save money. Maine, which ranked first in funding tobacco prevention programs from 2002 to 2007, reduced smoking among high school students by 67 percent between 1997 and 2013.[98] Alaska reduced its high school smoking rate by more than 70 percent since 1995, to just 10.6 percent in 2013.[99] In 2014, Florida reduced its high school smoking rate to 7.5 percent, representing a 73 percent decline in smoking since 1998, one of the lowest high school smoking rates in the nation.[100] Before greatly reducing its tobacco prevention program in 2011, Washington state reduced adult smoking by one-third, youth smoking by more than one-half, and saved more than $5 in tobacco-related hospitalization costs for every $1 spent on the program.[101,102] A 2013 study found that California's tobacco control program saved $134 billion in healthcare costs in its first 20 years, demonstrating that comprehensive tobacco control programs are a critical component of state healthcare cost containment.[103]

COMPREHENSIVE TOBACCO CONTROL PROGRAM POLICY RECOMMENDATION

4. **Fund sustainable, comprehensive tobacco control programs** consistent with CDC's *Best Practices for Comprehensive Tobacco Control Programs—2014*, designating a portion of the tobacco excise taxes, tobacco industry settlement payments, or other state funds for a comprehensive tobacco control program. **BEST PRACTICE**.

Secondhand Smoke and Secondhand Aerosol

Secondhand smoke exposure is associated with cardiovascular disease, lung cancer, heart disease, and numerous health problems in infants and children, including more frequent and severe asthma attacks, respiratory infections, sudden infant death syndrome, and ear infections. Even brief exposure to secondhand smoke can damage the lining of blood vessels and causing blood platelets to become stickier, leading to heart attacks or strokes. In the respiratory system, brief exposure to secondhand smoke can damage cells in ways that set cancer in motion. The greater the exposure to secondhand smoke, the greater the risk for developing disease.[104]

The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General noted that there is no safe level of exposure to secondhand smoke and that establishing smoke-free environments is the only proven way to prevent exposure.[105]

The Community Preventive Services Task Force concluded that smoke-free polices are effective at:

- Reducing exposure to secondhand smoke.
- Reducing the prevalence of tobacco use.
- Increasing the number of tobacco users who quit.
- Preventing tobacco use initiation among young people.
- Reducing tobacco-related morbidity and mortality, including acute cardiovascular events.[106]

The task force also found that smoke-free policies can substantially reduce healthcare costs and do not negatively financially impact businesses like bars and restaurants.[107]

Because workplace smoke-free air laws are very effective at preventing harm caused by secondhand smoke and supporting tobacco cessation, states, local governments, and tribes are encouraged to widely expand secondhand smoke protection policies to other settings and incorporate other tobacco products and electronic smoking devices in these policies. Governments may consider expanding these policies to worksites, bars, casinos, multi-unit housing, and affordable housing; healthcare and behavioral treatment campuses; K-12 schools, colleges, and trade schools; personal vehicles; and recreational outdoor spaces. Governmental agencies and communities are also encouraged to explore incorporating smoke-free and tobacco-free requirements into general plans, building codes, and zoning requirements.

SECONDHAND SMOKE AND SECONDHAND AEROSOL POLICY RECOMMENDATIONS

5. **Enact 100 percent clean air laws**, inclusive of electronic smoking devices, in all enclosed workplaces and public places, including all restaurants, bars, gaming facilities, and other hospitality venues. **BEST PRACTICE**.
6. **Adopt smoke-free multi-unit housing policies** that prohibit smoking and electronic smoking device use in all units and attached balconies and patios. **BEST PRACTICE**.
7. **Adopt and enforce 100 percent tobacco-free K-12 school policies** that prohibit the use of tobacco products and electronic smoking devices by students, staff, and visitors on school property, in school vehicles, and at school-sponsored functions away from school property. **BEST PRACTICE**.
8. **Adopt tobacco-free college and trade school campus policies** to prohibit the use of all tobacco products, including electronic smoking devices, on all facilities and grounds by students, faculty, staff, and visitors. **BEST PRACTICE**.
9. **Adopt tobacco-free healthcare and behavioral health treatment campus policies** to prohibit the use of all tobacco products, including electronic smoking devices, on all facilities and grounds, including in long-term housing or inpatient care. **BEST PRACTICE**.
10. **Adopt smoke-free car policies** that include electronic smoking devices in order to protect children under the age of 18 from exposure to secondhand smoke and aerosols. **BEST PRACTICE**.

11. **Adopt tobacco-free outdoor policies** that include electronic smoking devices in order to denormalize tobacco use (particularly in youth-sensitive areas) and protect the public from secondhand smoke exposure, fire hazards, and environmental harms resulting from toxic tobacco waste. ***PROMISING PRACTICE***.

Availability of Tobacco Products

Policies related to accessing tobacco products, including electronic smoking devices, encompass a variety of issues, including: the availability of flavored non-cigarette tobacco products and menthol cigarettes, the density and location of tobacco retailers, the legal age of sale, and tools for ensuring compliance with laws impacting tobacco products' sale and distribution. Policy strategies addressing tobacco products' availability are largely concerned with the impact that easy access to tobacco products has on youth initiation and on disparities among populations with high rates of tobacco use.

Flavored and Mentholated Tobacco Products

FDA banned the sale of flavored cigarettes, with the exception of menthol, in 2009, based on studies showing that tobacco companies used flavored cigarettes to target youth and young adult smokers because these products were highly appealing to them, that flavors make it easier for new smokers to start smoking by masking tobacco's unpleasant flavor, and that youth perceived that flavored cigarettes were safer than unflavored tobacco products.[108,109,110,111] Because the ban applies only to cigarettes, many flavored tobacco products remain on the market, including little cigars, cigarillos, hookah, smokeless tobacco, pipes, e-liquids used with electronic smoking devices, and menthol-flavored cigarettes. Additionally, little cigars are frequently packaged for individual sale, making them more affordable.[112] In California, a 2013 statewide survey led by local health departments found that 75.3 percent of tobacco retailers near schools sold flavored tobacco products, and 81.1 percent of retailers near schools sold Swisher Sweets flavored cigars for under $1.00.[113] Although flavored non-cigarette tobacco products usage varies by age, gender, subpopulation group, and geography, flavored tobacco products are popular overall among youth and young adults who use tobacco products.[114,115,116,117,118]

The Tobacco Control Act gave FDA the authority to prohibit menthol "if appropriate for the protection of public health."[119] As with other flavored tobacco products, many people use mentholated cigarettes because they mask the harshness of tobacco. In 2011, FDA's Tobacco Products Scientific Advisory Committee concluded that there is a relationship between the availability of menthol cigarettes and experimentation and regular smoking among youth and

adults, particularly African American adults. The committee also found that menthol plays a meaningful role in the severity of addiction to nicotine and lowered success at cessation.[120] Additional research suggests that menthol cigarette use is also high within the lesbian, gay, bisexual, and transgender community.[121]

Although FDA may still prohibit menthol cigarettes or restrict other flavored tobacco products in the future, the process is lengthy, and the tobacco industry has historically filed lawsuits to combat limitations of these products. In the meantime, states and localities throughout the United States have restricted the sale of flavored tobacco products, including menthol cigarettes in some cases. These include: Maine, Providence, Rhode Island, multiple Massachusetts municipalities, New York City, Chicago, Minneapolis, and several jurisdictions in California.[122,123,124,125]

Regulating Tobacco Retailers' Density and Proximity to Youth

Restricting tobacco retailers' geographic density or their proximity to youth-sensitive areas may reduce youth exposure to tobacco product marketing and decrease easy access to tobacco products. Research demonstrates that exposure to in-store tobacco marketing and the density and proximity of tobacco retail outlets to schools and residential areas are important factors that influence young people's desire to experiment with, initiate, and continue to use tobacco products.[126,127,128,129,130,131,132,133,134,135,136] Among children, exposure to point-of-sale tobacco promotions is associated with susceptibility to smoking, smoking initiation, and perceived ease of obtaining tobacco. Among adults, exposure to such promotions influences impulse buying and urges to smoke.[137] Higher density of tobacco retailers near schools is linked to experimentation with cigarette use, higher adolescent smoking prevalence, and minors purchasing their own cigarettes.[138,139,140,141] Living within walking distance of a tobacco outlet was found to reduce the likelihood of smoking cessation, and high convenience store density was associated with greater smoking status.[142,143,144]

Some populations, particularly African Americans, youth, and low-income individuals, are preferentially exposed to tobacco marketing as a function of the higher tobacco outlet density, greater tobacco marketing, and increased price promotions where these people live.[145,146,147,148,149,150] A study of tobacco outlets within walking distance of California high schools found that the proportion of black high school students who smoked was associated with in-store menthol advertising promotions for Newport cigarettes, along with a lower cost for Newport cigarettes.[151] In St. Louis, Missouri, researchers found a greater amount of tobacco marketing and menthol-specific marketing in neighborhoods with a higher proportion of African Americans.[152]

Changing zoning and tobacco retail licensing may help address both the density of tobacco retailers in a community and their proximity to youth-sensitive areas.[153,154,155] Tobacco retail licensing at the state or local level can be used to restrict the types of stores that can sell tobacco products, the store locations, tobacco sale and distribution practices (e.g., whether a store can sell flavored tobacco products, requirements for minimum pack size, and age identification requirements), and provides an effective means to incentivize and facilitate compliance through fines, license suspensions and, for repeat offenders, license revocation.

Changing the Minimum Legal Sale Age for Tobacco Products

Nationally, 95.6 percent of people who were ever daily smokers report trying their first cigarette by age 21, and 86.3 percent report becoming daily smokers by age 21.[156] Delaying the age when youth first use tobacco can reduce their likelihood of transitioning to regular tobacco use. Increasing the minimum legal sale age (MLSA) for tobacco products to 21 aims to prevent or severely restrict youth access to these highly addictive products.[157] Increasing the MLSA to 21 will delay the age when youth first experiment with or begin using tobacco, which can either reduce their risk of becoming regular smokers or increase their chances of successfully quitting later.[158]

An IOM report concluded that raising the MSLA to 21 would primarily prevent 15 to 17 year olds from starting to use tobacco. The report also projected that if the MLSA was simultaneously raised to 21 across the entire country, by the year 2100 adult smoking prevalence would decrease 12 percent more than it would under existing tobacco control policies.[159] IOM projected that the country will accrue substantial health benefits from such additional policies 30 to 85 years in the future, when the initial birth cohort affected by the MLSA increase is old enough to be in the age group where tobacco-related diseases (e.g., cancer, heart disease, and respiratory diseases) typically occur.

IOM projects that maternal and child health benefits from raising the MSLA to 21 would be smaller in magnitude, but accrue earlier due to smoking reduction during childbearing years. These modeling studies indicate that the United States could avert 249,000 tobacco-related deaths by 2100 if it raises the MLSA to 21 simultaneously nationwide.[160] IOM's findings are premised upon stringent enforcement with consistent application of fines and penalties and education across law enforcement, retailers, and the public.

As states think about raising the tobacco product MLSA to 21, they should also consider how to prevent unintended negative social justice consequences from a MLSA 21 law coupled with a tobacco possession law. Many groups with the highest rates of tobacco use, (e.g., men, low income individuals, and non-whites, members of the LGBT community, and people with mental health conditions) have historically been subjected to discrimination, and may be the most vulnerable to harassment or intimidation from tobacco possession laws. Therefore, laws should be written to place the burden and penalties on retailers rather than the individual purchasers.

MLSA 21 laws must also consider implementation strategies that ensure appropriate education and support for retailers, tobacco users, and enforcement agencies. Additionally, states must consider how MLSA 21 laws relate to their obligations under the federal Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act (the Synar Amendment). This act requires states to create and enforce laws prohibiting tobacco product sales or distribution to minors and to conduct compliance inspections without exceeding a 20 percent non-compliance rate. If states do not meet this noncompliance threshold, the government may restrict up to 40 percent of their Substance Abuse Prevention and Treatment block grants.[161]

States must also consider how increasing the MLSA to 21 will impact the age of decoys who participate in tobacco sales to minors inspections to assessing compliance with Synar requirements and testing compliance with the MSLA 21 law. To date, Hawaii and California are the only states that have raised the MLSA of tobacco products to 21, although more than 90 local jurisdictions have done so, including: New York City, Evanston, Illinois, Englewood, New Jersey, and many communities in Massachusetts.[162]

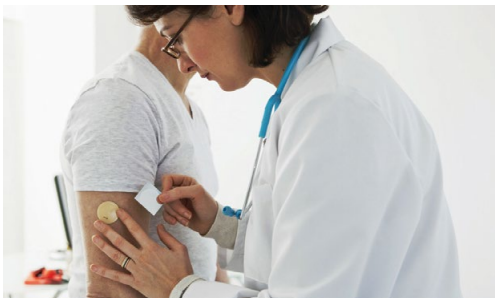
AVAILABILITY OF TOBACCO PRODUCTS POLICY RECOMMENDATIONS

12. **Adopt a policy to prohibit the sale of menthol and other flavored tobacco products, including e-liquids**, to reduce tobacco-related disparities and to prevent youth uptake of tobacco products and electronic smoking devices. ***PROMISING PRACTICE***.
13. **Enact retail licensing for the sale of tobacco products and electronic smoking devices** with fees earmarked for enforcement to address tax evasion, sales to minors, and other provisions that will reduce accessibility to tobacco products and electronic smoking devices. **BEST PRACTICE**.
14. **Promote local tobacco retailer, density, and zoning restrictions** to control the number, type, location, and density of tobacco retailers and vape shops, particularly in youth-sensitive areas and vulnerable neighborhoods with high rates of tobacco-related disparities. **BEST PRACTICE**.
15. **Raise the minimum legal sale age for tobacco and electronic smoking devices to 21** to prevent youth uptake of tobacco products. ***PROMISING PRACTICE***.
16. **Extend tobacco-related availability restrictions** (e.g., on age of sale, self-service display bans, vending machine sales, and free samples) to electronic smoking devices to prevent youth uptake of these products. ***PROMISING PRACTICE***.

Tobacco Marketing and Advertising

Although the Master Settlement Agreement and the Tobacco Control Act implemented several important restrictions on cigarette and smokeless tobacco marketing and advertising to prevent youth initiation and protect consumers from false and misleading claims, these restrictions do not apply to electronic smoking devices.[163,164] As a result, the companies that make and sell electronic smoking devices, e-liquids, and product accessories are advertising on television, radio, and in youth-oriented publications, sponsoring concerts and festivals, and using celebrity endorsements and movie placement to heavily market their products. E-liquids and electronic smoking device accessories are marketed to appeal to youth using cartoon characters, youth-oriented decorations, and flavors such as cotton candy, gummy bear, and chocolate mint.[165,166] The increase in youth and young adults who use electronic smoking devices shows that this marketing is effective.[167,168,169] According to National Youth Tobacco Survey, in 2014, nearly seven in 10 middle and high school students saw e-cigarette ads in stores, online, on movies or television, or in newspapers and magazines.[170]

Allowing companies to advertise and market electronic smoking devices in ways that are prohibited for conventional tobacco products tacitly implies that the government and public agencies approve of these products. It is legislatively difficult to force electronic smoking device companies to abide by the same marketing and advertising restrictions as conventional tobacco companies. However, state and local governments and private organizations can advocate for



businesses, organizations, and event organizers to voluntarily adopt policies that would prohibit or restrict such advertising on television, the radio, and billboards, at events, and in brick and mortar and online stores. In California, these kinds of voluntary efforts in 1997 resulted in tobacco sponsorship and advertising bans in 22 state, county, and local fairs, seven rodeos, and 20 universities, colleges and communities.[171] In 1995, media company Knight-Ridder, Inc. voluntarily stopped accepting tobacco ads with cartoon characters or those that implied that smoking and using tobacco products would lead to prominence, social distinction, success, sexual attraction, or beauty. *The New York Times* voluntarily stopped accepting any tobacco ads in 1999.[172,173]

TOBACCO MARKETING AND ADVERTISING POLICY RECOMMENDATIONS

17. **Promote adoption of voluntary policies to restrict the marketing and advertising of electronic smoking devices**, such as agreements prohibiting placement of electronic smoking device ads on television and radio, or outdoor and transit ads; prohibiting brand name sponsorship of electronic smoking devices at sporting and cultural events; prohibiting the use of cartoons to market electronic smoking devices; prohibiting use of brand names on merchandise; and prohibiting gifts with the purchase of electronic smoking devices. ***PROMISING PRACTICE***.

Tobacco Cessation

Smoking puts individuals at risk for many medical conditions, including heart disease, lung disease, cancer, Type 2 diabetes, low birth weight, and premature delivery.[174] In addition to being one of the greatest drivers of adverse health outcomes, smoking costs approximately $170 billion annually in public and private healthcare expenditures.[175] It also costs the United States more than $156 billion in lost productivity due to premature death and exposure to secondhand smoke.[176]

Tobacco Cessation Benefits for Medicaid Recipients

Although smoking is an enormous cost driver within state Medicaid programs, cessation treatment is one of the most cost-effective preventive services, with as much as a $2-$3 return on every dollar invested.[177,178] Approximately 70 percent of the nation's 42 million smokers express a desire to quit.[179] Research demonstrates that providing tobacco cessation treatment as a covered benefit increases the proportion of smokers who use cessation treatment, attempt to quit, and successfully quit. Removing cost barriers to cessation treatment yields the highest rates of treatment utilization.[180,181]

When Massachusetts' Medicaid program improved its tobacco cessation benefit in 2006 and made it easier to access cessation assistance, 37 percent of Massachusetts Medicaid enrollees who smoked utilized the benefit. As a result, the adult smoking rate in the state's Medicaid population fell from 38 percent to 28 percent.[182] A national study examining tobacco cessation

coverage among Medicaid recipients found that individuals with the most generous cessation benefit had the highest proportion of quit attempts and the highest successful quit rates. Individuals with access to cessation medications and no copay for counseling had a 12 month quit rate of 9.1 percent, compared to 4.7 percent for people without coverage.[183] Seven states cover all FDA-recommended cessation treatments (individual, group, and telephone counseling, plus all FDA-approved cessation drugs) for all Medicaid enrollees: Connecticut, Indiana, Massachusetts, Minnesota, Nevada, Pennsylvania, and Vermont.[184]

Creating a Uniform Cessation Benefit

Creating a minimum uniform cessation benefit that includes no copay, cost sharing, or deductible requirement and coverage of at least two cessation treatments per year consisting of counseling sessions and FDA approved cessation drugs without prior authorization across all types of health insurance plans (e.g., Medicaid, Medicare, Affordable Care Act plans, and employer-based plans) would minimize confusion among providers and beneficiaries as consumers move between health plans and insurance administrators. Older studies previously suggested that a uniform healthcare cessation benefit would cause a spike in premium costs. However, a 2012 study by a varied group of tobacco control researchers from across the country concluded that adding smoking cessation therapy does not appear to raise short-term healthcare costs and by the sixth quarter, sustained quitters healthcare service costs were $541 less per year than those who continued to smoke.[185]

In September 2015, the U.S. Preventive Services Task Force (USPSTF) posted a revised and strengthened tobacco cessation treatment recommendation for adults and pregnant women from the previous version. USPSTF's "Grade A" recommendation advises clinicians to ask all adult patients if they use tobacco, and to advise them to quit and provide cessation interventions if they do.[iv] The recommendation also supports using both behavioral interventions and cessation medication for non-pregnant adults.[186]

U.S. Preventive Services Task Force Recommendations[186]

- USPSTF recommends behavioral interventions, such as counseling, to help smokers quit, and found convincing evidence that alone or combined with cessation medications, such interventions substantially improved tobacco cessation in non-pregnant adults.
- USPSTF recommends FDA-approved smoking cessation medications, with or without behavioral counseling, and found convincing evidence that treatment with nicotine replacement therapy, bupropion hydrochloride sustained-release, and varenicline substantially improves tobacco cessation in non-pregnant adults.
- USPSTF did not find adequate evidence to determine if electronic nicotine devices are effective in helping smokers quit.
- USPSTF recommends behavioral interventions, such as counseling, to help pregnant tobacco users quit, but could not recommend providing cessation medications to pregnant women.

[iv] Recommendations labeled "Grade A" are highly likely to have a substantial net benefit.

Treating Tobacco Users with Mental Illness

In addition to improving tobacco cessation treatment within the healthcare setting, providers should actively screen and treat consumers in the behavioral health system for nicotine dependence. The 2010-2011 federal Medical Expenditure Panel Survey found that 24.9 percent of respondents with mental illness smoked, compared to 16.5 percent of the rest of the population. The 2009–2011 National Survey on Drug Use and Health also found that 36.1 percent of individuals who had any mental illness in the past 12 months were current smokers, and that smoking prevalence among individuals reporting any mental illness ranged from 18.2 percent in Utah to 48.7 percent in West Virginia.[187,188,189] As with smokers in general, people with mental health conditions who smoke are motivated to quit smoking.[190] Decreasing barriers to quitting in both the healthcare and behavioral health systems would therefore both improve health and save money.

TOBACCO CESSATION POLICY RECOMMENDATIONS

18. **Establish a uniform cessation benefit** across payer types, including Medicaid, state health insurance exchanges, government employee health plans, and non-government employee health plans, that at a minimum provides the following coverage with no copay or cost sharing or deductible requirement:
    - Routinely screen for tobacco use
    - Allow a minimum of two cessation treatments per year consisting of:
        a. Four cessation counseling sessions, which the beneficiary may attend in person or by telephone and individually or in a group, as she or he prefers.
        b. A 90-day treatment regimen of any FDA approved tobacco cessation drug without a prior authorization requirement. **BEST PRACTICE**.

19. **Support cessation treatment system change within healthcare and behavioral treatment systems**. Encourage and support healthcare systems and behavioral treatment systems to systematically implement tobacco user identification systems and to be reimbursed for the provision of comprehensive tobacco dependence treatment as the standard of care. **BEST PRACTICE**.

Emerging Tobacco Control Issues

TCN identified two emerging tobacco control issues that it believes are critical for membership to act on in the near future: how state and local laws define electronic smoking devices, and how legalizing retail marijuana sales will impact the tobacco control movement. Both of these issues are explored in further detail below.

Definitions for Electronic Smoking Devices

Although electronic smoking devices began as products used to heat liquid nicotine solutions, their sale, use, and marketing is rapidly evolving to include use for non-nicotine containing substances, including tetrahydrocannabinol (THC) oil, the psychoactive ingredient in marijuana. From a public health and compliance standpoint, it is therefore not practical to regulate these devices as exclusively for nicotine delivery. For example, age of sale laws and indoor air laws could become severely compromised if such restrictions only apply to devices containing

nicotine. Jurisdictions need to work closely with legal experts, such as the Tobacco Control Legal Consortium, to develop a definition for these products that recognizes their connection to tobacco use and advances tobacco control policy, notes that these devices are used for non-nicotine substances, and is tailored to an individual jurisdiction's needs.

Implications of Legalized Marijuana

Alaska, Colorado, Washington state, and Oregon have legalized retail marijuana sales, and other states are considering similar action. TCN members need to work with their respective states and territories to quickly learn how legalized retail marijuana sales intersect with tobacco control efforts and how to translate tobacco control best practices to legalized retail marijuana sales.

Marijuana retail sales present unique public health concerns, such as confirming safe packaging, regulating food products containing marijuana ("edibles"), preventing driving under the influence, laboratory testing and labeling of products, monitoring pesticide contamination of the plant and exposures for workers, and mitigating the risks of water use and its diversion in the growing process. However, many concerns directly impact tobacco control efforts, including the potential renormalization of smoking behaviors, potential erosion of secondhand smoke laws, the combined use of marijuana and tobacco products, the use of electronic smoking devices for marijuana oil, and the tobacco industry's potential entry into retail marijuana sales. Additionally, comprehensive tobacco control programs' subject matter expertise is directly applicable to the legalized retail marijuana sales, and they have the infrastructure to administer mass media campaigns, surveillance and evaluation systems, policy and system change campaigns, and health disparities perspectives. In the new landscape, tobacco control experts must explore how to best apply this expertise to regulating legalized marijuana.

Protecting Vulnerable Populations

The tobacco control movement's interests in protecting youth, young adults, and vulnerable populations directly intersect with the issue of legalized marijuana. Colorado's 2012 experience legalizing and commercializing recreational marijuana offers an early public health warning sign for other states and territories to consider. The 2014 Colorado Behavioral Risk Factor Surveillance System showed that over one third of marijuana users were daily marijuana users, and one third of 18-24 year olds were using marijuana. In addition, findings showed a disproportionate rate of use among certain communities, suggesting possible increased health disparities in some populations. Marijuana use among African American adults was almost 50 percent higher than the state average for adults, low income adults were using marijuana at higher rates than the state average, and nearly one third of lesbian, gay, bisexual, and transgender individuals were using marijuana — more than twice the state average for adults.[191]

Even as the perceived risk associated with marijuana use has declined, emerging research shows that the real risk for negative health effects associated with marijuana use has increased, especially among young people and people susceptible to mental illness.[192] Persistent marijuana use has been shown to permanently impair cognitive functioningand brain development, with impairment concentrated among adolescent-onset marijuana users, and more persistent use is associated with greater cognitive decline.[193] In addition, studies have shown that regular marijuana use is linked with chronic psychosis disorders in users with a predisposition to such disorders; heavy usage may exacerbate and be associated with an earlier onset of schizophrenia.[194]

The evidence indicates that dual-use of tobacco with marijuana products has increased. A 2015 study by researchers from Emory University and the University of Washington showed that between 2003-2012, co-use of tobacco and marijuana increased overall in adults, was highest among adults aged 18-25 years, and at each time point, and was increasingly higher for African Americans at each time point, suggesting disparities in co-use.[195] Emerging products gaining popularity, especially among young people, include Butane Hash Oil (BHO), which is derived from soaking marijuana trimmings in what is essentially lighter fluid. The resulting product contains super-concentrated THC in varying forms of viscosity, and is often smoked with vaping devices, which are popular with adolescents. The THC concentration in BHO has been reported to be up to 90 percent potency, compared to 15-20 percent THC potency of today's typical marijuana joint. In addition, the illegal method of manufacturing BHO is often done in home garages by untrained people, is extremely and inherently dangerous, and in California has resulted in an increase in home explosions and severe burns requiring long-term hospitalizations.[196]

In order to minimize the threat to tobacco control efforts, and the negative consequences associated with legalizing and commercializing recreational marijuana, states and localities need:

- Comprehensive marijuana education and prevention campaigns to inform and protect young people, non-users, and the general public from the harms of marijuana use. Tobacco prevention stakeholders should utilize mass media, statewide and community education interventions, surveillance and evaluation, and cessation and treatment opportunities, and decide how to fund such interventions.
- Uniform clean indoor air and smoke-free laws for marijuana that equal those for conventional cigarettes and electronic smoking devices in indoor and outdoor settings.
- Tobacco-related policies that protect the public, help prevent young people from using tobacco products, and reduce tobacco-related disparities. These policies can include age of sale restrictions, signage about age of sale restrictions, new requirements for licensing retailers and new zoning considerations for retailers, restrictions on youth marketing and advertising, restrictions on free sampling, restrictions on flavored products, child-resistant packaging, restrictions on products packed as candy and baked goods, and strong warning labels to protect children and adults from accidental poisonings.
- Taxation and illicit trade restrictions, including requirements for marijuana stamps.
- Compacts with tribes who may manufacture, distribute and sell marijuana products.
- To address unique issues related to legalized marijuana, including the impact on the environment, product laboratory testing, ingredient labeling, package warnings, child-resistant packaging, and driving under the influence.[197]

EMERGING TOBACCO CONTROL ISSUE POLICY RECOMMENDATIONS

20. **Expand the definition of tobacco products to include electronic smoking devices**, but ensure that the definition for these devices is sufficiently flexible to capture the fact that they are used for other substances which may have public health implications that extend beyond tobacco control goals. ***PROMISING PRACTICE***.
21. **Convene a tobacco control and medical-recreational marijuana task force** to address regulating marijuana and (1) its impact on tobacco control efforts, (2) areas of alignment, and (3) potentially translating tobacco-related policies to marijuana, including taxation, packaging and labeling, sale and distribution, licensing manufacturers, wholesalers, and retailers, advertising and marketing, and clean air. ***PROMISING PRACTICE***.

Conclusion

The above policy recommendations articulate TCN's vision for reducing tobacco-related harms across the country and ending the tobacco epidemic. We hope that tobacco control partners use these recommendations to proactively engage and inform stakeholders and create collective action to reduce tobacco use. Although the United States has made much progress in reducing tobacco use rates and associated death and disease, tobacco use is still the leading cause of preventable death and disease in this country and costs billions of dollars each year. States and localities must take bold steps to promote additional progress in the face of an aggressive, predatory tobacco industry.

Comprehensive, multi-pronged policies will have wide-ranging impact on multiple populations, especially those disproportionately affected by tobacco. The policies described in this document will advance many areas of the tobacco control movement including preventing exposure to secondhand smoke, reducing youth initiation of tobacco use and access to tobacco products, promoting cessation, denormalizing tobacco use, and regulating and monitoring emerging products like electronic smoking devices. The proven policy approaches also require tobacco control partners to simultaneously monitor emerging issues and develop innovative approaches to addressing them. We urge public health leaders to find renewed inspiration and ideas in these recommendations to continue working toward a tobacco-free United States.

Resources

Organizations

- Americans for Nonsmokers Rights
- Campaign for Tobacco-Free Kids
- ChangeLab Solutions
- Smoking Cessation Leadership Center
- Tobacco Control Network
- Tobacco Control Legal Consortium
- The Truth Initiative

Guides and Information

- CDC Office on Smoking and Health:
  > State and Community Resources
  > Best Practices User Guide: Coalitions – State and Community Interventions

- Partnership for Prevention:
  > Smoke-Free Policies: Establishing a Smoke-Free Ordinance to Reduce Exposure to Secondhand Smoke in Indoor Worksites and Public Places—An Action Guide

- The Guide to Community Preventive Services:
  > Reducing Tobacco Use and Secondhand Smoke Exposure

- U.S. Preventive Services Task Force:
  > Tobacco Recommendations

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Appendix A

Tobacco Control Network Executive Committee

TOBACCO CONTROL NETWORK OFFICERS

2014-2015:

Chair: Miranda Spitznagle, Indiana State Department of Health

Chair-Elect: Barry Sharp, Texas Department of State Health Services

Immediate Past Chair: Karen Girard, Oregon Health Authority

Policy Chair: April Roeseler, California Department of Public Health

Secretary/Treasurer: Tracey Strader, Oklahoma Tobacco Settlement Endowment Trust

Funders Alliance Representative: Andrea Mowery, ClearWay Minnesota

2015-2016:

Chair: Barry Sharp, Texas Department of State Health Services

Chair-Elect/Policy Chair: Andrea Mowery, ClearWay Minnesota

Immediate Past Chair: Miranda Spitznagle, Indiana State Department of Health

Secretary/Treasurer: Erin Boles Welsh, Rhode Island Department of Health

Funders Alliance Representative: Tracey Strader, Oklahoma Tobacco Settlement Endowment Trust

TOBACCO CONTROL NETWORK REGIONAL REPRESENTATIVES

2014-2015:

Regions 1-3: Erin Boles-Welsh, State of Rhode Island Department of Health, and Lisa Brown, Virginia Foundation for Healthy Youth

Region 4: Kenny Ray, Georgia Department of Health

Region 5: Andrea Mowery, ClearWay Minnesota

Regions 6-8: Vacant

Regions 9-10: Paul Davis, Washington State Department of Health, and Alison Kulas, Alaska Department of Health and Social Services

2015-2016:

Regions 1-3: Erin Boles-Welsh, State of Rhode Island Department of Health, and Lisa Brown, Virginia Foundation for Healthy Youth

Region 4: Kenny Ray, Georgia Department of Health, and Andrew Waters, Kentucky Department for Public Health

Region 5: Katelin Ryan, Indiana State Department of Health, and Christina Thill, Minnesota Department of Health

Regions 6-8: Adrienne Rollins, Oklahoma State Department of Health, and Terry Rousey, Colorado Department of Public Health and Environment

Regions 9-10: Luci Longoria, Oregon Health Authority, and Elizabeth Guerrero, Guam Department of Public Health and Social Services

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