Tobacco Control in Pennsylvania

More than 50 years have passed since the 1964 Surgeon General’s Report on Smoking and Health, and tobacco use remains the leading cause of preventable death and disease nationwide, accounting for more deaths than alcohol, AIDS, vehicle fatalities, illegal drugs, murders, and suicides combined.\(^1\) In Pennsylvania, 19 percent of adults and 9 percent of high school students are current smokers, representing nearly 2 million current smokers.\(^{1,2,3}\) In addition, the State of Tobacco Control states that more than 20 percent of adults and more than 32 percent of high school students are current tobacco users.\(^4\)

Cigarette smoking causes more than 22,000 deaths each year in Pennsylvania.\(^4\) In addition to these fatalities, smoking leads to increased rates of heart disease, stroke, and emphysema, and lifelong health impacts stemming from smoking-related preterm deliveries, stillbirths, and low birth weights.\(^5\) Exposure to secondhand smoke also poses serious health threats, including heart disease, lung cancer, and stroke among adults; and asthma attacks, bronchitis and pneumonia, and sudden infant death syndrome (SIDS) among children.\(^6\) In fact, the Centers for Disease Control and Prevention (CDC) states that there is no safe level of exposure to secondhand smoke.\(^6\) In Pennsylvania, non-smokers continue to be exposed to life-threatening secondhand smoke at thousands of public spaces across the Commonwealth, such as bars, restaurants, and parks. The risks of secondhand smoke are particularly acute for children living with smokers.
Tobacco also has a significant negative impact on Pennsylvania’s economy. Annually, cigarette smoking costs Pennsylvania over $12 billion in healthcare expenses and lost productivity. While these costs are shared across various stakeholders, they impact all Pennsylvanians—smoking-caused government expenditures increase the state and federal tax burden by an average of $1,020 per household.

The American Lung Association in Pennsylvania has outlined tangible programs, practices, and policy priorities to assist policy makers and elected officials in protecting Pennsylvanians from the harmful impacts of tobacco use, including preventing youth from becoming addicted to tobacco, reducing non-smokers’ exposure to secondhand smoke, and better assisting current smokers to successfully quit using tobacco. The American Lung Association in Pennsylvania asks for and encourages your support with the following issues:

- Defend and increase state funding to the CDC-recommended level of $140 million annually for tobacco prevention and control programs, and ensure that funding is spent according to CDC’s Best Practices;
- Increase the minimum legal sales age for tobacco products, including electronic cigarettes, to 21;
- Close the loopholes in the Clean Indoor Air Act that leave employees vulnerable to secondhand smoke;
- Create tax parity, with cigarettes, on all other tobacco products;
- Adopt legislative or regulatory standards for comprehensive smoking cessation treatment coverage by insurance companies and Medicaid programs;
- Adopt legislation to prohibit tobacco surcharges across all health insurance plans in the Commonwealth;
- Support flavored tobacco product restrictions, including e-cigarettes.

All of these efforts will help to build a healthier workforce and more robust state economy.
Raise the Minimum Legal Sales Age to Purchase Tobacco Products in Pennsylvania to 21

Protecting youth from the adverse health impacts of tobacco use is a critical component of tobacco control. Youth are more vulnerable to nicotine addiction than are older adults, yet nearly 9 percent of high school students in Pennsylvania are current smokers and over 11 percent are current e-cigarette users. Preventing youth initiation of tobacco use is an important strategy for reducing the overall burden of tobacco in part because 81 percent of current smokers first began smoking before they turned 21. According to a 2015 report from the National Academy of Medicine (formerly the Institute of Medicine), a nationwide minimum legal sales age of 21 would:

- Immediately improve the health of adolescents and young adults;
- Decrease tobacco use among adults by 12% by the time today’s teenagers become adults;
- Prevent 223,000 premature deaths due to tobacco use;
- Result in 50,000 fewer lung cancer deaths; and
- Save 4.2 million years of life that would otherwise be lost to tobacco-related premature death among those born between 2000 and 2019.

Pennsylvanians support raising the minimum legal sales age from 18 to 21 (Tobacco 21). A representative survey of more than 3,000 Pa. voters found that the majority of voters (68.4%) favor raising the tobacco sales age from 18 to 21. Most current smokers (54.4%) and former smokers (72.7%) favor raising the sales age as well. The survey also found that Tobacco 21 is a non-partisan issue for Pennsylvanians with most Democrats (72.3%) and Republicans (67.5%) supporting raising the age. Only about 1 in 10 Pennsylvania voters strongly oppose Tobacco 21.

A minimum legal sales age 21 would be particularly impactful on youth ages 15–17, a majority of whom obtain tobacco through social contacts such as family and friends. A minimum legal sales age of 21 would make it significantly less likely that high school youth would be able to get tobacco products through social connections at school; the National Academy of Medicine estimates that a minimum legal sales age of 21 will reduce initiation of tobacco use in this age group by 25 percent.

State-level efforts to raise the minimum legal age of sale are critical. The Food and Drug Administration (FDA), which has federal regulatory authority of tobacco products per the 2009 Family and Smoking Prevention and Tobacco Control Act, is prohibited from raising the nationwide legal sales age. Currently, Hawaii, California, Maine, Massachusetts, New Jersey and Oregon as well as New York City, Chicago and more than 350 other municipalities nationwide have made the change and led the way the increase the age of sale from 18 to 21.

**RECOMMENDATION:**

Increase the minimum legal sales age to purchase tobacco products to 21 to significantly reduce youth tobacco use and to prevent related disease and premature death among younger generations.
Comprehensive Clean Indoor Air Legislation

In Pennsylvania, over 2,200 venues are exempt from the Clean Indoor Air Act (CIAA), leaving many hospitality workers exposed to harmful carcinogens. Only by enacting a comprehensive law can we give all workers the protection they deserve. Current exemptions to the law include:

- Bars with 20% or less revenue from food
- Casinos (up to 50% of the gaming floor)
- Hotel/motels (up to 25% of rooms)
- Private clubs and private residences
- Tobacco shops
- Cigar bars
- Truck stops with shower facilities
- Outdoor sports, recreational facility, theater or performance establishment
- Tobacco manufacturer cigar exhibitions
- Non-profit fundraisers that feature tobacco products

Pennsylvania’s law is exemption heavy, in part due to the common misperception that smokefree laws hurt businesses. Yet numerous scientific and economic analyses show that smokefree laws do not hurt restaurants or bars when measured in terms of patronage, employment, sales, or profits. In 2014, an economic impact study of Pennsylvania was published in the Journal Health Promotion Practice; the study found that CIAA exemptions for drinking establishments do not offer a clear economic benefit. Consistent with the growing body of literature in the field, CIAA had no negative effects on per capita restaurant and drinking establishment taxable sales and drinking establishment exemptions were not economically beneficial. The vast majority of exemption applications were filed within the first weeks of the law’s passage, before businesses could see how CIAA might affect their patronage, employment, sales, or profits.10

A study of air quality in the state’s hospitality industry before and after CIAA in locations across the state found that **indoor air pollution levels in newly smokefree venues declined by nearly 90 percent**. American Lung Association estimates that smokefree air would save 52 hospitality workers’ lives annually.11

The current law also preempts all local governments from adopting or enforcing their own, more restrictive indoor air regulations.10 Alarmingly, in 2018 an amendment attached to the state budget bill eliminated the city of Philadelphia’s ability to pass additional regulations on tobacco sales, giving the state legislature preemptive control. While this will not impact ordinances and regulations adopted prior to implementation, any pending or future legislation, such as a proposed flavored tobacco ordinance, will be prevented from moving forward.

**RECOMMENDATIONS:**

Remove exemptions from the Clean Indoor Air Act, extending full protection from the effects of secondhand smoke to all Pennsylvania workers. Remove preemption from CIAA, enabling any locality to adopt and enforce indoor air regulations that set higher standards than the existing state law.
Tax Non-Cigarette Tobacco Products at 58% Wholesale

Tobacco taxes are one of the most intuitive approaches to tobacco control – higher prices induce consumers to reduce their use of tobacco products, and have the added benefit of providing government with a stable source of long-term revenue. According to the CDC, “Increasing the price of tobacco products is the single most effective way to reduce consumption.”\(^{12}\) Research suggests that a 10 percent hike in the cost of cigarettes leads to a three to five percent decrease in consumption, and that youth are particularly sensitive to price increases, decreasing their consumption by two to three times as much as adults do in response to the same price jump.\(^{12}\)

Pennsylvania has developed the following tax structure for its tobacco products:

<table>
<thead>
<tr>
<th>Product</th>
<th>Cigarettes</th>
<th>E-Cigarettes (Model Tax Structure)</th>
<th>Loose and Smokeless Tobacco</th>
<th>Cigars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax Rate</td>
<td>$2.60 per pack</td>
<td>40% of wholesale, including devices and liquid cartridges</td>
<td>55 cents per ounce</td>
<td>None</td>
</tr>
<tr>
<td>Adjusted to Inflation</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Date</td>
<td>August 2016</td>
<td>October 2016</td>
<td>October 2016</td>
<td>Never</td>
</tr>
</tbody>
</table>

The American Lung Association in Pennsylvania applauds the legislature's decision in 2016 to increase cigarette taxes and to join the rest of the country by implementing a first-time tax on other tobacco products, such as smokeless and roll-your-own tobacco. This tax will prevent thousands of young Pennsylvanians from becoming addicted to tobacco, and will save the commonwealth millions of dollars in averted health care expenditures and lost productivity.

However, Pennsylvania missed an opportunity to fully protect residents from the health harms of tobacco by introducing the tax as a weight-based tax on smokeless and roll-your-own tobacco, and by not taxing cigars. Pennsylvania remains one of only two states that do not tax cigars.

The failure to tax cigars creates a disparity in prices between cigars and other tobacco products, even though cigars are just as harmful as any other tobacco product.\(^{13}\) Artificially low cigar prices may encourage youth and other Pennsylvanians to switch to using cigars in lieu of other tobacco products. Furthermore, low cigar prices make it easier for youth to initiate tobacco use. An even tax structure is critical to preventing youth tobacco use.
The weight-based tax on loose and smokeless tobacco also creates an uneven tax structure on tobacco products in Pennsylvania. Lowweight products, especially new ultra-light products such as moist snuff, are marginally taxed under a weight-based system, creating price distortions that encourage consumption of low-weight tobacco products. As more consumers shift toward consuming lowweight products, this robs the state of tax revenue. Additionally, because weight-based taxes are not tied to wholesale prices, they do not adjust to inflation over time, further limiting tax incomes to the state while reducing the real cost of tobacco products over time.

Alternatively, the state’s new tax on e-cigarettes is effectively designed to respond to inflationary changes in product pricing over time, thereby consistently protecting future consumers from the harms of tobacco use. This taxation model also ensures consistent state revenues over time.

The American Lung Association supports creating tax parity, with cigarettes, on all other tobacco products, including cigars (using percentage of wholesale price)—this creates tax parity between cigarettes and other tobacco products, and properly includes cigars as a taxed tobacco product. This would create an even tax structure, which is the simplest and most effective way to protect our youth from the health harms of tobacco. Furthermore, it would institute a tax system that would increase in accordance with inflation, thus assuring the state consistent revenues.

Tobacco related illnesses currently cost Pennsylvania $6.38 billion dollars in annual health care expenditures.\(^1\) One of the most significant solutions to improve health and support an ailing economy is to significantly increase taxes on tobacco products. While Pennsylvania’s tobacco tax increase and concurrent inclusion of non-cigarette tobacco products are important strides forward, unequal tax rates and the exemption of cigars continue to leave our youth and other tobacco users unprotected, while at the same time limiting commonwealth’s revenues and leaving Pennsylvania vulnerable to inflation.

**RECOMMENDATION:**

Create tax parity, with cigarettes, on all other tobacco products, using percentage of wholesale price, to prevent youth from initiating or switching use due to an uneven tax regime.
Insurance Coverage for Tobacco Cessation

In 2016, over half of adult smokers in Pennsylvania made an attempt to quit. However, some estimates suggest that the average smoker may make between 20 and 30 quit attempts prior to successfully quitting. Because so many quit attempts are unsuccessful, it is crucial to ensure that smokers who are motivated to quit have access to the resources they need.

The CDC recommends the use of smoking cessation treatments, including counseling, nicotine replacement products, and non-nicotine cessation medications; the use of counseling in combination with appropriate medication is significantly more effective than using either one alone. In fact, according to a meta-analysis of 18 studies, providing counseling in addition to medication increases estimated abstinence rates by more than 20 percent, as compared to providing only medication.

Unfortunately, Pennsylvania does not guarantee comprehensive insurance coverage for smoking cessation.

Currently, Medicaid programs in Pennsylvania cover all seven recommended cessation medications, as well as individual and group counseling. However, this coverage has several barriers, including limits on counseling duration, limits on counseling per year, and minimal copayments. Many commercial plans offer nominal benefits, such as a limited number of counseling sessions, or coverage for only one type of smoking cessation medication, but do not offer comprehensive coverage. Even the Pennsylvania Employees Benefit Trust fund, which provides health benefits to the state government's 80,000 employees, denies access to comprehensive smoking cessation coverage.

Insurance companies and Medicaid contractors should cover comprehensive tobacco cessation treatments and eliminate barriers to their use, including required co-payments, prior authorization requirements, limits on treatment duration, yearly or lifetime limits, dollar limits, “stepped care” therapy, and counseling requirements for medication.

Increasing access to cessation treatments will help smokers in Pennsylvania quit, save lives and reduce short and long-term costs. Economic analyses of cessation coverage substantiate the efficacy of such approaches: one review estimates that employer savings total more than $5.00 for every dollar spent covering cessation. Tobacco cessation is more cost-effective than other common and covered disease prevention interventions, such as the treatment of hypertension and mammography screenings, and should be a standard insurance benefit for all Pennsylvanians.

**RECOMMENDATION:**

Adopt legislative or regulatory standards for comprehensive smoking cessation treatment coverage by insurance companies and Medicaid programs in Pennsylvania.
American Lung Association Opposes the Use of Tobacco Surcharges

A tobacco surcharge is a variation in insurance premiums based on a policyholder (or dependent’s) tobacco use. Tobacco surcharges are sometimes called tobacco premiums, premium incentives, or non-smoker discounts. Starting January 1, 2014, many insurers and employers were able to charge tobacco users up to 50 percent more in premiums. The rule implementing this provision in the Affordable Care Act requires insurers in the small group market to remove the tobacco surcharge for a tobacco user who agrees to enroll in a program that will help them quit.23

In an attempt to discourage use of tobacco products and cover additional health care costs associated with tobacco use, many employers and insurance companies are considering tobacco surcharges. However, punitive measures like tobacco surcharges have not been proven effective in reducing tobacco use. In fact, some research suggests that surcharges may reduce smoker enrollment in health care plans, and that low surcharges in particular may actually decrease smoking cessation.23

The American Lung Association opposes the use of tobacco surcharges.

While the Affordable Care Act allows tobacco surcharges up to 1.5 times the regular premium, states are able to limit these surcharges or prohibit them altogether.24 Pennsylvania policymakers should ensure that health insurance is affordable for tobacco users.

**RECOMMENDATION:**
Adopt legislation to prohibit tobacco surcharges across all health insurance plans in the Commonwealth.
E-Cigarettes and Flavored Tobacco

In recent years, use of electronic cigarettes has increased at an alarming rate. E-cigarettes are battery-powered devices that use a heating element to heat e-liquid, typically containing nicotine, from a cartridge that produces a chemical filled aerosol. Currently, the most popular e-cigarette among teens is JUUL, which looks like a USB flash drive and produces very little aerosol when being used. Many JUUL pods contain high levels of nicotine – one JUUL pod claims to contain roughly the same amount of nicotine as one pack of cigarettes.

While e-cigarettes generally emit fewer toxicants than combustible tobacco products, the Surgeon General has concluded that e-cigarettes aerosol is not safe. Studies have shown formaldehyde, benzene, and other items in secondhand e-cigarette emissions. With more than 470 brands and more than 7,700 flavored products available, there is little scientific based evidence of the long-range health effects on consumers. The vast majority of current e-cigarette users are also current smokers, or dual users, including 59 percent of adult users and 76 percent of youth users. The FDA has not found any e-cigarettes to be safe and effective in helping smokers quit.

In January 2018, the National Academies of Science, Engineering and Medicine released a consensus study report that reviewed over 800 different studies. That report made clear: using e-cigarettes causes health risks, increases the chance that children and youth will start to use combustible tobacco products and exposes others to dangerous secondhand e-cigarette emissions.
The Centers for Disease Control and Prevention announced that youth use e-cigarettes has skyrocketed, with a 78 percent increase in high school students’ use of e-cigarettes – meaning that one in five high school students are using e-cigarettes. It also shows a nearly 50 percent increase in the use of e-cigarettes by middle-school students. These products are now the most commonly used form of tobacco among youth nationwide, and the Surgeon General has declared their use a major public health concern.

A number of steps have been taken towards regulating e-cigarettes. In 2014, Philadelphia categorized e-cigarettes the same as regular tobacco, meaning the vapor producing products would be eliminated in most public places and those under 18 would be prohibited from buying them.

In 2016, the Food and Drug Administration’s (FDA) final “deeming rule” was put into law, giving the FDA the authority to regulate the manufacture, sales and marketing of all tobacco products including e-cigarettes, cigars, hookah, little cigars and other tobacco products. This rule means that the FDA can crack down on industry marketing to youth, unproven health claims and sales to minors. Unfortunately, the tobacco industry continues its attempts to weaken this rule by successfully urging the United States House of Representatives to attach so-called appropriations “riders” to the FDA’s funding bill, which would prohibit FDA from implementing key provisions of the final rule. We continue to advocate with our partners against these riders to keep the Tobacco Control Act strong and effective.

The American Lung Association will continue to push for meaningful action from the FDA, but while this occurs, states have the authority to restrict or prohibit flavorings in tobacco products.

The American Lung Association calls on the Governor and the State Legislature to take swift action to protect kids from this e-cigarette epidemic and a lifetime of nicotine addiction by enacting policies to support flavored tobacco product restrictions; raise the retail sales age of all tobacco products, including e-cigarettes, to 21; and to sustain funding for tobacco control programs and services from the Tobacco Master Settlement Agreement.

**RECOMMENDATION:**

Support flavored tobacco product restrictions including e-cigarettes that focus on tobacco-free policies and regulations rather than smokefree policies and regulations.
Master Settlement Agreement (MSA) with the Tobacco Industry

In 1998, Pennsylvania and 45 other states entered into a Master Settlement Agreement with the tobacco industry. The Master Settlement Agreement was estimated at $206 billion dollars nationwide. Pennsylvania was allotted an estimated $11 billion dollars to be disbursed over a period of 25 years, from 2000 to 2025.\textsuperscript{28} Between July 2016 and June 2017, Pennsylvania received approximately $354 million in MSA funding.

During the 2018 legislative session, Tobacco cessation and prevention funding comprised of $15.5 million from the MSA and approximately $3.0 million in federal funding, for a total of about $18.6 million. The previous year saw these funds borrowed against to fill the budget gap by selling the rights to part of the state’s future annual tobacco MSA payments for a lump sum payment up front. This represents less than 14 percent of the CDC-recommended spending level of $140 million. While Governor Wolf’s budget allocated what remained from the annual MSA payment towards the Commonwealth’s tobacco prevention and cessation programs, the funds still stand at risk of not being appropriated to these lifesaving services in the future.

| 2001: Pennsylvania passed legislation (ACT 77) to allocate MSA funds as follows: |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| 30% Insurance for uninsured adults | 19% Health-related research | 13% Home and community-based senior care | 12% Prevention and Cessation (in FY2015 < 5%) | 10% Hospital charity care | 8% Prescription drug assistance for seniors (PACENET) | 8% Endowment for future health care programming |

**FY2010:** Tobacco Cessation and prevention funding decreased by 45%, forcing the elimination of the majority of tobacco prevention programs that target youth and the community.

**September 2013:** An MSA-related arbitration panel ruled against Pennsylvania in a non-participating manufacturer adjustment dispute, reducing the 2014 payment by $196.9 million.

**2017:** The Pennsylvania legislature floated a bond using MSA funds to balance the state budget. MSA funds no longer support tobacco cessation and prevention programs in Pennsylvania, and the future of MSA funding is undetermined.

**RECOMMENDATION:**
Allocate state funding to the CDC-recommended level of $140 million annually for comprehensive tobacco prevention and control programs and ensure that funding is spent according to CDC’s Best Practices.
Contact the American Lung Association in Pennsylvania

Tobacco use continues to be the single largest cause of preventable death and disease in Pennsylvania: 22,000 Pennsylvanians die every year from tobacco-related causes, including many who have never used tobacco themselves. Furthermore, tobacco use costs employers and taxpayers billions of dollars each year in health care expenditures, lost productivity, and absenteeism. The good news is that commonsense policies, such as standardized tobacco taxes and comprehensive clean indoor air legislation, can protect everyone from secondhand smoke, help tobacco users to quit, and prevent non-users from ever initiating tobacco use, all while saving the commonwealth billions of dollars.

Reducing, and eventually eliminating, tobacco use in Pennsylvania is an investment in the future of our state – in our youth, in the health of our families, in our economy – that will pay dividends for decades to come. The American Lung Association in Pennsylvania is here to support and assist you in your work to build a healthier Pennsylvania.

Sarah Lawver
Director | Advocacy | Pennsylvania
American Lung Association
O: 717-971-1130 | sarah.lawver@lung.org
www.lung.org | Lung HelpLine: 1-800-LUNGUSA
References


