February 11, 2019

Randi Frank
Office on Smoking and Health
Centers for Disease Control and Prevention
4770 Buford Hwy
Mail Stop S107-7
Atlanta, GA 30341

RE: Docket No. CDC-2018-0115; Advancing Tobacco Control Practices to Prevent Initiation of Tobacco Use Among Youth and Young Adults, Eliminate Exposure to Secondhand Smoke, and Identify and Eliminate Tobacco-Related Disparities; Request for Information

The American Cancer Society Cancer Action Network (ACS CAN) is pleased to submit comments on the request for information concerning advancing tobacco control practices to prevent initiation of tobacco use among youth and young adults, eliminate exposure to secondhand smoke, and identifying the eliminating tobacco-related disparities.

The American Cancer Society Cancer Action Network (ACS CAN) is making cancer a top priority for public officials and candidates at the federal, state and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's (ACS's) nonprofit, nonpartisan advocacy affiliate, ACS CAN is critical to the fight for a world without cancer.

For the last 50 years, the tobacco industry has vehemently denied and misled the American public about the dangers of tobacco use and marketing its products to youth. ACS has documented the lethal consequences of smoking and its detrimental effects on almost every organ of the body; and ACS CAN has advocated for comprehensive public policies to effectively reduce tobacco use and exposure to secondhand smoke in the U.S. In fact, the national reductions in overall cancer mortality over the past few years can be partially attributed to our work in tobacco control to prevent youth from starting to use tobacco products and helping current users quit.[1] Yet tobacco use remains the leading cause of preventable death in the U.S. More than 480,000 deaths each year are caused by cigarette smoking,[2]

[1] American Cancer Society. Cancer Facts & Figures 2018. Atlanta: American Cancer Society; 2018.
[2] US Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Washington, DC: US Department of Health and Human Services, CDC; 2014. Available at http://www.surgeongeneral.gov/library/reports/50-years-ofprogress/full-report.pdf.

including 28.8 percent of all cancer deaths and 85.5 percent of lung cancer deaths.[3] Tobacco use costs the U.S. more than $300 billion in healthcare costs and productivity losses.[4]

The Office of Smoking and Health (OSH) in the U.S. Centers for Disease Control and Prevention (CDC) has been a leader in reducing the death and disease caused by tobacco use and exposure to secondhand smoke. OSH has a proven record of providing evidence-based, comprehensive tobacco prevention and control information through educational materials, technical assistance, and media campaigns, and critically important, through partnerships with state and local governments. ACS CAN has advocated against any proposed cuts to OSH's funding, as any reduction in their output would be devastating for public health. Considering the vital role played by OSH in combating the leading cause of preventable premature death in our nation, ACS CAN appreciates having this opportunity to provide comments to inform OSH's future activities to enhance tobacco control practices that prevent youth and young adult initiation, eliminate exposure to secondhand smoke, and identify and eliminate tobacco-related disparities.

OSH Goal: Prevent Initiation of Tobacco Use Among Youth and Young Adults

Nearly all tobacco use begins in adolescence or young adulthood so it is essential to target these populations with interventions to prevent the initiation and progression to regular use of any tobacco product.[5] In 2018, nearly 5 million students (27.1 percent of high school students and 7.2 percent of middle school students) were current users of any tobacco product.[6] The most commonly used tobacco products among youth are e-cigarettes. In 2018, 20.8 percent of high school students and 4.9 percent of middle school students reported using an e-cigarette. These represent a 78 and 48 percent increase from 2017, respectively. Other tobacco use by youth also remains too high. In 2018, 8.1 percent of high school students smoked cigarettes and 7.6 percent smoked cigars. Among male high school students, 8.4 percent used smokeless tobacco.[7] Also, in 2018, 1.8 percent of middle school students smoked cigarettes and 1.6 percent smoked cigars, while 2.7 percent of middle school boys used smokeless tobacco.

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[3] Islami F, Goding Sauer A, Miller KD, Siegel RL, Fedewa SA, Jacobs EJ, McCullough ML, Patel AV, Ma J, Soerjomataram I, Flanders WD. Proportion and Number of Cancer Cases and Deaths Attributable to Potentially Modifiable Risk Factors in the United States. CA: A Cancer Journal for Clinicians. 2018 Jan 1;68(1):31-54.

[4] U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. Xu X, Bishop EE, Kennedy SM, Simpson SA, Pechacek TF. Annual Healthcare Spending Attributable to Cigarette Smoking: An Update. American Journal of Preventive Medicine 2014;48(3):326–33.

[5] U.S. Department of Health and Human Services. Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2012.

[6] Cullen KA, Ambrose BK, Gentzke AS, Apelberg BJ, Jamal A, King BA. Notes from the Field: Use of Electronic Cigarettes and Any Tobacco Product Among Middle and High School Students — United States, 2011–2018. MMWR Morb Mortal Wkly Rep 2018;67:1276–1277.

[7] Gentzke AS, Creamer M, Cullen KA, et al. Vital Signs: Tobacco Product Use Among Middle and High School Students — United States, 2011–2018. MMWR Morb Mortal Wkly Rep. ePub: 11 February 2019.

The increased use of e-cigarettes and the continued use of other tobacco products by youth is no accident but has been fueled by industry efforts. The 2014 U.S. Surgeon General's report concluded that "the tobacco epidemic was initiated and has been sustained by the aggressive strategies of the tobacco industry, which has deliberately misled the public on the risks of smoking cigarettes," and that "advertising and promotional activities by the tobacco companies cause the onset and continuation of smoking among adolescents and young adults."[8] Manufacturers of newer tobacco products are using the same marketing strategies that cigarette and smokeless tobacco manufacturers have long used to attract youth, including advertising on television and radio, sponsoring music and sports events, featuring celebrity endorsements, and disseminating images of their products as cool, sexy, and rebellious.[9] In 2016, 78 percent, or more than 20 million, middle and high school students reported seeing e-cigarette advertisements in retail stores, on the internet, on television and in newspapers and magazines.[10] Given this troubling record, we need to be vigilant in ensuring implementation of the most effective, evidence-based interventions to combat these industry efforts.

One of the most valuable resources OSH has developed over the years is *Best Practices for Comprehensive Tobacco Control Programs*.[11] This guide, which was last updated five years ago, provides detailed information by state, including funding recommendations, on the components of an effective tobacco prevention and control program. This resource has been an invaluable tool for states to use to build and sustain their programs. ACS CAN strongly recommends that OSH update this guide. As noted above, the tobacco product marketplace has changed dramatically, and industry marketing practices have evolved as well. At the same time, most states have invested woefully insufficient funds for their programs.[12] It is important, therefore, to better understand the consequences of insufficient, or declining, investment in state tobacco prevention and control programs. A modernized version of the guide, which should address the changing tobacco product marketplace, including the exponential growth in youth use of e-cigarettes, would better inform state efforts to combat the tobacco epidemic.

Additionally, we recommend updating OSH's *Best Practices Users Guides: Health Communications in Tobacco Prevention and Control*.[13] Tobacco industry marketing, combined with the use and influence of

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[8] US Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Washington, DC: US Department of Health and Human Services, CDC; 2014. Available at http://www.surgeongeneral.gov/library/reports/50-years-ofprogress/full-report.pdf.

[9] A Gateway to Addiction? A survey of popular electronic cigarette manufacturers and targeted marketing to youth. April 2014. http://www.durbin.senate.gov/public/index.cfm/files/serve/?File_id=81d14ff7-f2f6-4856-af9d-c20c0b138f8f

[10] Marynak K, Gentzke A, Wang, TW, Neff L, King BA. Exposure to Electronic Cigarette Advertising Among Middle and High School Students – United States, 2014-2016. MMWR Morb Mortal Wkly Rep 2019; 67: 294-299.

[11] Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs—2014. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

[12] American Cancer Society Cancer Action Network. How Do You Measure Up? A Progress Report on State Legislative Activity to Reduce Cancer Incidence and Mortality, 2018. https://www.fightcancer.org/sites/default/files/National%20Documents/HDYMU-2018.pdf

[13]Centers for Disease Control and Prevention. Best Practices User Guide: Health Communications in Tobacco Prevention and Control. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health

social media, has continued to exploit youth. In August 2017, ACS CAN, along with eight tobacco control and medical group partners, filed a petition with the Federal Trade Commission asking the agency to issue an order requiring tobacco companies to disclose that their social media campaigns are actually paid advertising for the products. A two-year investigation by the Campaign for Tobacco-Free Kids and Netnografica LLC found that tobacco companies had secretly paid popular young people with large online followings – known as social media influencers – to post images of their products. Other studies have similarly documented the rise in online advertising of e-cigarettes during the same period youth use rates have increased. The ways in which youth and young adults receive information, and from whom, has changed. Updating the *Best Practices Users Guides: Health Communications in Tobacco Prevention and Control* will further support public health efforts to counter the tobacco industry's targeting of youth and young adults.

Two new interventions have become increasingly popular in local jurisdictions and some states: policies to raise the age of sale of all tobacco products from 18 to 21, and policies to restrict or prohibit the sale of flavored tobacco products. It would useful to have a trusted scientific agency, particularly OSH, provide evidence on effectiveness of these interventions, including the specific policy and enforcement tools that make them most effective. Regarding "Tobacco 21" interventions, the Institute of Medicine, now known as the National Academies of Sciences, Engineering and Medicine, issued a well-received report on the subject in 2015. The report used mathematical modeling to quantify the likely public health outcomes of raising the national minimum legal age for tobacco products to 19 years, 21 years, and 25 years, but empirical evidence on these types of interventions is lacking.[14]

Furthermore, additional surveillance data on each of these issues would be helpful. For example, research shows that licensing of retailers is an important component of compliance for any age of sale policy. Unfortunately, there is lack of surveillance data available on the location and licensing of retailers. Mapping of retailers and technical assistance for identifying retailers, as well as other surveillance data and information could also assist in the compliance of these and other tobacco control policies, such as the collection of taxes on tobacco products.

Additionally, flavorings, such as candy and fruit, in tobacco products are a means to lure new, young users, and are aggressively marketed.[15] Among youth who have ever used a tobacco product, more than 80 percent started with a flavored product.[16] Among current e-cigarette high school users in 2018, 67.8 percent used any flavor and 51.2 percent used a menthol- or mint-flavored e-cigarette with similarly high flavored use rates among youth users of other tobacco products, including cigars,

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Promotion, Office on Smoking and Health, 2018.

[14] IOM (Institute of Medicine). 2015. Public health implications of raising the minimum age of legal access to tobacco products. Washington, DC: The National Academies Press.

[15] Delnevo, C, et al., "Preference for flavoured cigar brands among youth, young adults and adults in the USA," Tobacco Control, epub ahead of print, April 10, 2014. King, BA, et al., "Flavored-Little-Cigar and Flavored-Cigarette Use Among U.S. Middle and High School Students," Journal of Adolescent Health 54(1):40-6, January 2014.

[16] Ambrose et al. Flavored tobacco product use among U.S. youth aged 12-17 years, 2013-2014. JAMA, 2015; 314(17): 1871-3.

smokeless tobacco, and hookah.[17] While this data from the Population Assessment of Tobacco and Health (PATH) study on the use of these products is quite valuable, it would be helpful to have additional surveillance data and information on the availability, types, and use of flavored products.

Finally, laws that preempt local jurisdictions from developing their own policies are a tactic of the tobacco industry to undermine existing or outright prevent effective local tobacco prevention and control policies. It would be helpful if OSH documented the effects of these laws on the implementation of local tobacco prevention and control policies.

Eliminate Exposure to Secondhand Smoke

Secondhand smoke causes nearly 42,000 deaths, including more than 7,300 lung cancer deaths, among nonsmoking adults each year.[18,19] The total annual costs of secondhand smoke exposure are estimated to be at least $5.6 billion in indirect costs.[20] As the types of products on the market have changed and policies to protect against secondhand smoke have become more comprehensive, we encourage OSH to provide definitions of smoke-free to include all combustible products and tobacco-free to include all tobacco products. Having clear definitions of what comprehensive smoke-free or tobacco-free policies cover would be beneficial to employers, businesses, and communities in both implementing and enforcing such a policy.

Comprehensive smoke-free policies have been effective tools to reduce exposure to secondhand smoke and promote quitting among current users. OSH has provided invaluable resources on the benefits to communities, employers and businesses of these policies. Many of these studies are now outdated and may no longer appear relevant to existing businesses. It would be helpful to have updated evaluations of the benefits and return on investments for employers, businesses, and communities of these policies. Additionally, it would be helpful to have data on the costs to employers and businesses of not having a comprehensive smoke-free policy. This includes surveillance data on the populations that remain uncovered by smoke-free and tobacco-free policies. As public health advocates, we are finding it increasingly difficult to differentiate the populations that remain uncovered by policies and exposed to secondhand smoke, particularly by various places they work.

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[17] Cullen KA, Ambrose BK, Gentzke AS, Apelberg BJ, Jamal A, King BA. Notes from the Field: Use of Electronic Cigarettes and Any Tobacco Product Among Middle and High School Students — United States, 2011–2018. Corey, CG, Ambrose BK, Apelberg BJ, King, BK. Flavored Tobacco Product Use Among Middle and High School Students – United States, 2014. MMWR, October 2, 2015; 64(38): 1066-1070.MMWR Morb Mortal Wkly Rep 2018;67:1276–1277.

[18] Max W, Sung HY, Shi Y (2012). Deaths from Secondhand Smoke Exposure in the United States: Economic Implications. American Journal of Public Health;102(11):2173-80.

[19] U.S. Department of Health and Human Services (HHS). (2014). The Health Consequences of Smoking—50 Years of Progress: A report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Center for Diseases Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. Printed with corrections, January 2014.

[20] U.S. Department of Health and Human Services (HHS). (2014). The Health Consequences of Smoking—50 Years of Progress: A report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Center for Diseases Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. Printed with corrections, January 2014.

ACS CAN also recommends exploring new opportunities to educate the public about the harms of exposure to secondhand smoke and the benefits of smoke-free and tobacco-free policies. OSH might consider developing media campaigns much like the successful *Tips from Former Smokers* campaign. Additionally, opportunities to provide cessation information at the same time as information about the importance of maintaining a smoke-free environment could be very beneficial since they are two actions an individual or employer can take to reduce the risk of tobacco-related death and disease.

Finally, as reported by CDC and the Surgeon General, while approximately 90 percent of smokers started by age 18, fully 99 percent start by age 26, underscoring the importance of supporting those in the young adult age group with more effective prevention and cessation efforts while eliminating exposure to secondhand smoke and all tobacco use in their learning environments. To address the learning environment aspect of this issue, ACS, under the auspices of its Center for Tobacco Control, launched the Tobacco-Free Generation Campus Initiative, which provides grants to accelerate and expand the adoption and implementation of comprehensive smoke- and tobacco-free policies on college and university campuses across the U.S. To date, ACS has successfully partnered with 98 institutions of higher learning and helped many of them successfully adopt and implement 100-percent smoke- and tobacco-free policies. However, there are still many colleges and universities in the U.S., including those serving populations that experience greater health disparities, that lack strong policies. With this in mind, we encourage OSH to explore additional avenues for supporting the adoption of strong policies on college and university campuses and to form partnerships that particularly help minority-serving institutions and technical and vocational schools adopt and effectively implement strong campus smoke- and tobacco-free policies.

Identify and Eliminate Tobacco-Related Disparities

In order to continue to make progress on reducing tobacco product use in the U.S. population, it becomes even more important to identify those groups of individuals who are still initiating and using tobacco. In 2017, tobacco use rates were highest for adults with lower education attainment, with incomes below the federal poverty line, who resided in the Midwest or South, were uninsured or Medicaid recipients, were disabled, who experienced serious psychological distress, or were American Indians, Alaska Natives, multiracial, or lesbians, gays, or bisexuals.[21] Surveys have become better at identifying subpopulations, but we encourage OSH to find additional surveillance methods to be able to appropriately identify and track these users more consistently.

The most recent National Survey on Drug Use and Health (NSDUH) shows that the smoking rate among adults with mental health and/or substance use disorders (collectively referred to as behavioral health conditions) was 30.5 percent in 2017, a significant reduction from 34.2 percent in 2015.[22] The reduction

[21] Wang TW, Asman K, Gentzke AS, et al. Tobacco Product Use Among Adults — United States, 2017. MMWR Morb Mortal Wkly Rep 2018;67:1225–1232.

[22]Substance Abuse and Mental Health Services Administration. (2018). Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health (HHS Publication No. SMA 18-5068, NSDUH Series H-53). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/. Center for Behavioral Health Statistics and Quality. (2016). Key substance use and mental health indicators in the United

in smoking prevalence in the behavioral health population is encouraging, but the smoking rate remains more than twice as high for individuals with a behavioral health condition compared to the general population. In light of the extraordinary importance of reducing tobacco use in the behavioral health population, the American Cancer Society, with leading national partners from the public health and behavioral health communities, including key federal agencies, launched the National Partnership on Behavioral Health and Tobacco Use in 2016.[23] OSH is a vital partner in this endeavor and has played an important role in promoting smoking cessation in the behavioral health population, including through the Tips from Former Smokers campaign.[24] We encourage OSH to continue to give this critical area of tobacco control increased attention in its educational and media efforts.

As mentioned earlier, the *Best Practices User Guides*, including *Health Equity in Tobacco Prevention and Control*, play invaluable roles in supporting public health efforts to ameliorate the tobacco epidemic.[25] We recommend that OSH update the *Best Practices User Guides: Health Equity in Tobacco Prevention and Control* and we recommend additional guides or learning modules targeting specific audiences, such as tobacco control professionals, healthcare professionals and public health professionals. Additionally, these guides or training modules could focus on specific populations with higher tobacco use rates or

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States: Results from the 2015 National Survey on Drug Use and Health (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from http://www.samhsa.gov/data/

[23] Members of the Partnership include:
American Academy of Family Physicians
American Cancer Society
American Cancer Society Cancer Action Network
American Lung Association
American Psychiatric Association
American Psychiatric Nurses Association
American Psychological Association
Centers for Disease Control and Prevention, Office on Smoking and Health
National Alliance on Mental Illness
National Association of Social Workers
National Association of State Mental Health Program Directors
National Council for Behavioral Health
North American Quitline Consortium
Optum
Pfizer
Robert Wood Johnson Foundation
Smoking Cessation Leadership Center
Substance Abuse and Mental Health Services Administration
Tobacco Control Legal Consortium
Truth Initiative
UnitedHealth Group
University of Wisconsin—Center for Tobacco Research and Intervention
Veterans Administration

[24] Tips from Former Smokers. Rebecca's Story. https://www.cdc.gov/tobacco/campaign/tips/stories/rebecca.html

[25] Centers for Disease Control and Prevention. Best Practices User Guide: Health Equity in Tobacco Prevention and Control. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2015.

greater health disparities due to tobacco use. These guides or learning modules should incorporate cultural competency trainings.

ACS CAN encourages OSH to consider partnerships, both internally with other CDC programs, other federal programs, and externally, with programs and organizations that are already working with populations that are likely to have higher tobacco use rates or experience tobacco-related health disparities. For example, there may be opportunities to create appropriate partnerships with programs that serve low income populations, like the Supplemental Nutrition Assistance Program and the Special Supplemental Nutrition Program for Women, Infants, and Children.

In addition, healthcare systems have continued to evolve since the passage of the Patient Protection and Affordable Care Act in 2009. We recommend OSH consider guidance on how healthcare systems and organizations that work with healthcare systems can reach these tobacco users. Best Practices guides for different types of healthcare settings, such as behavioral health clinics, federally qualified health centers, Veteran Affairs hospitals and clinics, and Indian Health Services hospitals and clinics, would be useful. There is still a gap of tobacco users who remain uninsured or underinsured. OSH should consider whether programs like the National Breast and Cervical Cancer Program that serves low-income and underserved women could be a model for a cessation program; or the Colorectal Cancer Control Program that implements healthcare systems-based change to improve screening rates.

Finally, updated cessation guidance that is relevant to the current tobacco product marketplace is required if we are to have effective clinical cessation services interventions.

Conclusion

Thank you for the opportunity to provide input on this important topic. We appreciate the value of the tools and resources that OSH has disseminated to support tobacco prevention and control efforts and are ready to assist OSH in the development and implementation of these tools and resources. If we can provide additional information, please contact Katie McMahon, MPH, Policy Principal, at ACS CAN at 202-585-3245 or katie.mcmahon@cancer.org.