

March 2, 2016

CT General Assembly, Public Health Committee
Legislative Office Building, Room 3000
Hartford, CT 06106

Testimony Supporting SB 290, An Act Concerning the Sale and Purchase of Tobacco Products, Electronic Nicotine Delivery Systems and Vapor Products and Signage Concerning the Use of Such Products and Systems.

Dear Distinguished Chairpersons and Members of the Public Health Committee,

My name is Ruth Canovi. I am the Manager of Public Policy for the American Lung Association in CT. Thank you for the opportunity to discuss important tobacco prevention policies in Connecticut, specifically SB290. The American Lung Association supports the policy of increasing the age of tobacco sales to age 21. As part of the oldest voluntary health organization in America, our mission is to save lives by improving lung health and preventing lung disease. While we have come a long way, we still have a lot of work to do as tobacco remains the leading cause of preventable death and disease in Connecticut.

Raising the age of purchase of all tobacco products would help prevent more youth from succumbing to an addiction that could cost them their lives from any number of cancers and diseases including lung cancer and chronic obstructive pulmonary disease (COPD). Studies show that many underage smokers do not purchase their cigarettes from retailers but instead get their cigarettes from “social sources” such as older friends.¹ Raising the purchase age to 21 will further limit such social sources for our children.

Ninety percent of adults who smoke started by the age of 21, and half of them became regular smokers by their 18th birthday.² A recent report from the Institute of Medicine (IOM) found that raising the minimum age for tobacco sales to at least 21 years old will significantly reduce smoking rates. This report contains important findings that will help inform new policies that the IOM says could prevent about 223,000 deaths among people born between 2000 to 2019, including 50,000 fewer dying from lung cancer, the nation’s leading cancer killer. The report “Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products” concluded that increasing the minimum age of sale for tobacco products could benefit public health by reducing youth tobacco use. The report found that tobacco use would decrease by 12 percent by the time today’s teenagers were adults if the minimum age of sale were increased to 21 years.³

We at the Lung Association support including electronic cigarettes in such a law. Electronic

nicotine delivery systems, such as electronic cigarettes, have a growing following, particularly among youth. According to a new study from the U.S. Centers for Disease Control and Prevention, the use of e-cigarettes triples among both high school (4.5% in 2013 to 13.4% in 2014) and middle school (1.1% in 2013 to 3.9% in 2014) students in just one year.⁴ The same study found that e-cigarette use among teens exceeded use of all other tobacco products.⁵ Our overall policy view is that this products should be classified as tobacco products and regulated as such.

For all of these reasons, we believe that increasing the age of tobacco sales could be a great step for us in the continue fight against Big Tobacco. One concern we have is regarding where the burden of the tobacco transaction is placed. Because the Lung Association opposes laws that punish children in such tobacco sales transactions and all of the research from the IOM was based on the sale of tobacco, not its purchase age, we would prefer the law be amended to only deal with the sale of these tobacco products.

The trend to increase the minimum legal age of sale for tobacco to 21 is gaining traction throughout the country. Hawaii lead this initiative by being the first state to pass the law in 2015. To date, there are at least 125 municipalities that have adopted this regulation including Boston and New York City.⁶ All of our neighboring states are considering similar overall policy as well.

Increasing the age of tobacco sales could prove to be an important piece in what we hope is a more sustainable and comprehensive commitment to preventing youth from the dangerous path of nicotine addiction and helping those afflicted with the addiction to quit. Please note the attached 2016 State of Tobacco Control Report Card, which gives a quick overview as to where Connecticut stands in terms of a tobacco prevention and cessation program. Tobacco brings significant revenue into our state, but FY16 we are spending less than 60 CENTS on tobacco control programs per \$100 of tobacco related revenue we bring in. In FY17 we are scheduled to spend \$0 on tobacco control programming. A ZERO dollar investment to keep our kids off tobacco is unacceptable. We see the tobacco policies being discussed in today's hearing as part of a larger discussion as to how to address the leading cause of preventable death and disease in our state. This policy cannot be used to replace a fiscal commitment to reduce the burden tobacco places on our fiscal and public health. We understand that the state's budgetary climate is dire to say the least, however if there was ever a time to invest in fighting a product which causes \$2B in health care related costs to the state, NOW IS THE TIME.

Thank you for opening up the conversation about how to improve the state's work to reduce the burden of tobacco use we see day in and day out. We appreciate this committee's continued persistence and willingness to address these important topics year after year.

Sincerely,



Ruth Canovi, Manager of Public Policy
American Lung Association, Connecticut

¹ Substance Abuse & Mental Health Services Administration, U.S. Dept of Health & Human Services, 2003 National Survey on Drug Use and Health, September 9, 2004,

<http://oas.samhsa.gov/NHSDA/2k3NSDUH/2k3results.htm#ch4>

<http://www.oas.samhsa.gov/nhsda.htm#NHSDAinfo>. (Not: While there have been more recent NSDUH surveys, no questions on youth access have been asked since 2003.)

² Mowery PD, Brick PD, Farrelly MC. Legacy First Look Report 3. Pathways to Established Smoking: Results from the 1999 National Youth Tobacco Survey. Washington DC: American Legacy Foundation. October 2000.

³ Institute of Medicine, Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products, Washington, DC, The National Academies Press, 2015,

http://www.iom.edu/~media/Files/Report%20Files/2015/tobacco_minimum_age_report_brief.pdf

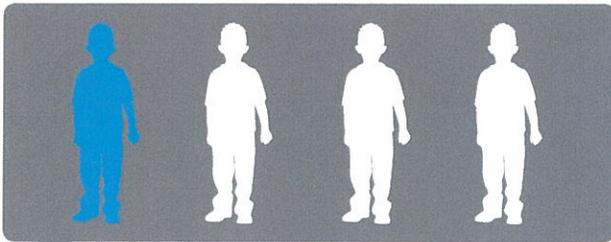
⁴ Centers for Disease Control and Prevention. "Electronic Cigarette Use Among Middle and High School Students – United States, 2013-2014." Morbidity and Mortality Weekly Report. April 17, 2015.

⁵ Ibid.

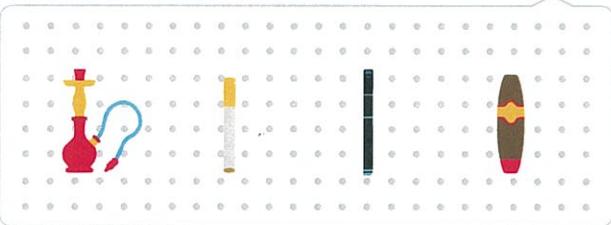
⁶ Campaign for Tobacco Free Kids. States and Localities that have raised the minimum legal sale age for tobacco products to 21.



	Tobacco Prevention & Control Program Funding	Tobacco Taxes	Smokefree Air	Access to Cessation Services
CT	F	B	C	D



ONE IN FOUR KIDS IN THE U.S. USES TOBACCO PRODUCTS.



CONNECTICUT STATE FACTS

Healthcare Costs Due to Smoking:	\$2,038,803,314
Adult Smoking Rate:	15.4%
Adult Tobacco Use Rate:	16.5%
High School Smoking Rate:	13.5%
Middle School Smoking Rate:	2.9%
Smoking Attributable Deaths:	4,900

To get involved with your American Lung Association, please contact:
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State Goals 2016

1. Restore and sustain funding for tobacco prevention and cessation programs to at least \$6 million per year;
2. Close loopholes in the state's clean indoor air act to protect all workers from secondhand smoke;
3. Achieve tax parity between cigarettes and other tobacco products.

Nationwide Goals 2016

1. Reduce rates of smoking and other tobacco use to less than 10 percent for all communities by 2024;
2. Protect all Americans from secondhand smoke by 2019; and
3. Ultimately eliminate the death and disease caused by tobacco use.