

March 4, 2019

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

Testimony of the American Lung Association in Connecticut supporting Raised House Bill 7200,
An Act Prohibiting the Sale of Cigarettes, Tobacco Products, Electronic Nicotine Delivery
Systems and Vapor Products to Persons Under Age Twenty-one.

Dear Distinguished Chairpersons and Members of the Public Health Committee:

My name is Ruth Canovi and I am the Director of Public Policy for the American Lung Association in Connecticut. The American Lung Association is a not-for-profit public health association working to save lives by improving lung health and preventing lung disease. Thank you for the opportunity to express the American Lung Association's support of House bill 7200 as it really is a comprehensive approach to reduce youth tobacco use and access.

Still in 2019, tobacco use is a very present and real issue in Connecticut impacting too many, especially our most vulnerable populations.

- 4900 Connecticut residents die due to tobacco annually.
- Tobacco costs Connecticut more than \$2B annually.¹
- Despite cigarette smoking rates being at all time lows, overall tobacco product use has not seen that same decline. Electronic cigarette use rates are increasing at alarming levels. In Connecticut, high school vaping rates doubled from 2015 to 2017.² This disturbing trend led the U.S. Surgeon General to call youth e-cigarette use an epidemic in 2018.
- In 2015, 19.9% of people 18 and over used tobacco products, however, if you look at the tobacco use rates among different populations, the disparities are clear. A chart highlighting tobacco use among different demographics in the state of Connecticut is included below, but here are a few highlights:
 - 29.3% of households with an annual income of less than \$25,000 used tobacco compared with 15.9% of households with an annual income of \$75,000 or more used tobacco.
 - 31.6% of people over 18 with no high school diploma used tobacco, compared to 11% of college graduates used tobacco in 2015.³

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The health disparities we see with tobacco use and tobacco related disease are some of the reasons the American Lung Association supports prohibiting the sale of all flavored tobacco products. Menthol cigarettes do not affect everyone equally. Use of menthol cigarettes is more common among youth, female smokers, LGBTQ smokers⁴, those with mental illness and racial and ethnic minorities, especially African-Americans. Nearly 9 in 10 African-American smokers (88.5 percent) aged 12 years old and older use menthol cigarettes.⁵ This is not by chance – the sale and marketing of menthol cigarettes disproportionately burdens the African-American community by the tobacco industry.⁶

Recognizing that almost all tobacco users begin their use during their adolescence or young adulthood, tobacco companies have spent billions of dollars marketing their products and making them more attractive to young people. It is well established that flavors are attractive to children and young people. Both the U.S. Surgeon General⁷ and the National Academy of Sciences, Engineering and Medicine⁸ have written comprehensive reports on e-cigarettes that discuss the subject. For decades, the tobacco industry has used flavors to attract youth. Indeed, the industry's decades-long conspiracy to deceive the public includes many documents that demonstrate the industry's understanding of the role flavors play in tobacco use initiation. While most flavored cigarettes are prohibited, the industry is once again using flavored e-cigarettes – as well as cigars – to attract youth – and then addict them. With products claiming to taste like Gummy Bears, Atomic Fireball, Captain Crunch, Apple Juice and a wide variety of other fruit, candy and sweet flavors, there is no question that these flavors appeal to youth.

There is even more evidence that flavor additives in e-cigarettes – especially those that are based on natural plant-based extracts, are menthol-based and food-related additives such as cinnamaldehyde – are particularly toxic to lungs when they are inhaled. One study found that these additives significantly affect the lung cell viability and the respiratory barrier integrity.⁹ Another study found that lower concentrations of these flavor additives in e-cigarettes caused inflammation and created symptoms consistent with endothelial dysfunction.¹⁰ And of course, the presence of chemicals such as a diacetyl and acetyl propionyl, are associated with respiratory disease.¹¹

According to the Campaign for Tobacco Free Kids, there are 56,000 youth under the age of 18 in Connecticut who will ultimately die prematurely from smoking.¹² Connecticut must and can do better to protect our young people. Raising the tobacco sales age of all tobacco products in the state would help prevent more youth from succumbing to an addiction that could cost them their lives from any number of cancers and other diseases including chronic obstructive pulmonary disease (COPD). We already know that the teen brain is especially sensitive to nicotine - and with e-cigarette use now at epidemic levels, we are in danger of reversing so much of the progress we've made against tobacco over the last few decades. This legislation



gives us the best chance to protect Connecticut's children from a dangerous and lifelong addiction to tobacco. Studies show that many underage smokers do not purchase their tobacco products from retailers but instead get their cigarettes from "social sources" such as older friends. Smokers aged 18 and 19 years old are a major supplier for younger kids who rely on social resources to buy their tobacco products.¹³ Because most high school students graduate before 21, raising the tobacco age of sale to 21 will further limit such social sources for youth.¹⁴

Nearly 95% of adults who smoke tried their first cigarette by the age of 21.¹⁵ The National Academy of Medicine (formerly known as Institute of Medicine) found that raising the minimum age for tobacco sales to at least 21 years old will significantly reduce youth tobacco use and save thousands of lives.¹⁶ The report, "Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products" concluded that the tobacco use rates would decrease by 12 percent by the time today's teenagers were adults if the minimum age of sale were increased to 21 years.¹⁷ The National Academy of Medicine also predicts that this policy could save 223,000 premature deaths among people born between 2000 – 2019, including 50,000 premature deaths due to smoking related lung cancer; lung cancer is the leading cancer killer in the United States.¹⁸

This policy is gaining support throughout the country. A Centers for Disease Control and Prevention (CDC) study found that 75 percent of adults, including adult smokers are in favor of increasing the age of sale to 21.¹⁹ In 2015, Hawaii passed the first state wide law in the country to raise the age of tobacco sale to 21 and California followed in 2016. Oregon, New Jersey and Maine all passed legislation in 2017. Just this summer, Massachusetts passed a bill to raise the tobacco sale age to 21. The policy is gaining more support each year in Connecticut. In fact three municipalities in Connecticut recently joined the more than 380 local governments across the country that have raised the tobacco sale age.²⁰

Each year we learn a bit more about what works best in a tobacco 21 policy. A few important highlights:

- All tobacco products MUST be included in this law.
- The Lung Association opposes laws that punish young people in tobacco sales transactions. The Lung Association commends you for following the data from the National Academy of Medicine and focusing on the sales age of tobacco, not its purchase age.
- We should not carve out the military in this legislation. Places with a large military presence like Hawaii and San Antonio, Texas, have not only passed tobacco 21 laws, but the military bases have voluntarily decided to adopt the local law on base. Military tobacco use rates are substantially higher than in the civilian population. Military leaders



have submitted testimony in favor of proposed tobacco 21 legislation throughout the country: “Raising the age for purchasing tobacco products is good for the health of our services members as well as the readiness of our military. Tobacco use degrades our military’s ability as a fighting force, causes significant health problems for military members and makes recruiting an even greater challenge.” – from General Daugherty’s testimony to Washington State Lawmakers in support of raising the age of tobacco sales.

Increasing the age of tobacco sales is an important step in what we hope is a more sustainable and comprehensive approach to preventing youth from the dangerous path of nicotine addiction. We commend the public health committee for putting together a very strong bill that addressing outdated fines and fee structures. We also support the proposed prohibition of flavored tobacco products.

In the early 2000s, Connecticut was a leader in fighting the public health epidemic of tobacco use; it is time to step up again. The American Lung Association strongly supports House Bill 7200. Thank you for taking action on this serious public health issue and trying to do more to prevent the next generation of nicotine addiction. We urge you to pass this bill.

Ruth Canovi, MPH
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American Lung Association, Connecticut

FROM: “Prevalence of Tobacco Use Among Connecticut Adults (18+ years old), 2015.”
Connecticut Department of Public Health. <http://www.portal.ct.gov/-/media/Departments-and->



[Agencies/DPH/dph/hems/tobacco/PDF/2015TobaccoQuickStatsCTadultpdf.pdf?la=en](https://www.portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/hems/tobacco/PDF/2015TobaccoQuickStatsCTadultpdf.pdf?la=en)

Prevalence of Tobacco Use Among Connecticut Adults (18+ years old), 2015												
Demographic Characteristics	Current Tobacco Use ¹		Current Tobacco Use ²		Current Cigarette Smoking		Current Other Tobacco Use ³		Current E-Cigarette Use		Current Cigar Smoking	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Overall	19.9	(18.7-21.0)	17.5	(16.4-18.6)	13.5	(12.5-14.4)	3.2	(2.5-3.8)	5.0	(4.3-5.7)	4.7	(4.0-5.3)
Sex												
Male	26.0	(24.1-27.9)	21.8	(20.0-23.7)	16.3	(14.7-17.8)	4.4	(3.6-5.5)	5.8	(4.7-6.9)	8.0	(6.8-9.2)
Female	14.1	(12.8-15.5)	13.5	(12.2-14.8)	10.9	(9.8-12.0)	2.0	(1.2-2.8)	4.4	(3.5-5.2)	1.6	(1.1-2.1)
Age												
18-24	30.5	(25.2-35.8)	27.0	(21.8-32.1)	9.9	(6.7-13.0)	11.1	(7.1-15.2)	14.5	(10.6-18.4)	9.4	(6.1-12.8)
25-34	29.3	(25.5-33.0)	26.1	(22.5-29.8)	20.6	(17.3-24.0)	5.5	(3.5-7.6)	9.5	(7.0-12.0)	8.3	(6.0-10.6)
35-44	18.5	(15.7-21.2)	16.7	(14.0-19.3)	14.3	(11.7-16.8)	2.0	(1.2-2.9)	3.8	(2.5-5.1)	3.1	(2.0-4.3)
45-54	19.9	(17.5-22.2)	17.9	(15.6-20.1)	15.9	(13.7-18.1)	2.0	(1.1-2.9)	3.0	(2.2-3.8)	3.7	(2.6-4.9)
55-64	17.4	(15.5-19.3)	14.8	(13.0-16.7)	13.9	(12.1-15.7)	—**	—	2.8	(2.0-3.7)	3.5	(2.7-4.4)
65+	9.7	(8.3-11.1)	8.2	(6.9-9.4)	7.3	(6.1-8.6)	0.7	(0.4-1.1)	1.1	(0.7-1.5)	2.3	(1.6-3.1)
Race/Ethnicity												
NH-White	19.2	(17.9-20.5)	16.7	(15.5-18.0)	12.9	(11.8-14.0)	2.7	(2.0-3.3)	5.3	(4.5-6.2)	4.9	(4.1-5.6)
NH-Black	23.5	(18.9-28.1)	20.8	(16.4-25.1)	16.9	(12.9-20.9)	4.3	(1.9-6.6)	3.9	(1.8-5.9)	5.7	(3.2-8.3)
Hispanic	20.6	(17.1-24.0)	18.7	(15.4-21.9)	15.4	(12.5-18.3)	3.7	(1.7-5.7)	4.8	(3.0-6.6)	3.9	(2.3-5.5)
NH-American Indian/Alaskan Native	45.6	(25.6-65.6)	38.8	(18.8-58.7)	—**	—	—**	—	—**	—	—**	—
NH-Asian	17.4	(9.2-25.7)	16.4	(8.1-24.6)	—**	—	—**	—	—**	—	—**	—
NH-Other	28.2	(18.8-39.6)	25.5	(14.1-37.0)	17.1	(10.3-24.0)	—**	—	—**	—	—**	—
Annual Household Income												
Less than \$25,000	29.3	(26.3-32.3)	28.1	(25.1-31.0)	24.1	(21.4-26.9)	3.9	(2.3-5.5)	6.1	(4.6-7.7)	4.8	(3.6-6.1)
\$25,000 - \$34,999	20.0	(15.8-24.2)	19.7	(15.5-23.9)	17.7	(13.7-21.8)	—**	—	3.9	(1.9-5.8)	3.1	(1.4-4.8)
\$35,000 - \$49,999	20.2	(16.4-24.1)	18.3	(14.6-22.1)	13.5	(10.5-16.6)	—**	—	7.4	(4.3-10.4)	4.2	(2.0-6.5)
\$50,000 - \$74,999	19.5	(16.2-22.8)	17.6	(14.4-20.9)	14.9	(11.9-17.9)	3.6	(1.7-5.5)	4.7	(2.9-6.6)	4.0	(2.6-5.5)
\$75,000+	15.9	(14.0-17.7)	12.4	(10.7-14.1)	8.1	(6.7-9.4)	3.1	(2.0-4.2)	4.0	(3.0-5.1)	5.5	(4.3-6.8)
Education												
Less than High School (no diploma)	31.6	(26.5-36.7)	30.0	(25.0-35.0)	25.1	(20.4-29.7)	5.0	(2.1-7.9)	7.4	(4.3-10.4)	6.3	(3.6-9.0)
High School or GED Diploma	23.6	(21.3-25.9)	21.4	(19.2-23.6)	17.0	(15.0-18.9)	3.6	(2.3-4.8)	5.5	(4.3-6.8)	4.3	(3.3-5.4)
Some College or Tech School	22.0	(19.6-24.3)	19.3	(17.1-21.5)	14.1	(12.3-15.8)	3.7	(2.3-5.1)	6.3	(4.8-7.8)	5.7	(4.2-7.1)
College Graduate	11.1	(9.8-12.3)	8.6	(7.4-9.7)	6.1	(5.2-7.1)	1.8	(1.1-2.5)	2.8	(2.1-3.6)	3.6	(2.8-4.4)

Data source: 2015 CT Behavioral Risk Factor Surveillance System Abbreviations: CI = Confidence Interval NH = Non-Hispanic.
 Notes: Adult current cigarette smokers are defined as persons who reported smoking at least 100 cigarettes during their lifetime and who, at the time of the interview, reported smoking some days or every day. Adult current use of tobacco products other than cigarettes is defined as using a product on 1 or more of the 30 days before the survey.
¹including cigarettes, cigars, chewing tobacco, snuff, dip, hookahs (water pipes), snus, and e-cigarettes
²including cigarettes, chewing tobacco, snuff, dip, snus, hookahs, and e-cigarettes
³including chewing tobacco, snuff, dip, hookahs, and snus
⁴These estimates are suppressed because the data are statistically unreliable (i.e., the relative standard error was >30% or the sample size was <50).

- ¹ Campaign for Tobacco Free Kids. *The Toll of Tobacco in Connecticut*. Accessed February 8, 2017. https://www.tobaccofreekids.org/facts_issues/toll_us/connecticut
- ² High School Student Vaping Doubles in Two Years. Press Releases. Department of Public Health. 10/11/2018. <https://portal.ct.gov/DPH/Press-Room/Press-Releases---2018/High-School-Student-Vaping-Doubles-in-2-Years> Accessed February 13, 2019.
- ³ Prevalence of Tobacco Use Among Connecticut Adults (18+ years old), 2015. Connecticut Department of Public Health. <http://www.portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/hems/tobacco/PDF/2015TobaccoQuickStatsCTadultpdf.pdf?la=en> Accessed June 3, 2018.
- ⁴ Menthol cigarette smoking among lesbian, gay, bisexual, and transgender adults. Fallin A1, Goodin AJ2, King BA3. <https://www.ncbi.nlm.nih.gov/pubmed/25245795>
- ⁵ <https://truthinitiative.org/news/6-key-takeaways-new-fda-plan-e-cigarettes-flavored-tobacco-products>
- ⁶ Too Many Cases, Too Many Deaths: Lung Cancer in African Americans, American Lung Association. <https://www.lung.org/assets/documents/research/ala-lung-cancer-in-african.pdf>
- ⁷ U.S. Department of Health and Human Services. (2016.) E-Cigarette Use Among Youth and Young Adults. Retrieved from https://e-cigarettes.surgeongeneral.gov/documents/2016_sgr_full_report_non-508.pdf
- ⁸ National Academies of Sciences. (2018). Public Health Consequences of E-Cigarettes. Retrieved from <http://nationalacademies.org/hmd/Reports/2018/public-health-consequences-of-e-cigarettes.aspx>
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- ¹² Campaign for Tobacco Free Kids. *The Toll of Tobacco in Connecticut*. Accessed February 8, 2017. https://www.tobaccofreekids.org/facts_issues/toll_us/connecticut
- ¹³ Ribisl, KM, et al., "Which Adults Do Underaged Youth Ask for Cigarettes?" *American Journal of Public Health*, 89(10):1561 – 1564, 1999.
- ¹⁴ Institute of Medicine, *Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products*, Washington, DC: The National Academies Press, 2015, <https://www.nap.edu/catalog/18997/public-health-implications-of-raising-the-minimum-age-of-legal-access-to-tobacco-products>
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- ¹⁶ Institute of Medicine, *Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products*, Washington, DC: The National Academies Press, 2015, <https://www.nap.edu/catalog/18997/public-health-implications-of-raising-the-minimum-age-of-legal-access-to-tobacco-products>
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