

California Legislature

BACKGROUND

Thursday, December 17, 2015

10:30 a.m. to 12:30 p.m.

Elihu Harris State Office Building

1515 Clay Street, Room 1

Oakland, California

Informational Hearing: Public Health Impacts of Tobacco Use in California: PROBLEMS AND SOLUTIONS

Introduction.

On June 16, 2015, Governor Jerry Brown issued a proclamation calling for an Extraordinary Session devoted to matters pertaining to Medi-Cal and services for people with developmental disabilities. One of the charges of which is to improve the efficiency and efficacy of the health care system, reduce the cost of providing health care services, and improve the health of Californians. During the Extraordinary Session the Assembly and Senate created the Joint Conference Committee on AB2X 1 (Bonta) and SB2X 2 (Ed Hernandez). The Conference Committee called this hearing to discuss one of the most pervasive and expensive public health threats facing Californians today: tobacco consumption.

Health Impacts of Smoking and Tobacco Use.

Tobacco smoke is a toxic mix of more than 7,000 chemicals. The chemicals in tobacco smoke reach the lungs quickly when inhaled. They go from the lungs into the blood and the blood carries the chemicals to tissues in all parts of the body, causing damage. Smoking can cause cancer almost anywhere in the body, including the bladder, blood, cervix, colon, esophagus, kidney, larynx, liver, pancreas, stomach, trachea, bronchus, and lungs. According to the Centers for Disease Control and Prevention (CDC), smoking causes about 90% of all lung cancer deaths.



As serious as cancer is, it accounts for less than half of the deaths related to smoking each year. Smoking is a major cause of many other deadly health problems – heart disease, aneurysms, bronchitis, emphysema, and stroke. Using tobacco can damage a woman’s reproductive health and hurt babies. Tobacco use is linked with reduced fertility, a higher risk of miscarriage, early delivery (premature birth), and stillbirth. It’s also a cause of low birth-weight in infants, and has been linked to a higher risk of birth defects and sudden infant death syndrome.

Smoking can make pneumonia and asthma worse and has been linked to other health problems, including gum disease, cataracts, bone thinning (osteopenia and osteoporosis), hip fractures, and peptic ulcers. Some studies have also linked smoking to macular degeneration, an eye disease that can cause blindness.

Smoking causes 80% of all deaths from chronic obstructive pulmonary disease, and causes stroke and coronary heart disease, the leading causes of death in the United States.

Smokers are 30 to 40% more likely to develop type 2 diabetes than nonsmokers, and people with diabetes who smoke are more likely than nonsmokers to have trouble with insulin dosing and with controlling their disease. Smokers with diabetes have higher risks for serious complications, including heart and kidney disease, poor blood flow in the legs and feet that can lead to infections, ulcers, and possible amputation, retinopathy (an eye disease that can cause blindness), and peripheral neuropathy (damaged nerves to the arms and legs that causes numbness, pain, weakness, and poor coordination).

Smoking causes more than 480,000, or about one in five, deaths each year in the U.S. The average annual smoking-attributable mortality rate in California from 2000 to 2004 was 235 per 100,000. The range across states is from 138.3 per 100,000 to 370.6 per 100,000. California ranks sixth lowest per capita among all 50 states. If nobody smoked, one of every three cancer deaths in the U.S. would not happen.

Nicotine is a highly addictive drug contained in cigarettes. Like heroin or cocaine, nicotine changes the way the brain works and causes smokers to crave more and more nicotine. Smoking can cause both physical and mental addiction. Cigarettes today deliver more nicotine and deliver it quicker than ever before. Most smokers must attempt to quit several times before they are successful.

Secondhand Smoke.

According to the 2014 Surgeon General’s Report, “How Tobacco Smoke Causes Disease,” there have been more than 20 million smoking-related deaths in the United States since 1964; 2.5 million of those deaths were among non-smokers who died from exposure to secondhand smoke. During that same time, 100,000 babies died due to parental smoking (including smoking during pregnancy).

Secondhand smoke can be harmful in many ways. Each year in the U.S. alone, it's responsible for an estimated 42,000 deaths from heart disease in people who are current non-smokers; about 7,000 lung cancer deaths in non-smoking adults; worse asthma and asthma-related problems in up to 1 million asthmatic children; and, between 150,000 and 300,000 lower respiratory tract (lung and bronchus) infections in children under 18 months of age, with 7,500 to 15,000 hospitalizations each year.

In the U.S., the costs of extra medical care, illness, and death caused by secondhand smoke are over \$10 billion per year.

Costs Attributable to Smoking.

The total economic cost of smoking nationwide is more than \$300 billion a year, including nearly \$170 billion in direct medical care for adults and more than \$156 billion in lost productivity due to premature death and exposure to secondhand smoke. The 2012 California Department of Public Health (DPH) State Health Officer's Report on Tobacco Use and Promotion in California estimated that adult tobacco related health care expenditures cost California \$6.5 billion that year, or about \$400 per taxpayer. Those figures did not include other health care costs for children, costs resulting from secondhand smoke exposure, the value of lost time/productivity, or lives lost. According to a 2014 University of California San Francisco report, "The Cost of Smoking in California, 2009," one out of every seven deaths in California is due to smoking, at a total cost of \$18.1 billion, with 54% of the cost attributed to direct health care services (\$9.8 billion).

Tobacco Use in California.

Adults. The 2012 DPH report on tobacco use found that tobacco takes a tremendous toll on the state, from both a health and economic perspective. Smoking kills more people than alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined.

According to DPH's California Tobacco Control Program (CTCP), "California Tobacco Facts and Figures 2015," California has made significant progress in decreasing smoking rates, which, among adults, declined from 23.7% in 1988, to 11.7% in 2013. This reflects a 51% decline since the CTCP began. However, the decline in tobacco use rates has stalled in the last few years.

Over the last 15 years smoking rates declined steadily in all racial/ethnic groups for both men and women. African Americans smoke more than other race/ethnic group, with few differences between men and women. Gender differences in smoking rates are more substantial within the Asian/Pacific Islander (API) and Hispanic populations in California. The American Lung Association reports that Lesbian, Gay, Bisexual, and Transgender women smoke at almost triple the rate of women in general.

Male Smokers	1996	2011	% Decline
<i>White</i>	21.5%	14.3%	33.5
<i>African American</i>	21.6%	18.9%	12.5
<i>Hispanic</i>	19.0%	15.5%	18.4
<i>API</i>	19.0%	13.1%	31.3

Female Smokers	1996	2011	% Decline
<i>White</i>	16.6%	11.2%	32.5
<i>African American</i>	23.7%	15.2%	35.9
<i>Hispanic</i>	10.6%	5.7%	46.2
<i>API</i>	8.3%	4.5%	45.8

California has one of the lowest overall smoking rates in the nation, second only to Utah; however, California is the state with the largest number of smokers because it is by far the most populous state in the nation.

Children. California monitors smoking rates among high school students using the California Student Tobacco Survey. The 2012 survey showed the percentage of California high school students who reported smoking a cigarette within the previous 30 days was 10.5%, or 297,000 students.

Smoking among high school students in California is declining consistently and is lower than for the rest of the U.S. Student smoking rates declined 51% from 2000 to 2012; however, there are substantial differences in student smoking prevalence when examined by race or ethnicity. While rates declined for non-Hispanic whites, Hispanics, and API populations, the rate for African-Americans increased by 15.9% over this same time period.

Student Smokers	2002	2012	% Decline
<i>Non-Hispanic White</i>	19.9%	13.0%	34.7
<i>Hispanic</i>	14.0%	10.4%	25.7
<i>African American</i>	8.2%	9.5%	-15.9
<i>API</i>	13.6%	5.9%	56.6

Smokeless Tobacco.

Cigarettes are not the only type of tobacco used in California. In 2010 about 1.5% of adults and 3.8% of adolescents were smokeless tobacco users. Smokeless tobacco (also known as spit, plug, dip, chaw, rack, spits, grizz, and tasties) comes in two forms: chew and snuff. Chewing tobacco is available in loose-leaf, twist, and plug forms. Snuff comes in moist, dry, and sachet

forms. There are also dissolvable tobacco products, pieces of compressed powdered tobacco, similar to small hard candies, which dissolve in the mouth and require no spitting of tobacco juices. Sometimes called tobacco lozenges, they can be confused with nicotine lozenges used for smoking cessation.

According to the National Cancer Institute, smokeless tobacco contains at least 28 carcinogens in varying concentrations. Similar to smoked tobacco, smokeless tobacco contains nicotine, which is addictive. The amount of nicotine absorbed from smokeless tobacco is three to four times greater than the amount delivered by a cigarette. Harmful health effects of smokeless tobacco include:

- Mouth, tongue, cheek, gum, and throat cancer
- Cancer in the esophagus (the swallowing tube that goes from your mouth to your stomach)
- Stomach cancer
- Pancreatic cancer
- Possible increase in risk of heart disease, heart attacks, and stroke
- Addiction to nicotine (which can lead to smoking)
- Leukoplakia (white sores in the mouth that can become cancer)
- Receding gums (gums slowly shrink from around the teeth) and gum disease (gingivitis)
- Bone loss around the roots of the teeth
- Abrasion (scratching and wearing down) of teeth
- Cavities and tooth decay
- Tooth loss
- Stained and discolored teeth

Smokeless tobacco is a particular problem among rural youth in the U.S., who are more likely to be poor, white, and have less educated parents.

E-Cigarettes.

Electronic cigarettes are products designed to deliver nicotine or other substances to a user in the form of a vapor. Typically, they are composed of a rechargeable, battery-operated heating element, a replaceable cartridge that may contain nicotine or other chemicals, and an atomizer that, when heated, converts the contents of the cartridge into a vapor. This vapor can then be inhaled by the user. These products are often made to look like such products as cigarettes,

cigars, and pipes. They are also sometimes made to look like everyday items, such as pens and USB memory sticks, for people who wish to use the product without others noticing.

E-cigarettes have not been fully studied, so consumers currently do not know the potential risks of e-cigarettes, how much nicotine or other potentially harmful chemicals are being inhaled during use, or whether there are any benefits associated with using these products.

The federal Food and Drug Administration (FDA) has not completed its evaluation of e-cigarettes for safety or effectiveness. When the FDA conducted limited laboratory studies of certain samples, it found significant quality issues that indicate that quality control processes used to manufacture these products are substandard or non-existent. The FDA also found that cartridges labeled as containing no nicotine contained nicotine and that three different e-cigarette cartridges with the same label emitted a markedly different amount of nicotine with each puff. Experts have also raised concerns that the marketing of products such as e-cigarettes can increase nicotine addiction among young people and may lead kids to try other tobacco products.

The FDA has issued a proposed rule that would extend the agency's tobacco authority to cover additional products that meet the legal definition of a tobacco product, such as e-cigarettes. The agency intends to regulate e-cigarettes and related products in a manner consistent with its mission of protecting the public health.

According to the January 2015 State Health Officer's report on e-cigarettes, "A Community Health Threat," e-cigarette use is rising rapidly. In California, use among young adults ages 18 to 29 tripled in one year. The report notes that while the long-term health impact resulting from use of this product is presently unknown, it is known that e-cigarettes emit at least 10 chemicals that are found on California's Proposition 65 list of chemicals known to cause cancer, birth defects, or other reproductive harm.

A study published online on July 27, 2015, in the *Journal of Pediatrics* surveyed almost 2,100 California high school students, and found that one-quarter had tried e-cigarettes. Ten percent were currently using e-cigarettes, and those current users were much more likely than their peers to also smoke cigarettes. California law prohibits anyone from selling or furnishing an e-cigarette to anyone under the age of 18. There are no statewide restrictions on where they may be used.

Background on Tobacco Regulation.

In November 1988, California voters approved the California Tobacco Health Protection Act of 1988, also known as Proposition 99. This initiative increased the state cigarette tax by \$0.25 per pack and added an equivalent amount on other tobacco products. The new revenues were earmarked for programs to reduce smoking, provide health care services to indigents, support tobacco-related research, and fund resource programs for the environment. The money is

deposited by using the following formula: 20% is deposited in the Health Education Account (HEA); 35% in the Hospital Services Account; 10% in the Physician Services Account; 5% in the Research Account; 5% in the Public Resources Account; and, 25% in the Unallocated Account (funds in this account are available for appropriation by the Legislature).

The HEA funds both community and school-based health education programs to prevent and reduce tobacco use and is jointly administered by the CTCP and the California Department of Education (CDE). Currently, CTCP receives approximately two-thirds of the funding and CDE receives approximately one-third of the funding available in the HEA. CTCP is responsible for supporting a statewide tobacco control program, one of the largest public health interventions of its kind ever initiated, nationally or internationally. CTCP provides funding for 61 Local Lead Agencies, competitively selected community-based organizations, a statewide media campaign, and an extensive evaluation of the entire program. CDE administers school-based funding to grades 4 through 8 based on an allocation method and to high schools through a competitive grant program.

In 1992, Congress passed Section 1926 of Title XIX of the federal Public Health Service Act, commonly called the Synar Amendment. The Synar Amendment requires states to pass and enforce laws that prohibit the sale of tobacco to individuals under 18 years of age. It also requires federal alcohol and substance abuse block grant funding to be applied to enforce state law in a manner that can reasonably be expected to reduce the illegal sales rate of tobacco products to minors. Up to 40% of the block grant funding can be withheld from states for not complying with the Synar Amendment.

In May 1994, the Department of Health Services (DHS, the predecessor of DPH), Tobacco Control Section, and tobacco control advocates from 23 counties throughout the state undertook an unprecedented effort to document how easily available tobacco products were to minors. Over 400 youth, 13 to 17 years of age, surveyed more than 1,800 California retailers. The results of the 1994 Youth Purchase Survey indicated that the illegal sales rate was 52.1%.

In September 1994, the Stop Tobacco Access to Kids Enforcement (STAKE) Act was signed into law to address the increase in tobacco sales to minors and fulfill the federal mandate. The STAKE Act created a new statewide enforcement program authorizing regulatory actions against businesses that illegally sell tobacco to minors. Authority for enforcement and responsibility for implementation of the program was delegated to the DHS Food & Drug Branch.

The Master Settlement Agreement (MSA) is an accord reached in November 1998 between the state Attorneys General of 46 states (including California), five U.S. territories, the District of Columbia, and the five largest tobacco companies in the U.S. concerning the advertising, marketing, and promotion of tobacco products. In addition to requiring the tobacco industry to pay the settling states approximately \$10 billion annually for the indefinite future, the MSA also

set standards for, and imposed restrictions on, the sale and marketing of cigarettes by participating cigarette manufacturers.

Under the MSA, states must pass laws requiring non-participating manufacturers to make payments to the state based on their cigarette sales, and to diligently enforce the payments requirements by tracking all cigarettes sold in the state. To fulfill California's obligations under the MSA, the Legislature created new programs administered by the Board of Equalization (BOE) and the Department of Justice, including BOE's Cigarette and Tobacco Licensing Program.

On June 22, 2009, the Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act) gave the FDA the authority to regulate the manufacture, distribution, and marketing of tobacco products, specifically cigarettes, cigarette tobacco, roll-your-own tobacco, and smokeless tobacco, to protect public health and reduce tobacco use in the U.S. To oversee the implementation of the law, the FDA established the Center for Tobacco Products, which works to prevent tobacco product use initiation, encourage current users to quit, and reduce the overall harm caused by tobacco use.

Additional Regulation Needed to Reduce Tobacco Use.

Although tobacco products are taxed in California, there is more that can be done to reduce tobacco use in California. California is one of three states, with Missouri and North Dakota, which have not increased their cigarette tax since 1998. California's tobacco tax rate is \$0.87, and ranks 33rd when compared to the rates of other states. The national median cigarette tax rate is \$1.54 per pack. The highest tobacco tax rate is in New York at \$4.35 per pack and the lowest is Virginia at \$0.30 per pack. Some local governments, such as New York City (\$5.85 per pack total tax rate) and Chicago (\$5.66 per pack total tax rate) have their own tax in addition to the state tax.

Tobacco tax regulation has proven to be an effective tool to reduce tobacco use. Various economic studies in peer-reviewed journals ("The Effects of Prices and Tobacco Control Policies on the Demand for Tobacco Products, 2011" and "The Economics of Smoking, 1999") have recognized that cigarette tax or price increases reduce both adult and underage smoking. The general consensus is that every 10% increase in the real price of cigarettes reduces overall cigarette consumption by approximately three to five percent. Additionally, every 10% increase in the real price of cigarettes reduces the number of young-adult smokers by 3.5%, and reduces the number of kids who smoke by six or seven percent.

Tobacco Legislation in the Second Extraordinary Session.

SBX2 5 (Leno) and ABX2 6 (Cooper) define the term smoking for purposes of the Stop Tobacco Access to Kids Enforcement (STAKE) Act; expand the definition of a tobacco product to include e-cigarettes and extend current restrictions and prohibitions against the use of tobacco products to electronic cigarettes. SBX2 5 is currently pending in the Senate Committee on Appropriations. ABX2 6 is pending a vote on the Assembly Floor.

SBX2 6 (Monning) and ABX2 7 (Stone) prohibit smoking in owner-operated businesses and remove specified exemptions in existing law that allow tobacco smoking in certain workplaces. SBX2 6 was heard on August 19, 2015 in the Senate Committee on Public Health and Developmental Disabilities and passed on a 9 to 2 vote. SBX2 6 passed out of the Senate on August 27, 2015 and is pending in the Assembly. ABX2 7 is pending a vote on the Assembly Floor.

SBX2 7 (Ed Hernandez) and ABX2 8 (Wood) increase the minimum legal age to purchase or consume tobacco from 18 to 21. SBX2 7 was heard on August 19, 2015 in the Senate Committee on Public Health and Developmental Disabilities and passed on a 9 to 3 vote. SBX2 7 passed out of the Senate on August 27, 2015 and is pending in the Assembly. ABX2 8 is pending a vote on the Assembly Floor.

SBX2 8 (Liu) and ABX2 9 (Thurmond and Nazarian) clarify charter school eligibility for tobacco use prevention program (TUPE) funds; require the California State Department of Education to require all school districts, charter schools, and county offices of education receiving TUPE funds to adopt and enforce a tobacco-free campus policy; prohibit the use of tobacco and nicotine products in any county office of education, charter school, or school district-owned or leased building, on school or district property, and in school or district vehicles; and, require all schools, districts, and offices of education to post a sign reading "Tobacco use is prohibited" at all entrances. SBX2 8 passed out of the Senate on August 27, 2015 and is pending in the Assembly. ABX2 9 is pending a vote on the Assembly Floor.

SBX2 9 (McGuire) and ABX2 10 (Bloom) allow counties to impose a tax on the privilege of distributing cigarettes and tobacco products. SBX2 9 passed out of the Senate on August 27, 2015 and is pending in the Assembly. ABX2 10 is pending a vote on the Assembly Floor.

SBX2 10 (Beall) and ABX2 11 (Nazarian) revise the Cigarette and Tobacco Products Licensing Act of 2003 to change the retailer license fee from a \$100 one-time fee to a \$265 annual fee, and increase the distributor and wholesaler license fee from \$1,000 to \$1,200. SBX2 10 passed out of the Senate on August 27, 2015 and is pending in the Assembly. ABX2 11 is pending a vote on the Assembly Floor.

SBX2 14 (Ed Hernandez) imposes an additional excise tax of \$2 per package of 20 cigarettes, and imposes an equivalent one-time "floor stock tax" on the cigarettes held or stored by dealers and wholesalers. Imposes a tax on e-cigarettes equivalent to the \$2 per package tax imposed on cigarettes by this bill. Requires revenue from tobacco and e-cigarette taxes to be used for various tobacco use prevention and research, law enforcement, medical school education, for improved payments for Medi-Cal funded services, and to backfill existing tobacco-tax funded

services for any revenue decline resulting from the additional tax. Imposes a managed care organization provider tax (MCO tax) on health plans and continuously appropriates funds from the MCO tax for purposes of funding the nonfederal share of Medi-Cal managed care rates, and transfers \$230 million, to be used upon appropriation by the Legislature, to increase the funding provided to regional centers and to increase rates paid to providers of service to the developmentally disabled. Repeals the 7% reduction in hours of service to each In-Home Supportive Services recipient of services.

Pending Tobacco Tax Ballot Initiative.

A coalition of doctors, dentist, health plans, labor organizations and non-profit health advocate organizations is currently working to qualify an initiative for the November 2016 ballot. The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 would increase the tax on a pack of cigarettes sold in California from 87 cents a pack to \$2.87, and place equivalent taxes on other tobacco products containing nicotine, such as e-cigarettes. The tax would fund healthcare programs in the Department of Health Care Services, including Medi-Cal; smoking prevention programs administered by the Department of Public Health Tobacco Control Program and the Department of Education; and, medical research on tobacco-related diseases including cancer, heart and lung disease through the University of California. The Legislative Analyst submitted a fiscal analysis of the proposed initiative to the Attorney General on November 10, 2015. The Attorney General released their proposed title and summary of the initiative on December 15, 2015.

Conclusion.

The Campaign for Tobacco Free Kids estimates the annual health care costs in California directly caused by smoking to be \$13.29 billion, with \$3.58 billion being covered by the Medi-Cal program. Bearing in mind the charge to reduce health care costs in California, it seems imperative that the Legislature continue to work to reduce the impacts of tobacco and nicotine addiction on the health of Californians.

The adverse health effects attributable to tobacco use are well known and indisputable. The effects of e-cigarette use has received less study; however, given the rapid rise in their use, especially among young people, it is clear that the Legislature should consider how best to protect the public from potential harm. An option is to raise the price of tobacco and tobacco products through a tobacco tax, which will, as requested by the Governor, improve the efficiency and efficacy of the health care system, by reducing the number of smokers in California, the number of Californians suffering from the negative health impacts caused by tobacco use, and lowering health care costs in California.