TOBACCO CONTROL NETWORK

2022 **Policy Recommendations Guide**

TOBACCO CONTROL NETWORK

Table of Contents

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TOBACCO CONTROL NETWORK POLICY WORKGROUP

Donna Asbury (NH)
Christy Cushing (UT)
Liz Hendrix (CA)*
Jennifer Park (NC)
Terry Rousey (CO)
Katelin Rupp (IN)
Cassandra Stepan (MN)
Christina Thill (MN)*

*Denotes workgroup lead

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Executive Summary

In the six years since the release of the Tobacco Control Network's (TCN) 2016 Policy Recommendations Guide, the tobacco control landscape has changed dramatically due to the alarming youth epidemic of e-cigarette use, a wide array of new tobacco products entering the market, heightened awareness of health disparities, and a greater commitment to advancing health equity in every aspect of our work. Tobacco control programs have forged new and innovative partnerships, advanced the most effective strategies to fight the tobacco epidemic, and adopted new strategies to advance our goals, even as tobacco industry interference has become ever more sophisticated.

Cigarette smoking is on the decline, yet smoking is still the leading cause of preventable death in the United States, responsible for nearly half a million deaths per year and killing about 1 out of every 5 adults. In addition, for every person who dies because of smoking, at least 30 people live with a serious smoking-related illness. Youth e-cigarette use has reversed our progress in reducing tobacco use among youth, which is particularly troubling given the substantial evidence that youth who use e-cigarettes are at increased risk to become cigarette smokers in the future.

This important work has been challenged in a new way as the country responded to the COVID-19 pandemic. Tobacco use does contribute to the death and disease burden of COVID-19, as current or past tobacco use increases one's risk of severe illness or death after contracting the virus.[1] This challenge comes with the backdrop of more than 15,000 kid-friendly flavors on the market for e-cigarettes driving youth uptake and use rates to never-before-seen numbers.[2]

Exposure to secondhand smoke also continues to pose a threat to the health of 1 out of 4 nonsmokers and bystanders in the U.S., contributing to deaths and serious illnesses in both adults and children.[3] In addition, the surgeon general has concluded that aerosol from e-cigarettes can contain substances that are harmful to bystanders. As is the case for tobacco use itself, the harms from secondhand exposure are shouldered disproportionately by underserved communities. Most notably, African American children and adults are more likely to be exposed to secondhand smoke than any other racial or ethnic groups in the U.S.[4]

Although the devastating harms of tobacco use are well-documented, new research continues to teach us even more about its harmful effects and how public health interventions can prevent them. At the same time, the tobacco industry continues to reinvent its products and marketing to sidestep regulations, increase profits, and create a new generation of lifelong customers. This is perhaps best demonstrated by the case study of flavored tobacco products. For both e-cigarettes and conventional combustible tobacco products, flavored products continue to be legally available to the majority of Americans. These flavors entice young people to become addicted to harmful nicotine-containing products, and additionally represent a powerful driver of health inequities in the numerous chronic conditions directly caused by tobacco use. FDA has taken recent action to regulate these products, such as the January 2020 partial e-cigarette enforcement policy and the April 2021 announcement outlining the intention to prohibit the sale of menthol cigarettes and flavored cigars. However, state, territorial, and local policy action is needed to protect future generations from addiction and harm and to combat injustices in the present landscape of tobacco product use in the pursuit of an equal opportunity to healthy living for smokers and nonsmokers alike.[5,6]

This guide offers the evidence and rationale for a policy-based approach to reduce tobacco use. It also provides (1) principles for advancing tobacco control policies and working with Tribal nations and (2) a summary of the changing tobacco control landscape, including the youth e-cigarette epidemic, information on health disparities and health equity, and addressing related issues such as marijuana, e-cigarette or vaping use-associated lung injury (EVALI), and COVID-19.

The policies recommended are based on CDC's Tobacco Control Best Practices Guide 2014; the surgeon general's reports on tobacco use, cessation, and prevention; and other well-documented, peer reviewed studies. The field of tobacco control is fortunate to have decades of research leading to proven strategies to prevent and reduce tobacco use. This guide recommends those policies that are most effective and offers states and territories a roadmap to prevent youth use and reduce rates. The recommendations also include emerging strategies that boost the effectiveness of best practices and make progress toward an endgame as well as cutting-edge strategies that more directly advance a tobacco-free future. Resources are provided for more in-depth exploration of the strategies described in each section.[7]

These policies and strategy recommendations offer tobacco control programs, coalitions, and decision-makers renewed opportunities to move our nation forward in ending the tobacco epidemic. We hope this guide will serve as a reference document and ignite inspiring conversations and bold action, as there is still much to be done and no time to waste.

Note to the reader: Unless otherwise specified, all references to "tobacco" and "tobacco use" in this guide refer to commercial tobacco and do not include the use of traditional or sacred tobacco as part of an Indigenous practice or a lawfully recognized religious, spiritual, or cultural ceremony or practice.

Tobacco Control Network Recommendations for Policy and System Change Strategies

The following policies and strategies are recommended for 2022 to 2026 and beyond:

2022 TCN POLICY RECOMMENDATIONS AND SYSTEMS CHANGE STRATEGIES

Fund Comprehensive, Sustainable, and Well-Resourced State and Territorial Tobacco Control Programs

Fund comprehensive, sustainable tobacco control programs consistent with CDC's Best Practices for Comprehensive Tobacco Control Programs—2014.

- Designate a portion of tobacco taxes, settlement payments, licensing fees, or other public funds for a comprehensive tobacco control program, including cessation and prevention programs for populations hardest hit by tobacco use.
- Create partnerships and cost-sharing agreements with other health and public health organizations to leverage additional funds and expand the reach of tobacco control programs.
- Preserve tobacco control program funding during public health emergencies.

Increase the Price of Tobacco Products

Increase the price of all tobacco products and revisit price increases regularly to ensure they keep pace with public health benefits. Tax new products at rates that are on par with cigarettes. Lower tax rates for products FDA determines to reduce risk should only be considered in the context of dual use and whether users will fully transition to those products. To eliminate or reduce tobacco industry efforts to negate the impact of tobacco tax increases, enact a package of tax and non-tax policies, whenever possible.

- Enact price increases on all tobacco products in amounts substantial enough to have a meaningful impact on lowering tobacco use rates among people of all ages. For example, $1-$3 per pack of cigarettes.
- Price increases should encompass all products, including cigarettes, e-cigarettes, cigars, little cigars and cigarillos, heated tobacco, and smokeless/oral nicotine products, proportional to the average cigarette tax rates in each state and territory.
- Ban or enact restrictions on tobacco product price discounts and coupon redemption.
- Establish minimum "floor" prices for all tobacco products comparable across all product lines.
- Establish minimum pack sizes for cigars, cigarillos, and other tobacco products, such as oral nicotine products and snus.

Eliminate Secondhand Smoke and Aerosol Exposure and Create Tobacco-Free Environments

Enact comprehensive 100% clean air laws that cover use of all combustible tobacco products and e-cigarettes, regardless of substance, in all workplaces and public places. Whenever possible, include smoke and aerosol from marijuana in clean air laws.

- Enact 100% tobacco-free property policies, both indoor and outdoor.
- If the environment does not yet support passage of a comprehensive clean indoor air policy in all public spaces, then pursue policies in the following environments to work toward the goal of a comprehensive policy:
  » Government buildings and property.
- Educational properties (e.g., K-12 environments, colleges and trade schools, and early learning and childcare centers).
- Healthcare and behavioral health facilities and properties.
- Multi-unit housing, both public and private.
- Cars and other enclosed vehicles.
- Foster care homes and facilities.
- Other outdoor venues in which people congregate, such as parks, beaches, farmer's markets, fairs, or sporting events, particularly in youth-sensitive areas.

Limit Tobacco Product Availability and Accessibility

Enact laws that restrict the availability and accessibility of tobacco products.

- Prohibit the sale of flavored tobacco products, including menthol products.
- Limit the number, density, and location of tobacco retailers. (This includes retail licensing, zoning and land use, and prohibiting sales in specific types of stores, such as pharmacies.)
- Prohibit internet sales and delivery of tobacco products.
- Raise the minimum legal sales age for all tobacco products to at least 21 and consider raising the minimum age for clerks who sell tobacco products to 21.
- Eliminate youth purchase, use, and possession (PUP) laws whenever possible.
- During public health emergencies, consider policies that limit tobacco product availability and accessibility, including online sales and delivery.

Expand Availability and Increase Use of Tobacco Cessation Treatment

Enact laws and health systems policies that expand availability and increase use of effective tobacco cessation interventions.

- Require a comprehensive barrier-free tobacco cessation benefit across payer types.
- Integrate tobacco treatment systems change within all types of healthcare settings, including behavioral health.
- Allow pharmacists to prescribe tobacco cessation medications.
- Expand the types of healthcare professionals (such as certified tobacco treatment specialists) allowed to bill Medicaid or other insurers for tobacco cessation counseling.
- Increase the availability and accessibility of tobacco cessation for youth, including e-cigarettes.
- Create public private partnerships to promote quitting, maximize quitline funding, and expand reach.

Limit Tobacco Marketing and Advertising

- Enact advertising restrictions on the size, location, type, and/or number of advertisements in retail outlets, regardless of content.
- Work with the state attorney general's office to address tobacco marketing to youth, learn which retail chains have entered into assurances of voluntary compliance, and collect and communicate in-store assessment data.

Advance Endgame and Cutting-Edge Strategies for a Tobacco-Free Future

- Prohibit the sale of all tobacco products or an entire class of tobacco products.
- Restrict the sale of tobacco products above a certain nicotine concentration.
- Enact policies to address hazardous tobacco waste:
- Prohibit the sale of tobacco products that include single-use plastic components.
  - » Require tobacco retailers to collect or pay a hazardous waste disposal fee per e-liquid/prefilled electronic cigarette-product they sell or intend to sell.
  - » Require tobacco retailers to pay litter mitigation fees.
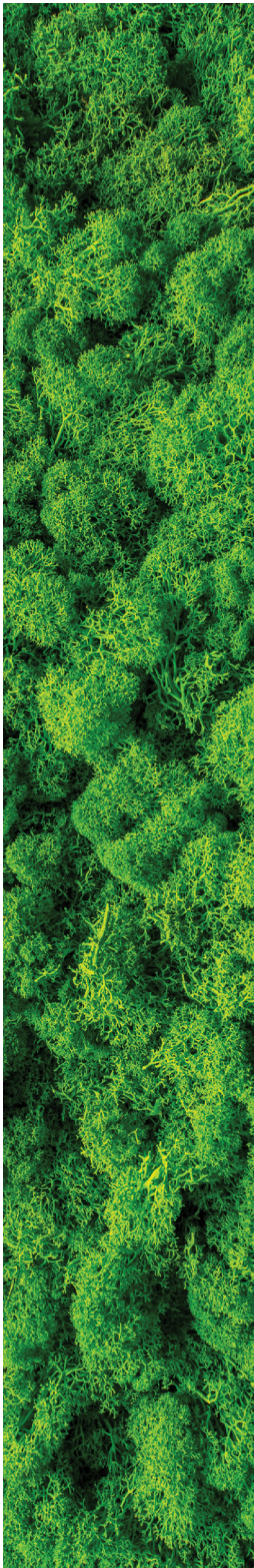
Focus Priority Populations and Health Disparities at the Center of All Policy, Systems, and Environmental Interventions to Implement Tobacco Control

The following principles should be integrated in all the above recommendations to ensure that the implementation all tobacco control policies has the end effect of reducing health disparities and promoting health equity. For more information, please see the "Health Disparities Persist" and "Advancing Health Equity" subsections within the "The Changing Tobacco Control Landscape, 2016-2022" section of this document.

- Coordinate efforts to reduce tobacco-related disparities with groups that are most affected by tobacco use, secondhand smoke exposure, and the ramifications of policy changes.

- Design policy and program interventions that address the social determinants of health impacting the lives of those most impacted by tobacco use. These interventions should address:
  1. Economic stability
  2. Education
  3. Neighborhood and built environment (i.e., the housing, environmental conditions, and safety of a person's neighborhood)
  4. Health and healthcare
  5. Social and community context (i.e., family structure, community civic participation, and perceptions of discrimination and equality)

- Ensure that policies and programs are informed by population changes, migrating population groups, and the complex needs of the communities that will be most impacted.

- Enact cost-effective policies that create funding to support wraparound services—such as cessation resources— to protect groups experiencing tobacco-related disparities.

- Engage a variety of stakeholders representing populations most affected by tobacco disparities to ensure policies, programs, and resources are appropriately distributed and culturally appealing for sustained impact.[8]

- Prioritize tobacco control programs and policy changes that address predatory marketing practices aimed at disenfranchised populations.

- Restrict dense advertising, sampling vans, sponsorships of community events, and price discounts in marginalized community retail outlets.[9]

Introduction

The Tobacco Control Network (TCN) is a peer network of state and territorial tobacco control program managers and staff on the frontlines of tobacco prevention efforts. TCN's mission is to improve the public's health by providing education and community-based expertise for tobacco prevention and control at the state/territorial and national levels. Network members collaborate and share experiences in implementing best practice interventions to prevent and reduce tobacco use and tobacco-related health disparities. The Association of State and Territorial Health Officials (ASTHO) provides staff support to TCN. ASTHO is the national nonprofit association representing the state and territorial public health agencies of the United States, the U.S. territories, and Washington, D.C.

The Tobacco Control Network 2022 Policy Recommendations articulate the network's vision for implementing evidence-based policy and system changes to prevent and reduce all forms of tobacco product use; eliminating exposure to secondhand smoke, aerosols, or other toxins emitted by inhaled tobacco products; and reducing tobacco-related health disparities, while advancing health equity.

This document was developed to help tobacco control program managers and staff educate their local and state/territorial partners, stakeholders, and policy leaders about the harms and costs of tobacco use and the efficacy of tobacco control best practices, and to also help set public health priorities to address the leading cause of preventable death and disease in the U.S. The specific policies in this guide were selected by TCN's Policy Committee and Executive Committee because they are evidence-based or evidence-informed best practices to reduce the prevalence of tobacco use and addiction, reduce or eliminate secondhand smoke or aerosol exposure, and reduce tobacco-related health disparities. Recommended strategies are based on the experience and effectiveness of tobacco control efforts from the field.

The Tobacco Control Vaccine and Booster

The Tobacco Control Vaccine is a framework of four proven population-based preventive measures to reduce tobacco use and tobacco-related morbidity and mortality: tobacco price increases, smoke-free policies, hard-hitting media campaigns, and access to cessation resources.[10] In recent years, we have also come to understand the important role that emerging strategies related to the point of sale or retail environment can play in deterring young people from tobacco use, encouraging people of all ages to quit, and reducing health disparities. These strategies, which are a complement to the Tobacco Control Vaccine, include restricting tobacco product availability, pricing and promotion, advertising and display, age of sale, and retail licensure. Collectively, these strategies are known as the Tobacco Control Vaccine Booster.[11]

The Tobacco Control Vaccine is founded on existing evidence-based frameworks and is intended to serve as a public health messaging complement to enhance understanding and implementation of proven interventions. Like other vaccines, a significant impact will only be experienced when stakeholders support and advance these policies on a population level, and that will require a coordinated approach among diverse partners with the knowledge that the public is on our side. Time and time again, numerous surveys have shown that the vast majority of Americans do not trust the tobacco industry and its influence over policies to prevent and reduce tobacco use and secondhand smoke exposure.[12] The majority of Americans continue to demonstrate strong support for actions to move toward a tobacco-free future.

As we advance the policy recommendations contained in this guide, we can be confident in our approach. There are decades of research and experience in implementing the best practice policies recommended in this guide, which have had the greatest impact on reducing tobacco use. In recent years, we have also come to understand the important role that emerging strategies related to the point of sale or retail environments can play in deterring young people from tobacco use and encouraging people of all ages to quit.

In the five years that have passed since the release of the TCN 2016 Policy Recommendations Guide, the tobacco control landscape has changed in a number of ways, including the alarming youth epidemic of e-cigarette use, a wide array of new tobacco products entering the market, a heightened awareness of preventable health disparities, and a greater commitment to advancing health equity in every aspect of our work. Tobacco control programs have forged new and innovative partnerships and adopted new strategies to advance our goals, even as tobacco industry influence and strategies have become ever more sophisticated.

We hope this guide will serve as a reference document and helpful tool in igniting inspiring conversations and bold action. As the recommendations will illustrate, there is much to be done and no time to waste.

Why Focus on Policy?

In the case of tobacco control, best practice policies are the most effective action for reducing tobacco use rates, protecting youth from addiction, and achieving more equitable protection from the harms associated with tobacco use. The development and implementation of policy offers the greatest impact on entire populations. Policy is a written reflection of a community's values and decisions. Once a policy is in place, it has the potential to ensure that public health protections are in place for years to come.[13]

Using this Guide

This document identifies policy and system recommendations to prevent and reduce tobacco use.[14]

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.
• Seize opportunities to advance health equity and optimal health for all.
• 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 to demonstrate the need and support for policy initiatives and evaluate policies post-implementation.
• Plan and implement training and technical assistance to build capacity among partners to advance and implement policies.

The recommendations in this guide 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 recommends that state/territorial and local tobacco control coalitions prioritize best-practice policies to have the greatest positive impact on health. However, some jurisdictions may face particularly challenging circumstances, such as preemption or other state/territorial or local factors, and may find it especially difficult to create momentum for the most effective policies. In these cases, passing other policies—such as tobacco-free schools, retail licensure, or Tobacco 21—can provide some early successes and educate stakeholders in order to lay the groundwork for more impactful policies. 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.[15,16,17]

Preemption: The Insidious Roadblock

Because policy passage is the most effective tool for reducing tobacco use, the tobacco industry opposes public health policies at every turn. One of the most common ways the tobacco industry does this is by lobbying to restrict a state, territory, or local government's public health powers. There are different ways in which authority can be restricted, but a common industry strategy is to seek "preemption." This term is used to describe when a federal law or regulation limits or prohibits state or local governments from passing stronger laws or regulations. Preemption can also occur at the state or territorial level, hampering local authority. Getting preemptive laws or regulations passed is a well-documented tobacco industry tactic, and it makes a community unable to enact local tobacco control laws.[18] Preemption of local authority can exacerbate health disparities by limiting communities' options to tailor solutions for their populations. TCN encourages its members and their partners to be vigilant against, and strongly oppose, attempts to preempt local authority to enact strong public health measures.

As an example, although the recent wave of Tobacco 21 laws has been a tobacco control success, the tobacco industry has leveraged these policies as opportunities to include preemptive clauses while appearing to be on the right side of reducing youth tobacco use. Although the tobacco industry routinely attempts to insert preemption clauses in bills that are specifically related to tobacco, in one egregious example from Hawaii in the final hours of the 2018 legislative session, a dialysis bill was used as a vehicle to preempt counties from regulating tobacco sales.[19] (One bright spot with respect to restoring local authority occurred in 2019, when Colorado proactively repealed a law that penalized local governments that adopted retail policies.[20])

States and territories should not only oppose preemption but, whenever possible, should seek to include in legislation the express authority or a "savings clause" explicitly allowing local governments to enact even stronger and more effective tobacco control policies within their jurisdictions.

Resources:
- ChangeLab Solutions—Assessing & Addressing Preemption: A toolkit for local policy campaigns
- Counter Tobacco—Tobacco Point of Sale Preemption
- Public Health Law Center—Preemption

Guiding Principles for Addressing Tobacco Control Policies

Guiding principles that may be helpful for tobacco control programs and stakeholders when addressing policy interventions include the following:

- Identify the policy interventions that offer the best combination of feasibility and impact.
- Understand your state or territory's context associated with the policy—including historical, legal, social, economic, population readiness/support, and political factors—before advancing the policy.
- Identify successful strategies and lessons learned from the experiences of other states/territories or localities.
- Use the technical assistance that is available from CDC's Office on Smoking and Health, the Public Health Law Center, and voluntary organizations.
- Identify partners who can communicate policy goals and priorities when tobacco program staff are not allowed to directly communicate with elected officials or decision-makers.
- Prioritize public policy over voluntary or organizational policy because voluntary/organizational policy is much more easily changed, can be inconsistently applied, and impacts far fewer people, resulting in fewer health improvements.
- Confirm that the policy intervention is not preempted by federal or state law.
- Build support for policies through education, coalition building, and mass media.
- Leverage early policy successes toward future efforts.
- Create policies with an eye on the future and consider the types of products or conditions that may not be conceivable in the present moment.
- Work with diverse partners and members of populations that have higher rates of tobacco use and tobacco-related disease. Such partners will help ensure that policies are appropriate and may help identify opportunities to build health equity or prevent unintended consequences, such as those that might worsen health disparities.
- Apply systems thinking to identify other public health issues that may affect or be affected by the policy intervention. For example, many current secondhand smoke policy protections may not extend to marijuana smoke or aerosols from e-cigarettes. Looking ahead may offer opportunities to prevent addiction, health disparities, or other harmful consequences well into the future.
- Include tobacco cessation treatment for those most affected, including staff, patients, customers, and the public, and promote its use.
- Allocate new taxes, fees, or settlement funds to tobacco control efforts.
- Evaluate the impact of polices to ensure that they are having the intended impact and do not have unintended consequences

Guiding Principles for Working with Tribal Nations and Organizations

When considering state or local policy, it is important to recognize tribal sovereignty and that tribal nations are not subject to state or local laws. Tribal sovereignty refers to the right of Native Americans and Alaska Natives to govern themselves. The U.S. Constitution recognizes Native American tribes as distinct governments that have, with a few exceptions, the same powers as federal and state governments to regulate their internal affairs.[21]

Tribal governments are permitted to enact tobacco control tribal laws to increase the price of tobacco products, eliminate secondhand smoke and aerosol exposure, enact retail licensure, and expand and promote tobacco cessation treatment, among others. Such measures are needed to reduce the tragically high rates of commercial tobacco use and tobacco-related disease and death among Native Americans.

Guiding principles that may be helpful for tobacco control programs and stakeholders when addressing policy interventions with tribal nations and organizations include the following:

- Recognize tribal sovereignty. All relationships between the state and a tribal nation are government-to-government relationships.
- Access state-developed tribal consultation policies and work with tribal liaisons. Both may be beneficial in providing context and establishing a working relationship with tribal nations.
- Build relationships with each tribal nation individually. Discuss unique cultural traditions, beliefs and attitudes associated with the use of tobacco before discussing a specific policy intervention.
- Understand the context of the state and tribal relationship regarding the policy—including historical, legal, social, economic, population readiness/support, and political factors—before advancing policy discussions.
- Develop a system for tobacco policy implementation that includes tribal guidance, advice, and decision-making to ensure policies are culturally relevant, appropriate, and adapted to the context.
- When considering a state or local policy change that affects tribal populations, work with tribes to identify potential conflicts and solutions. For example, when passing a state or local tobacco tax, it may be necessary to engage state leaders in creating or amending state compacts with the tribes to minimize price disparities between tribal and non-tribal retail outlets. A compact is a "negotiated agreement between two political entities that resolves questions of overlapping jurisdictional responsibilities."[22]
- Adapt policies as necessary and appropriate to address traditional, historical, and cultural use of tobacco. Public Health Law Center offers the following language for use when needed: "This does not include the use of traditional or sacred tobacco as part of an indigenous practices or a lawfully recognized religious, spiritual, or cultural ceremony or practices."
- When considering a policy intervention with tribal governments, work with tribes that have an interest in the policy and seek to broaden adoption by having tribal partners develop and discuss their successes and lessons learned.
- When seeking a tribal policy change, identify policy interventions desired by tribal leadership and public health workforce that offer the best opportunity for success.
- Begin with policies that have support of tribal leadership and leverage those successes in future efforts and make use of technical assistance and training resources on working with tribal nations. If a policy has little support among tribal leadership, provide information on the benefits of the policy and seek guidance on how the policy might be implemented within the tribal context.

> **Resources:**
> - CDC—Center for State, Tribal, Local, and Territorial Support
> - National Indian Health Board
> - National Council of Urban Indian Health
> - CDC—Overview of CDC-funded Tribal Epidemiology Centers Public Health Infrastructure (TECPHI)

The Changing Tobacco Control Landscape, 2016–2022

Numerous changes in the U.S. tobacco control landscape have taken place since the release of the TCN 2016 Policy Recommendations Guide. Although the devastation of tobacco use is well-documented, new research continues to tell us more about its harmful effects and how public health can stop them even as the tobacco industry continues to reinvent its products and marketing to sidestep regulations and increase profits. The following is an update since 2016.

Health Disparities Persist

Health disparities are responsible for high economic and human costs in the U.S. every year. The avoidable costs of health disparities include premature deaths, medical costs related to preventable chronic diseases, and the overutilization of healthcare resources. Health also impacts employment potential and workplace efficiency. According to a 2009 National Urban League Policy Institute study, health disparities cost the U.S. an estimated $60 billion in excess medical costs and $22 billion in lost productivity.[23]

According to CDC, current cigarette smoking among adults declined from 18% in 2016 to 14% in 2019. However, large disparities persist in smoking prevalence and tobacco-related diseases by race, ethnicity, educational level, income, geographic location, sexual orientation, gender identity, behavioral health conditions, and health insurance coverage for smoking cessation.[24,25,26] For example:

- Adults with a GED certificate smoke at a rate of 36%, while adults with an undergraduate degree smoke at rate of 7.1%.
- Adults in serious psychological distress smoke at a rate of nearly 32%, compared to 13% among those without serious psychological stress.

Data from the National Cancer Institute from 2015-2016 indicate that marked disparities also exist in secondhand smoke exposure by age, income, and education. For example, over 38.2% of children ages 3-11 are exposed to secondhand smoke, compared to 18.9% of adults 30 or older.[27]

At the federal level, in one of the most significant policy advancements to address secondhand smoke exposure among those with lower socioeconomic status, the U.S. Department of Housing and Urban Development finalized an administrative rule in December 2016 that required all public housing agencies to implement a smoke-free policy by July 30, 2018. The rule extended protections against secondhand smoke exposure to all residents living in public housing, because "the movement of secondhand smoke between units cannot be controlled in multifamily buildings."[28] To support implementation of this rule, tobacco control programs across the U.S. have partnered with public housing communities to provide education and smoking cessation support to property owners and residents.

Advancing Health Equity

Health disparities and health inequity walk hand in hand. While health disparities refer to the differences in outcomes or disease burden between disparate groups, health inequity refers to the structural or institutional patterns (social determinants of health) that cause health disparities.[29]

A health difference is considered a health disparity if it is the result of unjust or unfair exposure to detrimental health and social factors. In recent years, the U.S. has experienced a surge in racial and social justice movements resulting from heightened awareness of a variety of social problems, including racial profiling, the numerous unarmed African Americans killed

during encounters with law enforcement, sexual harassment in the workplace, and other discriminatory practices on the basis of religion, sexual orientation, or gender identity, among others. In this context, and in light of persistent and growing health disparities, advancing health equity has become a priority of the national public health agenda and CDC has declared racism a serious threat to public health.

Health equity is the opportunity for everyone to reach their full health potential, regardless of any socially determined circumstance.[30] Building health equity requires removing and preventing barriers to health (such as poverty and discrimination) and their consequences, including a lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare.[31]

When it comes to tobacco prevention and control, health equity is the opportunity for all people to live a healthy, tobacco-free life, regardless of their race, level of education, gender identity, sexual orientation, job, neighborhood, and whether or not they have a disability. Tobacco control programs can advance health equity and reduce health disparities by prioritizing policy and program efforts related to decreasing the prevalence of tobacco use and secondhand smoke exposure and improving access to tobacco control resources among populations experiencing greater tobacco-related health and economic burdens.[32]

Resources:
- CDC—Best Practices User Guide: Health Equity in Tobacco Prevention and Control
- The Center for Black Health & Equity—2021 Public Policy Platform
- American Public Health Association—Creating The Healthiest Nation: Advancing Health Equity
- Public Health Law Center—Focusing on Equity and Inclusion When We Work on Public Health Law
- U.S. Department of Housing and Urban Development—Smoke-Free Public Housing and Multifamily Properties

Tobacco Industry Strategies

Following dramatic declines in cigarette sales, the tobacco industry has attempted to redefine its image and introduce new addictive products to protect and expand its shrinking customer base.[33] Today, each of the major U.S. cigarette manufacturers has a stake in e-cigarette companies and continues to develop new products.

A report from the Truth Initiative, "Spinning a New Tobacco Industry: How Big Tobacco is Trying to Sell a Do-Gooder Image and What Americans Think About It," details four primary strategies the tobacco industry uses to wield its influence:

1. **Expanding product portfolios** to include e-cigarettes and heated tobacco products (such as IQOS) to attract new customers and retain existing ones.
2. **Marketing new products to youth and young adults who have rejected cigarettes**. The industry uses social media "influencers," targets kids at school, promotes kid-friendly flavors, and sponsors youth-focused events and promotions.
3. **Working to improve the industry's reputation** among influential audiences and the general public, including the use of sponsorships, community events, and outreach to marginalized communities.

4. **Cultivating influence with policymakers** and lobbying against policies that strengthen tobacco control efforts to improve health. Tobacco/e-cigarette companies have employed armies of lobbyists, many of whom are former lawmakers and political insiders, to erode and prevent tobacco control policies.[34]

By 2019, tobacco companies spent $22.5 million each day to market cigarettes and smokeless tobacco. A majority of tobacco marketing is spent on price discounts and point of sale advertising in the retail environment, including buy one get one free deals, coupons, and other consumer engagement strategies. Nationwide, the tobacco industry is outspending tobacco prevention funding in the U.S. by 13.8 to 1.[35]

The good news is that more than 70% of Americans view tobacco and e-cigarette companies unfavorably. However, in this new era of tobacco industry product development and marketing, state and territorial tobacco control programs must educate stakeholders and policymakers to expose industry tactics and influence and their harmful consequences.[36]

Resources:
- CDC—Tobacco Industry Marketing
- Truth Initiative—Spinning a New Tobacco Industry: How Big Tobacco is Trying to Sell a Do-Gooder Image and What Americans Think About It
- Action on Smoking and Health—U.S. Tobacco Industry Interference Index 2021

An Alarming Epidemic of Youth E-cigarette Use

For decades, data have shown that tobacco industry marketing significantly influences youth to try cigarettes and other tobacco products. Although youth cigarette smoking has declined to under 5% today, e-cigarette use has risen to epidemic levels. In 2020, 19.6% of U.S. high school students and 4.7% of U.S. middle school students—a total of 3.6 million youth—reported using e-cigarettes in the past 30 days. E-cigarettes have been the most commonly used tobacco product among U.S. youth since 2014, showing that, in recent years, patterns of e-cigarette use have driven patterns of overall tobacco product use among U.S. youth.[37] The meteoric rise in youth use over the last several years has been attributed to widespread industry marketing to attract youth, kid-friendly flavors to get them to try the easily concealed products, and high concentrations of nicotine to addict them in order to keep them using the products.

It is well documented that nicotine harms the developing brain, including the parts of the brain that control attention, learning, mood, and impulse control; therefore, no amount of e-cigarette use is safe for young people.[38] Youth e-cigarette use has reversed our progress in reducing tobacco use among young people, which is particularly troubling given the substantial evidence that youth who use e-cigarettes are more likely to become cigarette smokers in the future.[39]

JUUL, an e-cigarette that entered the market in 2015, uses a nicotine salt formulation that delivers nicotine 2.7 times faster than previous "first generation" e-cigarette products. In addition, JUUL's nicotine content is one of the highest among e-cigarettes.[40] By 2016, JUUL became the most popular e-cigarette brand in the U.S., capturing 40% of market share.

A 2018 Truth Initiative survey of youth found that the top reasons for using JUUL or e-cigarettes were its popularity with other young people, the variety of flavors, its perception as less harmful than other products and its ability to deliver a "buzz."[41] Given this trend in youth e-cigarette use, then Surgeon General Jerome Adams issued an Advisory on E-cigarette Use Among Youth in 2018 in which he referred to the dramatic rise in youth use of e-cigarettes as an epidemic.[42]

NO!
MENTHOL CIGARETTES

Federal law requires manufacturers to obtain FDA authorization before marketing their products. E-cigarette manufacturers needed to submit applications to FDA by Sept. 9, 2020, for products that were on the market as of that date to remain on the market. FDA intends to allow manufacturers who submitted timely applications to continue to sell their products for up to a year while FDA reviews their applications. As of December 2021, FDA has not finalized their review of all e-cigarette product applications, but they have issued a guidance document explaining how the agency will prioritize its enforcement activities with respect to flavored e-cigarettes.

In February 2020, FDA announced that no flavored, prefilled cartridge e-cigarettes (like JUUL), except tobacco- or menthol-flavored products, could be sold unless and until FDA authorized their sale. However, the enforcement policy exempted not only menthol in all forms, but also all flavored liquid nicotine used in disposable products (e.g., Puff Bar) and refillable cartridges, including fruit and candy flavors. These products remain on the market, and subsequent research indicates that users have shifted their consumption to the products that contain the flavors they want.[43]

2020 data from FDA and CDC show that current youth e-cigarette use has recently decreased. However, youth e-cigarette use remains at epidemic levels, driven in part by a dramatic increase in menthol and disposable e-cigarettes, two categories of products that were exempted from federal restrictions.[44,45] Among current e-cigarette users, the use of disposable e-cigarettes increased approximately 1,000% (from 2.4% to 26.5%) among users in high school and approximately 400% (from 3.0% to 15.2%) among users in middle school.[46]

The good news is that many of the evidence-based strategies and policies that work to curb cigarette use also decrease youth e-cigarette use. These include smoke-free policies, increasing the price of the products, restricting youth access in retail settings, raising the minimum legal sales age (MLSA) to at least 21, and prohibiting the sale of flavored products. Examples of progress include:

- Federal legislation passed on Dec. 20, 2019 raising the minimum legal sales age for all types of tobacco products in the United States from 18 to 21 years. In addition, 32 states, Washington, D.C., Guam, the Northern Mariana Islands, and Palau have all passed Tobacco 21 policies of their own.[47]
- At least 300 localities have passed restrictions on the sale of flavored tobacco products, although laws differ in their application to specific products and store types. At least 120 of these communities restrict the sale of menthol cigarettes in addition to other flavored tobacco products.[48]

Helping Tobacco Users Quit

In 2020, *Smoking Cessation: A Report of the Surgeon General* was released, making it the 34th tobacco-related surgeon general's report since 1964 and the first one specific to smoking cessation in the past 30 years.[49,50] The 2020 report's conclusions affirm that the Best Practices policies of increasing the price of cigarettes, establishing smoke-free regulations, and funding comprehensive state tobacco control programs can reduce smoking prevalence, reduce cigarette consumption and increase smoking cessation. In addition, policies that ensure comprehensive insurance coverage for evidence-based cessation can increase the availability and utilization of treatment services. Policies that link quality measures to payments to clinicians, clinics, or health systems can also increase the delivery of effective tobacco treatments.

Given that the smoking prevalence among the Medicaid population is twice as high as among privately insured adults, it is encouraging to note that between 2008 and 2018, the number of state Medicaid programs covering all nine cessation treatments (including counseling and medications) rose from six to 15 and the number of states covering all seven FDA-approved cessation medications increased from 20 to 36.[51]

As our understanding of the tobacco-related health disparities among people with behavioral health conditions (mental health and/or substance use disorders) has expanded, state tobacco control programs have become increasingly engaged in promoting policies that support tobacco cessation systems change within behavioral health settings. People with behavioral health conditions smoke 40% of all cigarettes sold and are four times more likely to die prematurely than those who do not smoke. As a result, the most common causes of death among people with behavioral health conditions are preventable: heart disease, cancer, and lung disease. Currently, fewer than half of mental health and substance use disorder treatment facilities in the United States offer evidence-based tobacco cessation treatments.

Tobacco and Marijuana

Many e-cigarette devices used for delivering nicotine can also be used to vape or deliver THC, the active ingredient in marijuana. As of December 2021, 36 states, Washington, D.C., Guam, Puerto Rico, and the U.S. Virgin Islands had approved "comprehensive" medical marijuana programs, which include protection from criminal penalties for using marijuana for medical purposes, allowing access to marijuana through home cultivation or dispensaries, allowing a variety of strains or products, and allowing smoking or vaping of marijuana products, plant material or extract. The recreational use of cannabis is legalized in 18 states, Washington, D.C., the Northern Mariana Islands, and Guam.[52]

With the expansion of legal medical marijuana across the U.S., fewer youth and adults perceive marijuana use as harmful.[53] In fact, a 2018 Gallup Poll found that Americans view marijuana as much less harmful than cigarettes and other forms of tobacco. Findings from at least one recent study indicate that large numbers of high school students who use tobacco products have also vaped cannabis.[54] As marijuana policies pass, they must be coordinated and reviewed to ensure that they do not intentionally or unintentionally weaken tobacco control policies.

Tobacco, EVALI, and COVID-19

In the summer of 2019, EVALI (E-cigarette, or Vaping, product use-Associated Lung Injury) emerged after numerous cases of severe and fatal lung injuries related to vaping occurred. Most of those cases were linked to vaping THC, particularly THC obtained from informal sources such as friends, family, or in-person or online dealers. According to CDC, vitamin E acetate, which was an ingredient in many of the products vaped, is strongly linked to EVALI. A final update from CDC in February 2020 indicated that there were 68 confirmed deaths from EVALI in 29 states and Washington, D.C. and a total of 2,807 hospitalized EVALI cases or deaths were reported to CDC from all 50 states, Washington, D.C., and two U.S. territories (Puerto Rico and U.S. Virgin Islands).[55]

The EVALI outbreak provides a valuable lesson in the importance of being vigilant as new tobacco products enter the market. Tobacco control programs can play a critical role in monitoring and tracking the trends of tobacco product marketing, use, and consequences, as these impacts can be quickly identified at the local level.

In December 2019, just a few short months after the peak of EVALI cases COVID-19, began to appear in Wuhan, China and quickly spread to the rest of the world. The available science shows that smokers are at increased risk of severe illness from the virus that causes COVID-19, including "being admitted to intensive care, requiring mechanical ventilation and suffering severe health consequences."[56,57] COVID-19 has since led to the deaths of hundreds of thousands of Americans.

Policy or System Change Strategies

The following policy and system change recommendations include the Tobacco Control Vaccine and Booster policies, as well as several cutting-edge endgame strategies.

Fund Comprehensive, Sustainable, and Well-Resourced State Tobacco Control Programs

Complex problems such as tobacco use require comprehensive and coordinated solutions. To help states plan and establish effective and efficient tobacco control programs based on a comprehensive review of the best knowledge and science available, CDC published *Best Practices for Comprehensive Tobacco Control Programs* in 1999, two subsequent updates in 2007 and 2014, and a series of six *Best Practices User Guides* between 2015 and 2021.[58]

For over 20 years the science has been clear and unwavering: statewide comprehensive tobacco control programs that are well-resourced and sustained over time are effective and cost-effective in preventing tobacco use initiation, eliminating exposure to secondhand smoke, increasing evidence-based tobacco treatment, and reducing or eliminating tobacco-attributable health disparities. A comprehensive statewide tobacco control program is a coordinated effort to establish smoke-free policies and social norms, prevent initiation of tobacco use, and promote quitting and help tobacco users quit. This comprehensive approach combines educational, clinical, regulatory, economic, and social strategies.[59]

Research has shown that the greatest impact occurs as a result of the synergy created when state/territorial and community interventions are combined with mass-reach health communication and cessation interventions supported by surveillance and evaluation systems and a strong infrastructure of efficient and effective administration and management.[60] In meta-analyses, comprehensive tobacco control programs are highly recommended based on the strongest evidence of effectiveness.[61]

In fact, the Community Preventive Services Task Force found that comprehensive programs are effective across diverse racial, ethnic, educational, and socioeconomic status groups.[62] In economic terms, the evidence confirms that comprehensive tobacco control programs are cost-effective, and that savings from averted healthcare costs exceed the costs of the interventions.

In contrast to these findings, state governments woefully underfund their tobacco control programs despite receiving massive amounts of annual revenue from tobacco taxes and tobacco lawsuit settlements with cigarette companies. In FY 2020, total annual smoking-caused health costs in the U.S. were $170 billion, and state revenues from tobacco were $27.2 billion, a gap of $142.8 billion. That same year, state tobacco prevention funding was a meager $739.7 million, or only 2.7% of total state tobacco revenue—far less than the 12% recommended by the CDC to achieve the greatest impact.[63]

State and territorial tobacco control programs typically receive federal funding from CDC and funding allocated by a state's legislature annually or biannually. Although CDC funding is fairly stable, unpredictable and dramatic shifts in tobacco program infrastructure and progress are possible as elected officials and political priorities change at the state/territorial level. However, in some states with a long history of sustainable funding, such as California, Colorado and Massachusetts, the tobacco control program is funded through a dedicated portion of a voter-approved tobacco tax increase. In Oklahoma and Florida, funding for the tobacco control program was secured through a voter-approved constitutional amendment and therefore, the funding cannot be changed without another vote of the people. In Minnesota, a 25-year tobacco control foundation was created as part of Minnesota's settlement with the tobacco industry.

Regardless of the mechanism for funding comprehensive tobacco control programs, support for these highly effective programs and their policy efforts may shift as the social, political, and economic environments shift. As a result, opinion leaders, policymakers, and the public must be educated continually about the importance of comprehensive tobacco control programs to the public's health and the need for adequate, sustainable funding.

Tobacco control programs and stakeholders are encouraged to seek or create opportunities to secure the most sustainable funding and partnerships available. The strong connections between tobacco use and maternal and child health, behavioral health, cancer, substance abuse, and other chronic health conditions provide strategic opportunities for partnerships and sustainability. State Medicaid beneficiaries are also disproportionately likely to use tobacco products, and the treatment of tobacco related illness results in approximately $68.3 billion of Medicaid payments annually.[64] Tobacco control programs should routinely build strong relationships and work collaboratively to secure funding that will advance the goals of each partner and enhance the impact for the populations they serve.

Tobacco control programs have played a critical role in addressing the recent EVALI and COVID-19 crises by providing data, monitoring developing trends, communicating the developing science, and assisting with policy development. Although these and other future public health emergencies can place a tremendous strain on state/territorial and local government budgets and workforces, tobacco control program funding must be preserved to minimize the harms to smokers and other tobacco users who are among the most physically and socially vulnerable Americans.

Policy Recommendation: Fund comprehensive, sustainable, and well-resourced state tobacco control programs consistent with CDC's Best Practices for Comprehensive Tobacco Control Programs—2014.

• Designate a portion of tobacco taxes, settlement payments, licensing fees, or other public funds for a comprehensive tobacco control program, including cessation and prevention programs for populations hardest hit by tobacco use.

• Partner with other health and public health organizations to leverage additional funds and expand the reach of tobacco control programs.

• Preserve tobacco control program funding during public health emergencies.

Increase the Price of Tobacco Products

Increasing the price of tobacco products has long been considered the single most effective means of reducing the initiation, prevalence, and intensity of smoking among both youth and adults.[65, 66] In fact, researchers who compared youth use just before and just after the federal cigarette tax increase in 2009 found that the tax led to at least 220,000 fewer middle and high school students taking up smoking.[67]

Strong evidence from numerous studies demonstrates that increasing the price of tobacco products:[68]

- Reduces initiation of tobacco use among young people.
- Reduces the prevalence of tobacco use.
- Reduces the total amount of tobacco consumed.
- Increases the number of tobacco users who quit.
- Reduces tobacco-related morbidity and mortality.
- Reduces tobacco-related disparities among different socioeconomic groups, and may reduce disparities by race and ethnicity.[69]

Numerous studies have also concluded that:

- A 10% increase in price has been estimated to reduce overall cigarette consumption by 3%–5%.[70]
- Youth and young adults are two to three times more likely to respond to increases in price than adults.
- Lower income populations are more likely to increase quit attempts or smoke fewer cigarettes in response to price increases. (However, it is important to note that due to inconsistent screening, counseling, and access to tobacco use, treatment successful cessation may not be consistent across all racial/ethnic groups.[71])

In response to rising tobacco taxes, tobacco companies have systematically employed a variety of strategies to minimize the loss of price-sensitive customers after a price increase.[72] Price-minimizing strategies often include offering multi-pack price discounts or coupons and providing products in different price tiers, including higher priced "premium" products and lower priced "discount products."[73] Therefore, TCN recommends a package of tax and non-tax policies to maintain a higher price on tobacco products to provide the greatest public health benefit.

Although the package of recommended policies below may include a suggested minimum dollar amount of a tax increase, tobacco control programs must consider that the value of any specific dollar amount will decrease over time and that each state or territory's social and political context—and tax code—is different. Each state or territory should assess the feasibility of any or all of the policies recommended and work with an attorney who is familiar with the jurisdiction's tax code to ensure that any tax is appropriately tailored to meet the policy goals.[74]

Taxes

The most common approach to increasing tobacco prices has been to increase state tobacco excise taxes. In fact, since Jan. 1, 2002, 48 states and Washington, D.C. have better than quadrupled the average state cigarette excise tax from 43.4 cents to $1.91 per pack as of December 2021.[75] Importantly, states have experienced significant declines in smoking among youth and adults during that same period.

As of December 2021, only 22 states, Washington, D.C., Puerto Rico, Northern Mariana Islands, and Guam have cigarette excise tax rates of $2.00 per pack or higher. Missouri currently has the lowest cigarette excise tax, at just 17 cents per pack, while Washington, D.C. has the highest, at $4.50 per pack.[76]

In light of the youth epidemic of e-cigarette use, the ever-changing tobacco product environment, and the fact that no e-cigarette tobacco product has been authorized for cessation purposes, no tobacco product should be treated more favorably than other tobacco products. All tobacco products should be taxed at high rates to disincentivize their use.[77]

The tax structure on tobacco products has become much more complex with the emergence of new tobacco products, such as e-cigarettes and heated tobacco products. In order to obtain the highest impact on price with the greatest consistency, it is necessary to consider taxes based on the types of tobacco products being addressed. The two major types of taxes are specific excise taxes (those imposed based on quantity or product characteristics) and ad valorem excise taxes (those imposed based on value).[78]

Specific taxes may be applied to products that are very similar, such as little cigars or combustible cigarettes, as these taxes can be levied on a specific quantity and apply to all brands equally. However, these taxes lose value over time and must be revisited in the future to maintain higher prices and the resulting public health benefit. Specific taxes also become problematic when applied to products that have significant differences within the product category, such as e-cigarettes.[79]

Ad valorem taxes may be more appropriate for e-cigarettes or other products that vary significantly, such as cigars, oral nicotine products, and snus. Ad valorem taxes help to avoid significant differences in the taxes applied by assessing the tax based on the value of the final product rather than each of its component parts. (For example, 5% of the retail price.) These taxes may also be more appropriate than an industry-favored weight-based tax for smokeless tobacco and new products such as snus, as weight-based taxes are likely to under-tax some of the very lightweight products.[80]

Ad valorem taxes also include an automatic adjustment for inflation and price increases, retaining their value over time. However, if the subsequent automatic adjustments are small, the consumer may not notice the difference at the point of sale, and the public health impact of those increases may be negligible. Another disadvantage to an ad valorem tax is that if the price of the product is low, the tax paid on that product will also be low.

In some cases, a combination of specific and ad valorem taxes may be most appropriate. For example, New Mexico imposes an ad valorem tax of 12.5% of the price to liquid intended to be used in an open system e-cigarette device and a specific tax of 50 cents per closed system single-use, pre-filled disposable cartridges containing five milliliters or less of e-liquid.[81] This helps to ensure an elevated price minimum on less expensive products.

Restrictions on Price Promotions and Coupon Redemption

Priority should be given to policies banning or restricting tobacco product price promotions and coupon redemption because research has shown that tobacco company price-minimizing strategies can create a price reduction great enough to negate the entire amount of some tax increases.[82] For example, when Louisiana's tax increased by 50 cents, the industry provided coupons valued at 50 cents. In Washington, D.C., the tax increased by $2.00 and the industry provided $2.00 coupons.

Research has also shown that:

- Tobacco company price-minimizing strategies may increase socioeconomic disparities in smoking and impact vulnerable populations. For example, lower income smokers are more likely to buy discount brands, while youth are less likely to use discount brands but more likely to use coupons or promotions.[83]
- People who accept these discounted products and offers make fewer cessation attempts and are less likely to reduce their smoking.

Minimum Price Laws

Minimum price laws (MPLs) prohibit tobacco wholesalers and retailers from selling cigarettes below cost, and about half of all states require a percent mark-up on prices.[84] However, research suggests this style of MPLs may not be very effective in raising prices.

An alternative approach is to set a flat rate floor price below which packs of cigarettes cannot be sold. Modeling suggests that these flat rate minimum price laws can reduce cigarette consumption by 67% more than corresponding taxes if the floor is set at or above the average pack price reported by smokers in that state. The floor price style of MPL may also reduce income-based smoking disparities by specifically targeting cheap prices reported by low-income smokers, especially if they are implemented in conjunction with other price policies and low-cost cessation services. It will be necessary to ensure that loopholes permitting discounts that would bring the sale price below the MPL are not permitted.[85] In addition, MPLs should be revisited every few years as inflation and tobacco prices increase. Legislation passed by Sonoma County, California, which established a minimum price floor of $7 per pack of cigarettes tied to tobacco retail licensure, offers an excellent case study on the passage and implementation of this type of policy.[86]

Minimum Pack Sizes

Currently there are no federal regulations on pack sizes for cigars, cigarillos, or other non-cigarette tobacco products. Products without minimum pack sizes can be sold at extremely low prices, making them attractive to price-sensitive smokers, including youth. However, states and territories and localities can establish minimum pack sizes, which may be most effective when paired with a minimum price. For example, in numerous localities in Massachusetts, a package of two cigars must cost more than $5.00 and a package of three must cost more than $7.50. In Boston and in three Minnesota cities, these regulations have resulted in higher average sales prices, fewer retailers selling single cigars, and a reduction in neighborhood-race- and income-based disparities in youth access to the products.[87]

Policy Recommendation: Increase the price of all tobacco products and revisit price increases regularly to ensure they keep pace with public health benefits. Tax new products at rates that are on par with cigarettes. Lower tax rates for products FDA determines to reduced risk should only be considered in the context of dual use and whether users will fully transition to those products. Designate a portion of any tax increases to tobacco control programs, including cessation and prevention programs for populations hardest hit by tobacco use.[88]

- To eliminate or reduce tobacco industry efforts to negate the impact of tobacco tax increases, enact a package of tax and non-tax policies, whenever possible.

- Enact price increases on all tobacco products in amounts substantial enough to have a meaningful impact on lowering tobacco use rates among people of all ages. (For example, $1–$3 dollars per pack of cigarettes.)
- Ensure that price increases encompass all products, including cigarettes, e-cigarettes, cigars, little cigars and cigarillos, heated tobacco, and smokeless/oral nicotine products, proportional to the average cigarette tax rates in each state or territory.
- Ban or enact restrictions on tobacco product price discounts and coupon redemption.
- Establish minimum "floor" prices for all tobacco products comparable across all product lines.
- Establish minimum pack sizes for cigars, cigarillos, and other tobacco products, such as oral nicotine products and snus.

> **Resources:**
> - Campaign for Tobacco-Free Kids—U.S. State Tobacco Taxes
> - Campaign for Tobacco-Free Kids—The Toll of Tobacco in the United States (Additional state-specific figures and modeling estimates are available by reaching out to factsheets@tobaccofreekids.org.)
> - Public Health Law Center—Taxation and Product Pricing
> - Counter Tobacco—Increasing Tobacco Prices Through Non-Tax Approaches

Eliminate Secondhand Smoke and Aerosol and Create Tobacco-Free Environments

Smoke-free laws and policies are among the most effective interventions promoted by comprehensive tobacco prevention and control programs to reduce heart disease, lung cancer, and stroke among nonsmokers and to increase tobacco cessation among smokers. The Health Consequences of Involuntary Exposure to Tobacco Smoke, a 2016 report of the surgeon general, noted that there is no risk-free level of exposure to secondhand smoke, and the only way to prevent exposure is by establishing smoke-free environments.[89, 90]

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.

As a result of smoke-free policies adopted over many years, for example, biochemical measures have shown that exposure to secondhand smoke steadily declined among adults from nearly 90% showing exposure between 1988-1991 to about 25% showing exposure from 2011-2012.[91] However, secondhand smoke still causes approximately 7,330 deaths from lung cancer and 33,950 deaths from heart disease annually. The home is the main place many children and adults breathe in secondhand smoke. In addition, in the U.S. about 2 in 5 children (including 7 in 10 black children) are exposed to secondhand smoke, mainly in the home.[92] Others left behind without protections are typically less educated and work in lower-paying, blue-collar, or hospitality industry jobs.

As of December 2021, 28 states and Washington, D.C. had comprehensive or 100% smoke-free laws covering workplaces, restaurants, and bars. At the same time, smoke-free laws in 36 states and Washington, D.C. covered workplaces and/or restaurants and/or bars and/or gambling venues, and 20 of these 36 state smoke-free laws, along with Washington, D.C., also cover e-cigarettes.[93] In today's complex environments, tobacco control professionals

must focus their efforts on disparities, such as those in blue-collar workplaces and low-income housing, and consider emissions from e-cigarettes and marijuana when promoting smoke-free policies to protect nonsmokers.

Smoke-Free Workplaces

As a result of successful efforts to eliminate secondhand smoke, most Americans are not affected by secondhand smoke at home, at work or in public places, and may therefore assume that secondhand smoke is no longer a problem. However, nearly 40% of U.S. workers are still exposed to secondhand smoke on the job.[94] The reality is that loopholes or exemptions in state/territorial and local laws have created health disparities by allowing smoking in restaurants, bars, casinos, and/or industries such as hospitality, construction, or manufacturing. Workers in these environments are often exposed to secondhand smoke at high levels, placing their health at risk.[95]

Importantly, unique challenges and opportunities exist for tobacco control professionals seeking to protect workers in casinos operated by tribal nations, where state and local governments do not have jurisdiction. Ideally, state tobacco control managers and staff will have well-established, strong relationships with tribal health and government partners through other collaborations before embarking on this path to create tobacco-free casinos.

In fact, the COVID-19 pandemic has provided an important opportunity to leverage the new smoke-free policies that many gaming venues, both commercial and tribal, adopted in order to comply with mask requirements and maintain a safer environment for workers and patrons. As of December 2021, 23 states required commercial casinos to be smoke-free, some as a condition to reopen after being closed to the public as part of statewide emergencies related to COVID-19.[96] As of December 2021, there were over 1,000 smoke-free casinos operating in the U.S., with a recent rise attributable to tribal casinos that adopted smoke-free policies to comply with mask requirements and protect their workers and patrons.[97] Tobacco control programs can explore partnerships with tribal health officials to leverage this opportunity by educating the public to expect smoke-free gaming venues and encouraging casinos to maintain their smoke-free policies. It is important to be ever-mindful that it is only through relationship-building, education, and support that sustainable smoke-free casinos will be achieved.

Smoke-free Homes and Vehicles

Smoking in homes and vehicles, among other places, continues to expose people to secondhand smoke, especially pregnant women, infants, and children. Secondhand smoke is a known cause of sudden infant death syndrome, low birth weight, and lung problems in infants. Children exposed to secondhand smoke at home have increased risk of bronchitis and pneumonia, and those with asthma may suffer with more frequent and more severe asthma attacks.[98]

People who live in multi-unit housing are especially vulnerable to secondhand smoke, which can travel through the building and into neighboring units through walls, hallways, ventilation systems, outlets, and gaps around fixtures.[99] Policies are needed to reduce secondhand smoke exposure in both public and private multi-unit housing environments.

Public Housing

Many states have accelerated work in public housing with the advent of the 2016 HUD rule prohibiting smoking in all public housing units and common areas. Efforts have included offering cessation support resources; providing technical assistance in maintaining compliance; expanding policies to include e-cigarette aerosols (and marijuana smoke or aerosols where marijuana is legalized); and making all grounds smoke-free/vape-free.

Affordable Housing

The federal Low Income Housing Tax Credit program requires each state agency that allocates tax credits, generally called a housing finance agency, to have a Qualified Allocation Plan (QAP).[100] States, and some local agencies, must develop this document in order to distribute federal Low Income Housing Tax Credits.[101] These tax credits can only be awarded to a building that fits the QAP's priorities and criteria. Each QAP must spell out a housing finance agency's (HFA's) priority and specify the criteria it will use to select projects competing for tax credits. The QAP provides an opportunity to advance smoke-free/vape-free housing policies by providing tax credits for these policies.

Private Multi-Unit Housing

Tobacco control programs can develop, track, and implement a voluntary, industry-led smoke-free/vape-free certification program that requires compliance through signage and the lease agreement, and is publicly marketed as smoke-free/vape-free.

E-Cigarette Aerosols and Secondhand Smoke Laws

The dramatic increase in e-cigarette use in recent years has given rise to growing concern about secondhand e-cigarette aerosol exposure, as well as the impact of e-cigarette use on enforcement of current secondhand smoke laws and regulations. E-cigarettes produce a dense visible aerosol of liquid sub-micron droplets consisting of glycols, nicotine, and other chemicals. Some of these chemicals are carcinogenic, such as formaldehyde; metals like cadmium, lead, and nickel; and nitrosamines.[102] Currently fewer than half of states have smoke-free laws that cover e-cigarettes.[103]

Mounting evidence has led the following organizations to recommend that e-cigarettes should not be used indoors and/or should be included in smoke-free laws:[104, 105]

- American Association for Cancer Research
- American Industrial Hygiene Association
- American Public Health Association
- American Society of Clinical Oncology
- American Society of Heating, Refrigerating, and Air Conditioning Engineers
- National Institute for Occupational Safety and Health
- U.S. Surgeon General
- World Health Organization

Marijuana Smoke and Smoke-Free Laws

Since the publication of the 2016 TCN Policy Recommendations Guide, the majority of states have legalized marijuana for medicinal and/or adult recreational use. However, marijuana smoke contains many of the same toxic chemicals as tobacco smoke.[106] In addition, since many of the same devices that deliver nicotine may also be used to deliver marijuana, this presents a complex problem for enforcement, and can send mixed signals to the public. As a result, it is important that tobacco control programs and stakeholders consider the inclusion of marijuana smoke and aerosols in smoke-free laws to provide the same protections as those for tobacco smoke or aerosols.

Unfortunately, even strong smoke-free laws, such as those in Berkeley, California, and Colorado, have recently been undermined or rolled back to increase the number of spaces where marijuana, and even tobacco, can be used indoors.

Opportunities for Leverage and Synergy

When addressing smoke-free laws, tobacco control professionals are encouraged to:

• Include 100% tobacco-free property policies, including outdoor areas, whenever possible. This is the preferred approach for most educational institutions, healthcare and behavioral health facilities, and government properties, as it helps denormalize tobacco use for impressionable youth and encourage recovery for people experiencing mental health and substance abuse disorders, among others.

• Expand the definition of tobacco products to include e-cigarettes, heated tobacco products, and other nicotine-containing products.[107] Also consider expanding the smoke-free law to include all substances that can be smoked or vaped, including marijuana, cannabidiol (CBD), and other substances.

• Offer and promote cessation support resources, such as a state or territorial tobacco quitline, in combination with efforts to advance smoke-free or tobacco-free policies.

• Be mindful of preemption. Repeal it where it exists, and guard against it in any new laws, and include a "savings clause" or explicit language in the law and policy allowing the lower governments to enact stronger policy regulations whenever possible.

Policy Recommendations: Enact comprehensive, 100% clean air laws, covering use of all tobacco products that produce smoke or aerosol, in all workplaces and public places. Whenever possible, include smoke and aerosol from marijuana in clean air laws, and enact 100% tobacco-free property policies, both indoor and outdoor.

A comprehensive law addressing smoke and aerosols across an entire state/territory, city, or county jurisdiction is the ultimate policy goal. However, if the environment does not yet support passage of a comprehensive policy, clean air policies and 100% tobacco-free environments should be pursued in the following environments to work toward a goal of a comprehensive policy:

• *Government buildings and property.* Prohibit the use of all tobacco products, including those which produce smoke or aerosol on government property, in government vehicles, and at all government-sponsored functions away from government property. This may be accomplished through a state/territorial or local law, or an executive order.

• *Educational properties*, to include K-12 facilities, colleges, and trade schools, as well as early learning and childcare centers.[108, 109] To prevent youth initiation to tobacco use, prohibit the use of all tobacco products by students, staff, and visitors on school property, in school vehicles, and at school-sponsored functions away from school property. This may be accomplished through a state/territorial or local law or by school board policy.

• *Healthcare and behavioral health facilities and properties*. Prohibit the use of all tobacco products in all indoor and outdoor areas.

• *Multi-unit housing, both public and private*. Prohibit the use of all tobacco products that produce smoke or aerosol in all units and attached balconies and patios. Focusing a prohibition on products that are smoked or aerosolized narrowly tailors the policy to products that pose a secondhand exposure risk to others in these spaces.

• *Cars and other enclosed vehicles*. Prohibit the use of all tobacco products that produce smoke or aerosol in order to eliminate exposure for children under 18.

• *Foster care homes and facilities*.

• *Other outdoor venues* in which people congregate, such as parks, beaches, farmer's markets, fairs, or sporting events, particularly in youth-sensitive areas, in order to denormalize tobacco use and protect the public from secondhand smoke exposure, fire hazards, and environmental harms resulting from toxic tobacco waste.

Limit Tobacco Product Availability and Accessibility

Prevention of youth tobacco use is the key to ending the tobacco epidemic. Tobacco use and addiction starts early in life and has implications throughout the lifespan. Among adults who smoke daily, almost 100% started smoking before 26 and 90% started smoking before 18.
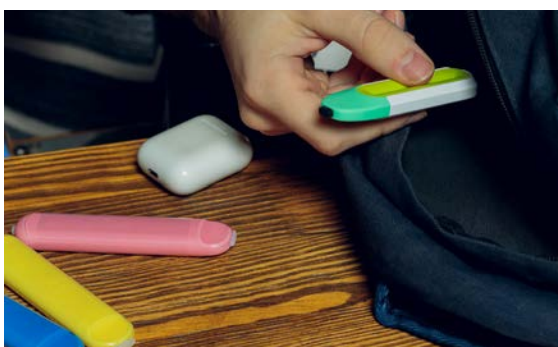
Youth are influenced to use tobacco products when they perceive it to be a normal part of everyday life among parents and peers and through marketing in stores, online, in movies, in magazines, and in other youth-oriented media channels. Coupled with high tobacco product prices and clean air laws, interventions that restrict the availability and accessibility of tobacco products are essential components of effective tobacco control programs to prevent and reduce youth tobacco use.

The innovative strategies focused on the tobacco retailer environment are a complement to, but not a replacement for, longstanding evidence-based components of the Tobacco Control Vaccine.[110] Please note that legal consultation tailored to the local legal and political environment is strongly advised when pursuing most of the policy strategies described below.

Prohibit the Sale of Flavored Tobacco Products, Including Menthol

Flavors increase the appeal of tobacco products to youth, promote youth initiation of tobacco products, and can result in lifelong tobacco product use. Eliminating the sale of all flavored tobacco products, including menthol flavored products, would address a number of tobacco-related health disparities among youth, African Americans, women, the LGBTQ community, and others.[111]

Youth are more likely than adults to initiate any tobacco product use with flavored tobacco products. The availability of products in appealing flavors is cited by youth as one of the main reasons for using e-cigarettes. In 2021, 84.7% of youth who currently use e-cigarettes reported using a flavored product, with fruit flavors being the most preferred flavor type across all different e-cigarette device types. In addition, mint and menthol flavors were used by 30.2% and 28.8% of youth e-cigarette users, respectively.[112]

As a result of targeted tobacco industry marketing, the majority of African Americans who smoke use menthol cigarettes, including 7 out of 10 African American youth. Menthol has also been found to increase nicotine dependence and impede tobacco cessation, especially among African American smokers. In addition, women, LGBTQ persons, adults with mental health conditions, and people with low levels of education are more likely to smoke menthol cigarettes than other cigarettes. According to 2019 National Survey on Drug Use and Health data, Native Hawaiians and Pacific Islanders use tobacco products at higher rates than Asian people (despite often being combined with Asians demographically in surveillance reports).[113] Among Native Hawaiian and Pacific Islander people who smoke cigarettes, approximately 53% prefer menthol cigarettes, a figure greater than other Asian American communities.[114, 115]

While fruit and candy flavored cigarettes were banned by the 2009 Family Smoking Prevention and Tobacco Control Act, it was not until 2020 that FDA removed fruit and candy flavored cartridge-based e-cigarettes, such as JUUL, from the market.[116] Menthol cigarettes and e-cigarettes were exempted from these bans and are still sold today despite FDA's April 2021 announcement that it intends to implement a rule prohibiting menthol cigarettes sometime in the future.[117] All flavors (including menthol, mint, fruit, candy, and others) are still allowed in cigars and refillable and disposable e-cigarettes as of December 2021. As of March 2022, Congress passed legislation enabling FDA to regulate synthetic nicotine products as tobacco products. This will require manufacturers of synthetic nicotine products (e.g., Puff Bar) to obtain FDA authorization to keep their products on the market.[118] The ongoing and widespread availability of flavored products continues to fuel the youth e-cigarette epidemic, and as noted previously, people shift their consumption to the products containing the flavors they want, including menthol and mint.[119]

All fruit, candy, mint, menthol, and other non-tobacco flavors should be banned to prevent youth from starting tobacco use. Menthol bans have been aggressively opposed by the tobacco industry. However, to advance health equity, they must be considered when addressing flavored tobacco products. For decades the tobacco industry has aggressively targeted the marketing of menthol to African Americans, youth, women, LGBTQ individuals, and low-income populations, which has led to widening health disparities. Menthol's cool, minty flavor helps mask the harshness of the smoke, making it easier to start smoking and more difficult to quit.

According to FDA:

- More than 19.5 million people are current smokers of menthol cigarettes.
- Currently, 85.8% of African American smokers, 46% of Hispanic smokers, 39% of Asian smokers, and 28.7% of White smokers smoke menthol cigarettes.
- Youth who smoke are more likely than older smokers to smoke menthol cigarettes. More than half of smokers ages 12-17 smoke menthol cigarettes.[120]

FDA's Tobacco Products Scientific Advisory Committee concluded in 2011 that the removal of menthol cigarettes from the marketplace "would benefit public health in the United States."[121] However, menthol was not included in FDA's 2020 ban on the sale of flavored refillable or disposable e-cigarettes. It was not until April 2021 that FDA announced it would work toward issuing proposed product standards "within the next year to ban menthol as a characterizing flavor in cigarettes and ban all characterizing flavors (including menthol) in cigars."[122]

As of December 2021, at least 335 local communities in the U.S. currently prohibit the sale of flavored tobacco products, at least 145 of which prohibit the sale of menthol cigarettes in addition to other flavored products.[123] In 2019, Massachusetts became the first state to end the sale of all flavored tobacco products, including flavored e-cigarettes, menthol cigarettes and flavored cigars. California adopted a policy to end the sale of all flavored tobacco products in 2020, and implementation was set to take effect Jan. 1, 2021. A referendum petition has since been submitted to challenge the law, effectively delaying the implementation for two years, until after a vote on the November 2022 ballot will either recall or confirm the law.[124,125]

Limit the Number, Density, and Location of Tobacco Retailers[126]

The number, density, and location of tobacco retail outlets have an impact on youth smoking, successful cessation, and tobacco use disparities among African American, Hispanic, or low-income populations. Research demonstrates that tobacco retailer density is greater in areas with higher proportions of households receiving public assistance, as well as counties with a higher proportion of African American residents, same-sex couples, and rural residents.[127] Reducing the number of tobacco outlets can be accomplished through licensing, zoning and land use, or direct regulation, and may include:

- Prohibiting sales near youth-populated areas, such as schools, parks, playgrounds, and childcare facilities, by implementing "tobacco-free zones."
- Prohibiting clusters of tobacco retail outlets operating within a certain distance of each other, an approach commonly used in alcohol control.
- Limiting the total number of tobacco retailers permitted to operate in a defined geographic area, or setting a maximum number of tobacco outlets proportional to population size. (However, limiting the overall number of tobacco outlets in a city or county may not reduce disparities related to the density of retailers in particular neighborhoods and should be considered in combination with other policies such as those limiting tobacco outlet density.)

One note of caution: City councils and county boards sometimes make zoning exemptions for business development or economic expansion reasons, and these should be opposed. For example, a community may cap tobacco licenses, but when a new grocery store wants to build in the community and wants to sell tobacco, the city may grant an exemption in order to attract new business.

Retail Licensing
State and local governments can require retailers to obtain and maintain a license, which is subject to conditions of operation, such as age verification at purchase. Licenses can be suspended or revoked if the retailer does not comply with the conditions of operation, and licensing fees can be allocated to fund enforcement efforts.

Implementation of a comprehensive tobacco retail license will:

- Establish a comprehensive list of all retailers of nicotine and tobacco products in the jurisdiction.
- Fund enforcement of tobacco sales regulations at no cost to the taxpayer.
- Prevent illegal sales of nicotine and tobacco products.
- Provide weight to current sales laws by imposing a threat of suspension for repeated violations.
- Reduce productivity loss, health insurance costs (including Medicaid-related costs), tobacco-related illness, and death.
- Advance public health through prevention and, as part of a comprehensive point of sale strategy, substantially increase health equity.[128]

Zoning and Land Use
While licensing generally regulates the operation of a business, zoning and land use laws regulate the use of the property. Zoning can be effective in reducing retailer density, particularly for new businesses, but it may be difficult to use zoning to regulate existing businesses, and zoning regulations do not typically include a funding stream to cover enforcement costs. Zoning has traditionally been considered a core function of local government and, as a result, is less likely to be preempted by state law.

Prohibiting Tobacco Sales in Specific Types of Stores
Communities can also enact direct laws to regulate tobacco outlet density; for example, communities can prohibit tobacco sales in pharmacies. Selling tobacco in pharmacies sends a mixed message to consumers about the dangers of tobacco products, makes it harder for

people who smoke to quit, and is a conflict of interest for pharmacists.[129] A 2014 survey found that two-thirds of Americans, including nearly half of people who smoke, would support a ban on tobacco sales in pharmacies.[130] In 2014, San Francisco used a combined approach of prohibiting tobacco sales in pharmacies and changing its tobacco retail licensing law to reduce retailer density.

Studies of tobacco sales in pharmacies found that pharmacies charge less for cigarettes than other stores, and that prohibiting tobacco sales in pharmacies would substantially reduce the number and density of tobacco retail outlets.[131, 132] Further, eliminating tobacco sales in pharmacies can encourage tobacco users to quit. During the two years after CVS Pharmacy stopped selling tobacco in its stores, quit attempts increased among smokers in counties with a high density of CVS Pharmacy stores compared to smokers who lived in an area with no CVS Pharmacy stores.[133]

It is important to note the potential impact on health disparities when pursuing tobacco-free pharmacies. In 2018, New York City implemented a tobacco-free pharmacy law, and an examination of the policy found an overall reduction in retailer density, but greater declines in neighborhoods with higher median household incomes and a higher proportion of non-Hispanic White residents.[134] Because pharmacy-based reduction strategies are important for social norm change and reducing access and exposure to tobacco products, but have demonstrated inequitable impacts, they may be most impactful when adopted in conjunction with other retail policies.[135]

Prohibit Internet Sales and Delivery of All Tobacco Products.
To adequately prevent and reduce youth tobacco use, tobacco product sales from online and app-based delivery-on-demand sources must be regulated. Online sellers are not subject to many of the regulations designed to prevent community-based retailers from selling tobacco to minors, and because of the virtual environment involved in these sales, youth are easily able to circumvent online age verification techniques.

In the absence of federal regulation, states/territories and localities have attempted a variety of strategies to restrict internet sales. However, state/territorial and local governments have faced significant legal challenges, and as a result, the Public Health Law Center suggests that "a complete prohibition on all internet sales of tobacco products appears to be the most effective way to substantially prevent such sales and protect the public health gains accomplished by age-of-sale laws."[136]

In 2019, San Francisco completely banned internet sales of e-cigarettes and prohibited internet-based businesses from shipping or delivering flavored tobacco products and e-cigarettes to San Francisco residents. In addition, during the COVID-19 pandemic, governors in California, Colorado, Minnesota, and New York issued executive orders prohibiting the online sale and delivery of tobacco products. Tobacco control programs are encouraged to help state/territorial and local officials enact similar important protections during a public health emergency.

Raise the Minimum Legal Sale Age for All Tobacco Products to at Least 21 and Consider Raising the Minimum Age of Retail Sales Clerks to 21
Raising the MLSA limits underage youth from accessing tobacco products from their older classmates at school and in other social circles and reduces successful purchases in retail outlets.[137]

On Dec. 20, 2019, Congress raised the federal MLSA for tobacco products from 18 to 21 years. This legislation, known as Tobacco 21 or T21, became effective immediately. It is now illegal for all retail establishments and people in all states, Washington, D.C., all U.S. territories, and all tribal lands to sell any tobacco product—including cigarettes, cigars, and e-cigarettes—to anyone younger than 21. There is no exemption in the federal law for active-duty military personnel or military veterans between the ages of 18 and 20 years, as had previously existed in some states.

The federal T21 law does not preclude state, local, tribal, or territorial governments from passing a law that that is more restrictive than the federal law, including raising the MLSA for tobacco products above 21 years. States, territories, tribes, and many communities are encouraged to raise their MLSA to age 21 (or higher) and continue enforcing their own laws and imposing their own penalties for violations. Retailers in jurisdictions that have not raised their MLSA to 21 years must still comply with the federal T21 law. State exemptions (e.g., military exemptions) do not override the applicability of federal requirements in states.

Cities, and states that passed T21 laws prior to passage of the federal law experienced substantial reductions in youth smoking rates; in some cases, the rates were cut in half. For example, in 2015, Hawaii became the first state to raise the MLSA for tobacco to 21.[138, 139] Hawaii then observed a sales decrease in cigarettes, cigars, and cigarillos.[140] An evaluation of California's Tobacco 21 law using youth decoys under age 18 found that the retailer violation rate decreased from 10.3% before the law was in effect to 5.7% afterwards.[141]

With the passage of the federal T21 law, there have been corresponding updates to the Synar program, which is the federal requirement that state enforce policies that prohibit the sale and distribution of tobacco products to underage consumers. To receive their substance abuse block grant funds, states and territories must now report on illegal sales to people younger than age 21, regardless of whether they have raised their own MLSA to 21. States with an MLSA of 18 or 19 may need to amend their laws to enforce their own laws to comply with the Synar requirements.[142]

Although there is no mandate that states and territories with an MLSA of 18 or 19 amend their laws to conform to federal law or to enforce their own laws to comply with the Synar requirements, it may be easier and more efficient for states and territories that have increased their MLSA to 21 years to ensure compliance with Synar requirements. For example, in jurisdictions where the state and federal MLSA are aligned, there is more clarity for retailers and enforcement officials. Data gathered in connection with enforcing state youth access laws can also be used for Synar compliance. Jurisdictions may also want to raise their MLSA to complement FDA's enforcement activities, and may consider adopting retailer licensing laws to help enforce their laws.

Cities and states/territories may also consider raising the age of tobacco retail sales clerks to 21, as underage youth are far more likely to successfully purchase tobacco products from underage clerks than from clerks of legal age. However, the benefits of this policy must be weighed against the possibility of limiting job opportunities for young people. One option to mitigate this may be to require retailers that have repeatedly violated the law to hire only clerks aged 21 or older.[143]

Eliminate Purchase, Use, or Possession Laws

For decades, the tobacco industry has successfully lobbied for youth purchase, use, or possession (PUP) laws to deflect attention for underage sales away from the retailers, where the responsibility rightfully belongs, to the youth who use tobacco products. Doing so has never proven to be an effective strategy in reducing youth tobacco use and needlessly penalizes and criminalizes youth, particularly youth of color. Studies have shown that PUP laws are four times more likely to be enforced than the laws prohibiting retailers from selling

to underage youth.[144, 145] Such laws may also place young people, particularly people from communities of color, in the pathway of law enforcement unnecessarily. This is a concern not only with respect to potential enforcement actions but also because such laws represent an unnecessary entry point into the criminal justice system, with long-term equity ramifications.

When considering policies to restrict the availability and accessibility of tobacco products, tobacco control programs and stakeholders should guard against new PUP laws and leverage opportunities to repeal existing PUP laws.

Policy Recommendations: Enact laws that restrict the availability and accessibility of tobacco products.

- Prohibit the sale of flavored tobacco products, including menthol.
- Limit the number, density, and location of tobacco retailers through retail licensing, zoning, and prohibiting sales in specific types of stores.
- Prohibit internet sales of tobacco products.
- Raise the MLSA for all tobacco products to 21 and consider increasing the minimum retail sales clerk age to 21.
- Roll back PUP laws whenever possible
- During public health emergencies, consider policies that limit tobacco product availability and accessibility.

Resources:
- Campaign for Tobacco Free Kids—Tobacco 21: Model Policy
- CDC—Summary of Scientific Evidence: Tobacco Retail Density, Location, and Licensure, April 2021
- Public Health Law Center—Location, Location, Location: Tobacco & E-Cig Point Of Sale
- Public Health Law Center—Retail Policy and Licensure
- Public Health Law Center—Tobacco Retail Licensing Calculator
- Tobacco 21—Tobacco Retail Licensing: An Essential Tool to Reduce Youth Usage and Foster Health Equity

Expand Availability and Increase Use of Tobacco Cessation Treatment

Population-based policy interventions such as tobacco price increases or clean air policies are a great bargain because they are both highly effective in preventing young people from ever starting to use tobacco and motivating people of all ages who use tobacco to quit. In addition, encouraging and helping tobacco users to quit is also the quickest approach to reducing tobacco-related disease, death, and healthcare costs.[146]

Combining population-based policy interventions with culturally appropriate clinical and health systems policy and procedural changes can increase the impact of all policy interventions and help to counter concerns that some policies may be punitive to those who are addicted to tobacco products. Together these interventions can prevent young people from entering the tobacco addiction pipeline and ensure that when tobacco users of any age are ready to make a quit attempt, they will have access to state-of-the art cessation treatment to increase their chances of quitting successfully.

A focus on clinical and health systems interventions is necessary because:

• Barrier-free insurance coverage for tobacco use treatment is not consistently available.
• Less than one in three smokers who make a quit attempt each year make use of proven treatments, including behavioral counseling or FDA-approved cessation medications.
• Nearly half of adult cigarette smokers who saw a health professional did not receive advice to quit, and barrier-free insurance coverage for tobacco use treatment is not consistently available.[147]

Tobacco cessation policy and systems interventions are also necessary to help narrow the gap in disparities that persist in cessation behaviors across certain population subgroups, defined by educational attainment, poverty status, age, health insurance status, race/ethnicity, and geography.[148]

For example:

• People with mental health disorders are more likely to have stressful living conditions, have low annual household income, and lack access to health insurance, healthcare, and help in quitting, but fewer than half of mental health and substance use disorder treatment facilities in the United States offer evidence-based tobacco cessation treatments.[149]
• Medicaid covers some of the most vulnerable groups in society, including poor families, low-income pregnant women, and people with disabilities. However, 49 states still have barriers for Medicaid enrollees to access tobacco cessation treatment. One notable study showed that Medicaid enrollees in Medicaid expansion states are utilizing tobacco cessation treatment at a higher rate than their peers in non-expansion states.[150]
• Studies have found that African American smokers are significantly less likely than White smokers to receive cessation advice from healthcare providers.[151,152,153,154] Such advice is especially needed by African American smokers because they have lower smoking quit rates than White smokers and suffer disproportionately from tobacco-related diseases.[155,156,157] Despite making more quit attempts, African Americans are less successful at quitting than White and Hispanic cigarette smokers, possibly because of lower utilization of cessation treatments and also the more addictive nature of menthol cigarettes compared to unflavored cigarettes.[158,159]

The following clinical and health system policy priorities have been identified to increase the availability and accessibility of tobacco cessation treatment:

• Barrier-free comprehensive tobacco cessation insurance coverage.
• Integrating tobacco use screening and treatment into routine care, including in behavioral health settings.
• Increasing availability and access to evidence-based cessation treatment assistance for youth.
• Increasing availability and access to culturally-specific cessation treatment options relevant to racially, ethnically and/or sexual orientation diverse populations.
• Cost-sharing partnerships that expand state and territorial quitline capacity and reach.

Provide Barrier-Free Comprehensive Tobacco Cessation Insurance Benefits

Comprehensive tobacco cessation benefits should be provided by Medicaid, Medicare, private or employer-sponsored insurance, and large self-insured employers, including the state as an employer. Benefits should require routine screening for tobacco use and allow a minimum of two cessation treatments per year that include:

• At least four cessation counseling sessions, which the participant may attend in person or by telephone and individually or in a group, as they prefer.
• A 90-day treatment regimen of any FDA-approved tobacco cessation drug without a prior authorization requirement or copay.

Establish Health Systems Interventions

In addition to promoting tobacco-free policies, tobacco control programs should encourage the integration of tobacco treatment into routine, culturally-sensitive clinical care within clinical health settings, including behavioral health, and support referrals to tobacco quitlines or other cessation services. In addition, strategies that remove cost and other barriers to access proven cessation treatments have been shown to increase the delivery and utilization of tobacco cessation treatment, especially when the covered treatments are proactively promoted to health plan beneficiaries. As mentioned earlier, these health system settings should be covered by comprehensive clean indoor air policies to promote tobacco-free living for clients and staff alike.

Actions taken at the clinical and health system levels include policies that transform systems of care (including integrating prompts and reminders in electronic health records) to better address tobacco use and dependence; promote evidence-based treatments for tobacco cessation; and implement policies that are clinically focused, address health insurance coverage, and promote cessation.

Provide Hospital Community Benefit and Tobacco Cessation

Another important opportunity to advance health systems interventions and state and local policy interventions is through partnerships with nonprofit hospitals. Under the Affordable Care Act, hospitals are required to conduct community health needs assessments and implementation plans every three years. Hospitals must publish their needs assessments on their websites. IRS regulations make it clear that hospitals must work with either state/territorial or local health departments. Tobacco control programs can partner with and provide support to hospitals who are integrating tobacco issues into their needs assessments and implement health systems interventions and effective tobacco control policies through their implementation plans.

Foster Youth Tobacco Cessation

According to the 2020 Surgeon General's Report on Smoking Cessation, far less is known about how to help youth quit compared with how to help adults, and use of effective cessation strategies is lower among youth than adults. The 2008 update to the Clinical Practice Guideline Treating Tobacco Use and Dependence found that counseling has been shown to be effective in treating adolescent smokers and recommended that adolescents be provided with counseling interventions to help them quit smoking. However, the guideline also found that, although medications have been shown to be safe in adolescents, there was little evidence that these medications were effective in promoting long-term smoking abstinence among adolescent smokers, and medication was not recommended at that time.

Although a great deal of research is needed to more fully understand the best approaches to helping youth quit tobacco, state tobacco control programs are encouraged to support cessation policies that address youth cessation, particularly in light of the e-cigarette epidemic among youth. Such policies include working with insurers to require screening for tobacco use and advice to quit and making barrier-free cessation services, including quitline services, available to youth—many of the same cessation policies that apply to adult use.

In addition, tobacco control programs are encouraged to support policies that include cessation in alternative-to-suspension programs in the school setting, including when students are attending school-sponsored events off campus, and to support research and funding for research on youth cessation interventions as outlined by the U.S. Preventive Services Task Force.[160]

Explore Cost-Sharing Partnerships to Expand Quitline Capacity and Reach

Tobacco cessation quitlines play an important role in population-level strategies designed to produce lasting changes in environments, health systems, and social norms that motivate people who use tobacco products to quit and make it easier for them to succeed in quitting. Promoting state quitlines during policy change communicates support to tobacco users and sends the message that quitting is possible and proven treatments are available to help.

Quitlines increase quit rates among individuals who use tobacco and are trying to quit, reach a large number of people who smoke, and are effective among diverse populations.[161] State and territorial quitlines are available in all 50 states, Washington, D.C., Puerto Rico, and Guam. Anyone in the U.S. can dial 1-800-QUIT-NOW to be seamlessly routed to a quitline, and most states offer access to services through the internet, email programs, and text messaging. Some quitlines have begun to offer mobile applications and other digital technologies as the science advances in these approaches.

However, quitline funding levels vary greatly among states and territories and, as a result, the number of people who may be served also varies considerably. To enhance quitline sustainability and expand their reach and capacity, tobacco control programs are encouraged to support policies that result in cost-sharing partnerships that provide or reimburse the cost of barrier-free quitline services.

Policy Recommendations: Enact laws and health systems policies that expand accessibility and increase use of effective tobacco cessation interventions.

- Require a comprehensive, barrier-free tobacco cessation benefit across payer types.
- Integrate tobacco treatment systems change within all types of healthcare settings, including behavioral health. Such policies may:
  » Require health facilities, including behavioral health facilities, to be tobacco free, screen for tobacco use, and integrate tobacco dependence treatment into routine care, including care provided via telehealth.
  » Implement quality measures that require providers to engage patients in cessation.25
  » Encourage health systems to select tobacco-specific quality improvement metrics, such as through the alternative payment models outlined in the Medicaid Access and CHIP Reauthorization Act.
  » Establish statewide standing orders for tobacco cessation medications to reduce the need for individual prescriptions. (At the state level, standing orders are most often signed by a Medicaid authorized physician within a state/territorial public health department or other state/territorial agency and can be carried out by the pharmacist when predetermined conditions have been met.)
  » Allow pharmacists to prescribe tobacco cessation medications.
  » Expand the types of healthcare professionals (such as certified tobacco treatment specialists) allowed to bill Medicaid or other insurers for tobacco cessation counseling.
  » Increase availability and accessibility of tobacco cessation for youth, including cessation for e-cigarettes.
  » Require clinicians to screen youth for tobacco use, including e-cigarettes, and provide advice to quit.
  » Make barrier-free cessation services available to youth.
  » Include tobacco cessation for youth as an alternative to suspension in school settings.
  » Create public-private partnerships to promote quitting, maximize quitline funding, and expand reach.

» Establish or expand cost-sharing agreements for quitline counseling and medications with Medicaid, managed care organizations, federally qualified health centers, large self-insured employers (including the state/territory as an employer), local governments, and private insurers.

» Work with the state Medicaid agency to require Medicaid managed care organizations to provide or contract for evidence-based quitline services for their members, including members with behavioral health conditions.

» Work with nonprofit hospitals to integrate tobacco control health systems change and policy measures into community health needs assessments and community health needs assessment improvement plans.

Resources:
- Million Hearts—Tobacco Cessation: Change Package
- CDC—Clinical Cessation Tools
- American Lung Association—Tobacco Cessation and Quality Measures: An Overview
- American Lung Association—What is a Comprehensive Tobacco Cessation Benefit?
- American Lung Association—Hospital Community Benefit and Tobacco Cessation Toolkit
- National Council for Mental Wellbeing —Identifying and Addressing Health Disparities Related to Tobacco Use Among Individuals with Mental Health and Substance Use Disorders: An Implementation Toolkit for Statewide Tobacco Control Programs
- Smoking Cessation Leadership Center—Behavioral Health Toolkits
- National Association of State Mental Health Directors—Policy Statement on Tobacco Cessation in all Behavioral Health Settings
- North American Quitline Consortium—Sustainability and Cost-Sharing

Limit Tobacco Marketing and Advertising

In addition to policy interventions to reduce the availability and accessibility of tobacco products, two noteworthy strategies provide additional avenues for restricting the marketing and advertising of tobacco products: (1) assurances of voluntary compliance agreements between retailers and state attorneys general, and (2) content neutral advertising restrictions.

Assurances of Voluntary Compliance

The 1998 Master Settlement Agreement, and settlements between individual states and the tobacco industry, prohibit certain tobacco marketing practices (such as cartoon advertisements, brand name merchandise, and billboards and other outdoor advertising). However, these prohibitions do not address other forms of tobacco marketing practices and the public health risk they pose, including all marketing of e-cigarettes, heated tobacco products, and other newer products.[162] An assurance of voluntary compliance (AVC) agreement can include additional restrictions, and may result in a greater public health impact.

An AVC is a legally binding agreement between a state attorney general and an individual or business that the attorney general believes has violated consumer protection law or may do so in the future. Tobacco-related AVCs are typically drawn up between a state attorney general and large national retailer chains as part of the ongoing multistate tobacco enforcement effort among state attorneys general. These AVCs limit the type and location of tobacco advertising permitted in retail stores and include provisions to address issues such as advertising, candy

cigarettes and other tobacco look-alike products, cash registers and other equipment used to verify age, franchises, monitoring and enforcement programs, hiring policies, placement of products within the store, sales restrictions, and training policies.

State and territorial tobacco control programs can work with the state attorney general's office to provide data, research, and other information that may aid in lawsuits or AVCs in response to investigations of settlement agreement violations. If a violation of an AVC occurs, the violating company could be held in contempt of court and ordered to pay for any monetary restitution, attorney fees, and penalties related to violating the agreements.

Content Neutral Advertising

A government can take two approaches in restricting advertising: (1) restrict all advertising without regard to its content, or (2) restrict the content, messages, or imagery within the advertisements. Restricting all advertising regardless of what the advertising says is often referred to as a content-neutral restriction. Content neutral advertising restrictions are generally placed at the point of sale for quality of life, aesthetic reasons, and safety concerns, such as increasing the visibility of parking lots, entrances, and the cash register/safe area.[163]

For example, California law states that no more than 33% of windows and doors of an alcohol retailer may have signs of any sort (including tobacco-related signs), and many jurisdictions have policies that restrict advertising of all types to 33% of window space in tobacco retail stores.[164]

A few of the ways in which state and local governments can limit advertisements without addressing content issues include restricting the size, location, type, and/or number of advertisements. Content neutral advertising restrictions are not as likely to face legal challenges for restriction of commercial speech as are restrictions that affect the content of the advertisements.

Policy Recommendations: Based on a state or territory's policy environment, a tobacco control program may wish to:

- Enact advertising restrictions on the size, location, type, and/or number of advertisements in retail outlets, regardless of content.
- Work with the state attorney general's office to address tobacco marketing to youth, learn which retail chains have entered into AVCs, and collect and communicate in-store assessment data.

Advance Endgame and Cutting-Edge Strategies for a Tobacco-Free Future

State/territorial and local tobacco control programs are often the first to identify new tobacco products, marketing practices, and tobacco industry-influenced policies. They are also uniquely positioned to drive new policies to end cigarette sales and create a tobacco-free future.

Ban the Sale of All Tobacco Products or an Entire Class of Tobacco Products

One example of an emerging endgame strategy is to prohibit the sale of all tobacco products, or to prohibit the sale of an entire class of tobacco products (e.g., cigarettes), to all consumers in a jurisdiction. The California jurisdictions of Beverly Hills and Manhattan Beach became the first two in the nation to implement such a policy, which prohibited the sale of all commercial tobacco products from virtually all retailers starting in 2020. Both policies have minor exemptions; the Beverly Hills policy exempts existing cigar lounges and hotels selling to guests, while the Manhattan Beach policy allows temporary exemptions in cases of financial hardship to retailers.[165,166] In localities where such a comprehensive policy might not be politically viable, prohibiting the sale of an entire class of products is also a policy option to consider.

A variation on this policy is the tobacco-free generation policy, which prohibits the sale of all tobacco products to consumers born after a certain year. The purpose of this policy is to encourage tobacco-free living among the next generations of a given jurisdiction, typically starting with present day youth and young adults. Brookline, Massachusetts became the first jurisdiction in the nation to have such a policy in effect after a locally adopted bill was approved by Massachusetts Attorney General Maura Healy in July 2021. Brookline's policy prohibits the sale of all tobacco products to any consumer born in the year 2000 or later.[167]

The caution against purchase, use, and possession (PUP) laws in the enforcement of Tobacco 21 policies also applies here: these policies should be worded to exclusively regulate the conduct of retailers, not tobacco consumers. Additionally, all of these policies should ideally be accompanied by increased investments in evidence-based tobacco cessation treatments to give tobacco consumers a more accessible offramp from tobacco use as their tobacco product(s) of choice are no longer available for sale locally.

Prohibit the Sale of Tobacco Products Above a Certain Nicotine Concentration

Another example of a cutting-edge tobacco policy strategy is prohibiting the sale of tobacco products above a certain nicotine concentration. For example, administrative rules in the state of Utah that took effect in September 2021 prohibit the sale of sealed e-cigarette products that exceed a nicotine concentration of 36 mg/mL or a weight of 3% of the container.[168]

It is important to note that all of these state and local laws are intended to prohibit the sale of products based on their characteristics as an end product to the consumer, and are not an attempt to set tobacco product standards or regulate the content or manufacturing of tobacco products.[169] States/territories and localities are preempted from adopting product standard and manufacturing regulations, which remain exclusively under the authority of FDA and Congress. According to a law review article on the topic, "how a thing is made and whether or where it can be sold are entirely different issues, in theory and as a matter of fact."[140]

A note of caution: jurisdictions considering enacting these cutting-edge policies must be ready to invest significant resources to educate the community, obtain legal consultation to carefully draft language to avoid potential legal battles, and combat vocal opposition and efforts to repeal the new restrictions. Despite these efforts, states should be prepared for possible legal challenges from the tobacco industry and their partner organizations. Additionally, jurisdictions should ensure that cutting-edge policies don't forfeit the opportunity to respond to the needs of people who are in the most disadvantaged position. Prohibiting flavors, couponing, and other industry marketing practices that prey on children and communities of color can serve as steps in the process toward a 100% prohibition on the sale of all tobacco products. Where the disparity is great, so should the urgent response to act while we work to end the sale of tobacco for everyone.

Policy Recommendation: Enact policies to reduce the use of the most harmful tobacco products and end the tobacco epidemic.

- Prohibit the sale of all tobacco products or an entire class of tobacco products, such as all cigarettes, all smokeless tobacco products, all cigars, all pipe tobacco, and all roll-your-own tobacco products. (These prohibitions can apply to all consumers or to consumers born after a certain year.)
- Restrict the sale of tobacco products above a certain nicotine concentration.

Tobacco Waste Strategies for a Tobacco-Free Future

Toxic cigarette litter remains commonplace throughout the U.S., and cigarette filters (or "butts") make up 30%-40% of all urban and coastal litter collected worldwide. Cigarette butts are made of the plastic material cellulose acetate, which does not biodegrade but instead breaks down into microplastics, moving deeper into the food chain and water supply.

The e-cigarette epidemic among youth has brought renewed attention to the harms of tobacco product waste. Liquid nicotine was classified by EPA as hazardous waste in 1980 because it is a highly toxic pesticide that can kill or seriously injure with a single dose. Between 2012 and 2015, after e-cigarettes entered the market, the National Poison Data System recorded a 1,500% increase in nicotine poisonings of children under the age of 6, and one documented nicotine-caused death in 2014.[170] EPA confirmed in 2015 that e-liquid and e-cigarettes are hazardous waste and reaffirmed that decision in 2019 after the tobacco industry asked EPA to reclassify them.

Policy Recommendation: Enact tobacco waste policies to prevent, reduce, and mitigate the damage of hazardous tobacco product waste on health and the environment. Tobacco control programs can collaborate with state hazardous waste programs to:

- Prohibit the sale of single-use plastic tobacco products.
- Require tobacco retailers to collect or pay a hazardous waste disposal fee per e-liquid/ prefilled electronic cigarette product they sell or intend to sell.
- Require tobacco retailers to pay litter mitigation fees.

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 the U.S. billions of dollars each year. States and territories and localities must take bold steps to promote additional progress in the face of an aggressive, predatory tobacco industry. Based on evidence and research, we know what works to reduce tobacco use rates, and we also know that the majority of the Americans don't trust the tobacco industry and favor policy actions to reduce tobacco use.

Comprehensive, multi-pronged policies will have wide-ranging impact on multiple populations, especially those disproportionately affected by tobacco use. 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. These proven policy approaches also require tobacco control partners to simultaneously monitor emerging issues and develop innovative approaches to address them. We urge public health leaders to find renewed inspiration and ideas in these recommendations to continue working toward a tobacco-free United States.

Definitions

Best Practices Continuum (adapted)[171]

- **A cutting-edge practice** is an innovative solution to a public health problem that has shown early signs of success and a commitment to evaluation.
- **An emerging practice** is based on characteristics, indicators, guidelines, standards, or practices that have been proven to lead to effective public health outcomes.
- **A promising practice** has strong quantitative and qualitative data showing positive outcomes but does not yet have enough research or replication to support generalizable positive public health outcomes. It incorporates a process of continual quality improvement.
- **A best practice** results from a rigorous process of peer review and evaluation that indicates effectiveness in improving public health outcomes for a target population. A best practice has been substantiated by experts, is replicable, and clearly links positive effects to the program/practice and not to other external factors.

Tobacco: Any product made or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product.[172] (**Note:** All references to "tobacco" in this document refer to commercial tobacco products and do not refer to the sacred or ceremonial use of tobacco.)

Policy: A law, regulation, procedure, administrative action, incentive, or voluntary practice of governments and other institutions.[173] Policy decisions are frequently reflected in resource allocations.
"Comprehensive Smoke-Free" and "100% Smoke-Free" Policies: "Comprehensive smoke-free" policies include all workplaces, restaurants, bars, gambling venues, and hotels. Smoke-free policies are considered to be "100%" when they include e-cigarettes and have no exemptions for separately ventilated rooms or for size, age, or hours.[174]

Comprehensive Smoking Cessation Coverage: This coverage includes all FDA approved cessation medications, both over the counter and prescription, as well as individual, group, phone, and online counseling.[175] Medications and counseling should be provided without limits on duration or attempts or costs, and without barriers like prior authorization, co-payments, or stepped-care therapy, and individuals shouldn't require counseling in order to receive medications.

Preemption: Preemption occurs when, by legislative or regulatory action, a "higher" level of government (state/territorial or federal) eliminates or reduces the authority of a "lower" level over a given issue.

- **Express preemption:** when a law contains a preemption clause or other explicit preemptive language.
- **Implied preemption:** when a court finds that a law is preemptive even in the absence of an express preemption clause.
- **Non-preemption clause or savings clause:** The only way to guarantee that a federal or state/territorial law will not preempt state/territorial or local laws is to include a non-preemption clause (also known as a savings clause). For example, a federal law might state, "Nothing in this law preempts more restrictive state or local regulation or requirements." [176]

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