Testimony

of

Mary T. Bassett, MD, MPH

Commissioner

New York City Department of Health and Mental Hygiene

before the

New York City Council Committee on Health

on

Tobacco and Health

April 27, 2017

Council Chambers, City Hall

New York City

Good morning, Chairman Johnson and members of the Committee. I am Dr. Mary Bassett, Commissioner of the New York City Department of Health and Mental Hygiene. I am joined today by Amit Bagga, Deputy Commissioner for External Affairs at the Department of Consumer Affairs, and Sheriff Joe Fucito from the Department of Finance.

The mission of the Department is to improve the health of all New Yorkers and to reduce health inequities. As Health Commissioner, I am the City's doctor – a role I take seriously. Among the most important advice for a long, healthy life that I can give my patients – the residents of this great city – is to stop smoking and using tobacco products. I am pleased to be here today to talk about this important issue. Thank you for the opportunity to testify on the suite of tobacco-related bills currently before the Council for consideration.

On April 19, I joined Mayor de Blasio, Deputy Mayor Palacio, Chairman Johnson, Council Members Lander and Cabrera to announce a series of proposals that will help us reduce the number of smokers in New York City by 160,000 over the next three years. The five bills, all of which I'm pleased will be discussed today, continue New York City's commitment to tobacco control by raising the minimum prices for all tobacco products, including cigarettes, and imposing a new 10% local tax on other tobacco products; reducing through attrition the number of tobacco retailers citywide; creating a retail license for e-cigarettes, and capping the number of e-cigarette retailers; requiring all residential buildings to create a smoking policy and disclose it to both current and prospective tenants; and banning the sale of tobacco products at pharmacies.

These bills will build on the work we have done with the Council in recent years. Since 2002, New York City's adult smoking rate has dropped by 33 percent, from 21.5 percent in 2002 to 14.3 percent in 2015, and the youth smoking rate has dropped by 67 percent between 2001 and 2015, from 17.6 percent to 5.8 percent. These reductions will have prevented 136,000 deaths in New York City by

2060. But we can't rest on our accomplishments. More than 900,000 adult and 15,000 young New Yorkers smoke, and an estimated 12,000 New Yorkers die from tobacco-related illnesses annually. I would like to acknowledge all of today's bill sponsors – Chairman Johnson, Council Members Lander, Cabrera, Torres, Vacca, Gentile, and Richards – and thank them for addressing tobacco and e-cigarette use.

Increasing the Price of Cigarettes and Other Tobacco Products

The first bill I will discuss is Intro 1544. This bill focuses on increasing the price of both cigarettes and other tobacco products, including cigars, smokeless tobacco and shisha. The City has had a tax on cigarettes since 2002 and a minimum price on cigarettes and little cigars since 2013, but it has never addressed the price of many other tobacco products. All tobacco products are inherently dangerous and contain nicotine, which is addictive. Health impacts from tobacco use include cancers, heart disease and lung disease.

The City's historical focus on reducing cigarette smoking has been justified by the heavy toll that cigarettes have had on the health of New Yorkers, and we've made remarkable progress decreasing smoking rates. However, consumption patterns and the market for tobacco products are changing. A greater proportion of our City's youth is using other tobacco products, such as cigars, including little cigars and cigarillos, and smokeless tobacco. In 2015, 5.8 percent of youth were smoking cigarettes while 5.7 percent were smoking cigars and 3.3 percent were using smokeless tobacco. In addition, between 2008 and 2014, the percentage of middle school students in New York City who had ever smoked hookah increased from 2.9 percent to 8.5 percent. In 2014, 16.1 percent of high school students reported that they had ever smoked hookah.

Raising the price of tobacco products through taxes and minimum prices is the single most effective way to decrease consumption and encourage tobacco users to quit. Studies have shown that

raising the price of tobacco decreases youth initiation, encourages tobacco users to quit and reduces consumption among those who do not quit. Since youth are particularly sensitive to price increases, measures that raise the price of tobacco products are an effective strategy for reducing use among this vulnerable population. Intro 1544 would increase the minimum price for cigarettes from $10.50 to $13.00 per pack. It is projected to lead to a 6.4% decline in adult cigarette smoking, or 28,000 fewer adult smokers. Among youth we project there would be a 10% decline in cigarette smoking, which would lead to 1,000 fewer youth smokers. With a minimum price of $13 a pack, New York City would once again claim the distinction of having the most expensive cigarettes in the nation. Intro 1544 also sets a minimum price for various tobacco product categories, including smokeless tobacco, loose tobacco and shisha, and would be the first minimum price of its kind in the country for these products. In addition, the bill would increase the existing minimum price for little cigars from $10.50 to $13.00 a pack.

Finally, a State Public Housing Law from 1939 authorizes the City to impose a tax on other tobacco products. Any revenue generated from the tax is required by law to support public housing. The tax would be set at 10 percent of the minimum price for each non-cigarette tobacco product category and is estimated to produce revenue of $1 million annually. We project the price increases will reduce cigar prevalence among youth by 10.5 percent, or 1,700 fewer cigar users. The smokeless tobacco prevalence among youth is projected to decrease by at least 23 percent, or 1,800 fewer users.

We must use every tool available to us to raise the price of these deadly products, especially since the State has not raised the cigarette tax since 2010 and has not allowed New York City to raise its local tax on cigarettes since 2002. We strongly support this bill and thank Chairman Johnson for introducing this needed piece of legislation.

Reducing Tobacco Retailers in New York City

Now I will turn to Intro. 1547. This bill updates the City's license for selling tobacco products in several important ways that, taken together, restrict access to tobacco. First, it acknowledges that to respond to changes in tobacco use, we need a license that applies to all tobacco products – not just to cigarettes. Tobacco products other than cigarettes have become increasingly popular among youth in recent years. To properly regulate these products, a license update to include all tobacco products is necessary.

Second, the bill establishes a process for reducing the number of licenses to sell these products over time. The City has a high level of tobacco retail density, with approximately 8,200 licensed cigarette retailers. Studies show that easy access to tobacco retailers makes it harder for smokers to quit. In addition, youth who visit retail stores that sell tobacco every week are twice as likely to try smoking as other youth. This bill will cap the number of tobacco retail licenses in each community district at 50 percent of the current number of licenses. No new tobacco licenses will be issued for that community district until the number of licenses falls below the 50 percent level. Based on estimates by the Health Department and Department of Consumer Affairs, in ten years, the bill may reduce the number of tobacco retailers by up to 40 percent. The map I've brought today illustrates what would happen in one neighborhood – East Harlem – over time, and you can see the dramatic difference in tobacco retail density. Current tobacco retailers are allowed to keep their license indefinitely unless those licenses are revoked for selling cigarettes to minors or committing other violations. And the person who buys ownership of a business with a current tobacco license will be able to apply for that license if the business has been in good standing with the law for three consecutive years. For these reasons, we strongly support passage of this bill and thank Council Member Lander for sponsoring this critical legislation.

We also enthusiastically support Intro 1131-A, Council Member Lander's bill that would prohibit pharmacies from selling cigarettes and, once the cigarette license is updated, prohibit them from selling any other tobacco products. Selling cigarettes and other forms of tobacco alongside health products runs counter to a pharmacist's mission, and the vast majority of independent pharmacies do not offer tobacco products. CVS also stopped selling tobacco in 2014, and I want to commend them for making that choice. More than 80 jurisdictions have banned pharmacies from selling tobacco products and e-cigarettes, including San Francisco and Boston, and I'm excited for New York City to join that list. It's important to note that the number of chain pharmacies in San Francisco has tripled since their pharmacy ban took effect in 2008, demonstrating that stores can thrive without tobacco sales.

Together, these two bills will greatly reduce the number of tobacco retailers over time, reducing tobacco use and improving health outcomes.

Creating a Retail License for E-Cigarettes

Next I want to discuss Intro 1532, which creates a separate license for selling electronic cigarettes. Despite being on the market for fewer than ten years, e-cigarettes were used by 15.9 percent of New York City high school students in 2015. E-cigarette use is now more than twice as common among youth as cigarette use. The increasing popularity of e-cigarettes shows the importance of this bill. Current e-cigarette retailers – except for pharmacies – will have the opportunity to apply for the new license during an open enrollment period. After the open enrollment period expires, no new licenses will be issued. Pharmacies will be prohibited from selling these products. Fourteen states and the District of Columbia have passed laws requiring e-cigarette retailers and vape shops to obtain either a license or a permit to do business, and it is time New York City does the same. By blocking any future growth of e-cigarette retailers, New York City will have the most protective policy in the country.

Although e-cigarettes do not contain tobacco, these products typically contain nicotine, which is addictive, as well as potentially harmful chemicals that should be studied to determine their cumulative health effects over time. Moreover, there is emerging evidence that youth who use e-cigarettes are more likely to later try cigarettes. For example, one study showed that youth non-smokers who used e-cigarettes were more than four times as likely to report having smoked one year later than non-smokers who did not use e-cigarettes. There is also insufficient evidence that e-cigarettes are an effective way to quit smoking, and in fact Big Tobacco is heavily invested in e-cigarettes. Many e-cigarette companies use the same marketing strategies that were once used to sell cigarettes as glamorous products, not cessation devices, while also appealing to youth with flavors like Sour Dream and Bazooka. For these reasons we thank Council Member Cabrera for this piece of legislation and we urge the Council to approve this bill.

Disclosure of Residential Smoking Policy

The next bill I would like to address is Intro 1585. This bill will empower individuals to make informed decisions about where to live, and it may encourage more buildings to adopt smoke-free policies. There is no safe level of exposure to secondhand smoke, and there is increasing evidence of risks from even low levels of smoke exposure. Air monitoring studies confirm that smoke commonly travels throughout the building from a smoker's apartment into other apartments. Adult non-smokers exposed to secondhand smoke have higher risks of stroke, heart disease and lung cancer. Children exposed to secondhand smoke have higher risks of asthma attacks, respiratory illnesses, middle ear disease and Sudden Infant Death Syndrome.

Secondhand smoke infiltration in City residences is a common basis for complaints to 311, and more than one-third of adults report smelling cigarette smoke in their home that comes from other

residences. Smelling secondhand smoke at home is more likely to afflict low-income New Yorkers than high-income New Yorkers, and those with children in the home than those without.

This bill requires all multi-unit residences in the City to choose a policy on smoking and to disclose that policy to the building's tenants on an annual basis. In addition, prospective tenants must receive a copy of the policy on smoking before signing a lease or agreeing to buy an apartment. This bill would inform tenants of rental, cooperative and condominium units where smoking is permitted and where it is prohibited in a particular building. Since the U.S. Department of Housing and Urban Development (HUD) recently issued a rule that will require public housing authorities nationwide, including NYCHA, to adopt smoke-free policies by mid-2018, we believe the time is right to empower all New Yorkers with information that will enable them to find smoke-free housing. Thank you Council Member Torres for sponsoring this important piece of legislation.

Finally, I'll briefly address the other bills on the agenda today. Intro 1471, sponsored by Chairman Johnson, would increase the cigarette retail license fee to $340, which would equal the cost of the proposed e-cigarette retail license fee. We support increasing the license fee. Intro 484, sponsored by Council Member Vacca, would extend the smoking ban in the Smoke-Free Air Act to common areas of all multiple-dwelling buildings with three or more units. We support the extension of the Smoke-Free Air Act to include these buildings. Intro 139-A, sponsored by Council Member Gentile, would cover non-tobacco shisha smoking under the Smoke-Free Air Act and allow certain hookah establishments to continue to operate. This bill was originally heard last year. We appreciate the Council tackling the important issue of hookah use, and this proposal represents important progress in regulating these establishments. We also appreciate that Fire Code language has been added to address concerns raised by the Administration. The next two bills – Intros 977 and 1140 – are more complicated. Intro 977, sponsored by Council Member Richards, would ban smoking in all housing owned and operated by

NYCHA as well as housing financed by the City. As mentioned above, HUD announced that it will ban smoking in all public housing, including NYCHA. But this bill would go further, and we don't believe it is fair for New York City to ban smoking only in subsidized housing for low-income New Yorkers, and we think there may be legal issues with doing so. We support the concept of smoke-free housing and would welcome more discussion about how to overcome legal and policy concerns. Similarly, we have questions about Intro 1140, which is sponsored by Council Member Cabrera and would ban smoking and vaping in vehicles carrying children under age 8. While we certainly don't want anyone to smoke or vape near children, it's not clear how this law would be enforced or if the age limit is appropriate to ensure public health benefits. We look forward to talking to Council about this bill.

Policies that reduce the availability of tobacco and reduce New Yorkers' exposure to secondhand smoke will have a positive health impact, and I thank the Council for introducing these important pieces of legislation. The package of bills that I have discussed today will put New York City at the forefront of tobacco control nationally, and I'm excited to continue to work with Council on this critical public health issue.

Thank you for the opportunity to testify. We are happy to answer questions.

Testimony of Deputy Commissioner Amit S. Bagga
New York City Department of Consumer Affairs

Before the
New York City Council Committee on Health

Hearing on
Introductions 1131-A, 1471, 1532, 1544 and 1547
in relation to tobacco product and electronic cigarette licensing and enforcement and other tobacco product price floors

April 27, 2017

Good morning, Chairman Johnson and members of the committee. My name is Amit S. Bagga and I am the Deputy Commissioner for External Affairs at the New York City Department of Consumer Affairs ("DCA"). I am joined today by several of my colleagues from the agency. We are pleased to be here today to support Introductions 1131-A, 1471, 1532, 1544, and 1547, which would prohibit pharmacies from selling tobacco products, expand the scope of the existing cigarette retail dealer license, create a new licensing category for the sale of electronic cigarettes, increase and establish price floors for cigarettes and other tobacco products, and establish a system by which the number of tobacco retail dealer licenses can be reduced over time.

As our colleagues from the Health Department have shared, the Administration believes that too many New Yorkers are still smokers, and for the sake of their health, as well as the public health of the City, it is critical that we take action to reduce tobacco use. We thank the Council for prioritizing this issue and look forward to working closely together on finalizing this legislative package, one that is strongly supported by Mayor de Blasio and First Lady McCray.

Licensing

I will begin my testimony by offering a brief overview of DCA's mission and licensing work. DCA's mission is to protect and enhance the daily economic lives of New Yorkers to create thriving communities. DCA enforces a variety of licensing laws across over 80,000 businesses in 57 categories of industries, as well as the City's Consumer Protection Law and certain State business laws.

There are currently more than 8,000 licensed cigarette retail dealers across the five boroughs. DCA licenses businesses that sell cigarettes directly to the public, and every location of any businesses must obtain its own license. The application process includes a basic license application, documentation relevant to the business's legal structure, and copies of their registration with the New York State Department of Taxation and Finance. DCA also often reviews applications to determine their overall veracity. In many instances, cigarette retail dealers who have received violations on multiple occasions, aware that recidivist penalties are higher and could lead to revocation, "sell" the ownership of their business as a way of avoiding enforcement. Through our process, we often attempt to identify whether or not this has been the

case when a new applicant is applying for a license at a particular physical location where a different business previously held a license.

Licenses are renewed every two years on a staggered basis; licenses with even-numbered license numbers expiring on December 31 of even years and licenses with odd-numbered licenses expiring on December 31. Staggering renewals in this way allows our licensing staff the ability to better manage the high volume of renewal applications.

We note that Intro 1471 would increase the cost of the new tobacco retail license fee from $110 to $340. Our initial analysis has yielded that the likely cost of administering this license will be between $400 and $500. We will gladly share our final analysis with the Council when it is complete.

Additionally, we seek to work with the Council and our sister agencies to standardize certain license requirements laid out in Intro. 1547. Certain new requirements posed by this bill, which DCA strongly supports, would ensure that the practice of sometimes "selling" a business for the sake of avoiding license revocation when one has received multiple violations would become more difficult. This critical update to existing law only applies to a certain subset of businesses in this bill; for the sake of consistency and ease of compliance, we would recommend it apply to a larger universe of businesses. I will now provide a brief overview of our enforcement efforts.

Enforcement

Given the City's commitment to reducing tobacco use and ensuring compliance with the law, DCA is proud to partner with the Departments of Health and Finance to enforce our tobacco laws. We inspect for unlicensed activity, the sale of cigarettes and liquid nicotine to anyone under 21, the sale of cigarettes to anyone under 18, the possession or sale of flavored tobacco, and for the provision of unlawful discounts. We also inspect businesses to ensure that they're not selling tobacco products below the legal price floor, and that cigarettes and cigars are being sold in a manner that complies with the minimum "package requirements." Cigarettes are required to be sold in a pack of no fewer than 20 and cigars in a pack of no fewer than four. There are two primary reasons why these requirements exist. First, the sale of individual cigarettes or cigars is likely an "untaxed" sale, which is unlawful and allows businesses to sell cigarettes for less than the legally-mandated minimum amount. Second, research has shown that the sale of cigarettes in packs with small amounts is more likely to result in continued smoking.

Beyond our inspections in the field, DCA attorneys review new and renewal license applications and pursue suspensions and revocations where appropriate.

We would like to note that the New York City Department of Finance plays a robust role in enforcing several tobacco-related laws; in particular, those that govern the sale of untaxed or out-of-state cigarettes. I will now speak briefly about the impact the bills would have on DCA in terms of licensing, enforcement, and legal review.

Impact on DCA

In terms of licensing, the agency would now have to track and implement licensing caps on a community district basis, which is neither an existing function nor capability. Additionally, the new electronic cigarette license category will result in what we believe is a large volume of work, as electronic cigarettes are often sold in the same stores as cigarettes, indicating that there could be thousands of potential licensees. DCA's legal division would see its work increase, as well, as the volume of "arm's length" transaction assessment would grow, as would the potential number of violations that might result in a revocation or suspension.

In terms of patrol enforcement, our inspectors would be enforcing new minimum price floors and license requirements for a new licensing category. Inspection times will likely increase, as our inspectors will have to check for compliance with several additional requirements, such as price floors for other tobacco products and requirements related to the sale of electronic cigarettes. DCA inspectors will require handhelds in order to enforce the new package of bills, as enforcement history would need to be known in the field in real time to enable inspectors to issue correct violations.

Conclusion

In closing, we want to reiterate our strong support for the bills before us today and our commitment to implementing these important policies effectively and as quickly as possible. Thank you again for your commitment to this important public health initiative; we would be happy to take any questions.

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Testimony of Assembly Member David I Weprin (D-24) Before the New York City Council Committee on Health
Council Chambers, City Hall
April 27, 2017

Good Morning Ladies and Gentlemen, thank you for joining us today.

I'd like to thank Council Member Fernando Cabrera for introducing this legislation in the New York City Council to prohibit smoking in cars with children under the age of 8 present.

I have similar legislation in Albany that bans smoking in vehicles with children under the age of 14 present. New Yorkers have known of the dangers of second hand smoke for some time now and the tobacco industry has taken notice. The harmful effects of second-hand smoke have been well documented. The American Lung Association states that secondhand smoke causes approximately 7,330 deaths from lung cancer and 33,950 deaths from heart disease each year.

Children are even more susceptible to the harmful effects of second hand smoke. When children inhale the over 7000 chemicals in cigarettes and tobacco products, they are more likely to develop ear infections, asthma, bronchitis, pneumonia, and other ailments. On top of all that, children who inhale second hand smoke are at an increased risk of developing far more serious ailments in the future, including cancer and heart disease.

New York was among the first to take action to limit the dangers of second hand smoke. We were among the first to ban smoking in restaurants and bars; and among the first to ban smoking in public parks.

You're not allowed to smoke in stadiums, airplanes, trains, or buses.

So while we protect ourselves, we continually expose our children to second-hand smoke in cars. We have a responsibility to protect our children from this threat to their health.

The bills Councilmember Cabrera and I have introduced are not new concepts --- my bill has been in the Assembly for 20 years - since 1997.

And while NY is known for making legislative precedent, just last year, Virginia became the 8th state to make it illegal to smoke in cars with children under 8.

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There are certain counties within NY such as Rockland County that already ban smoking in all cars with passengers under the age of 18. I am here to shed light on the importance of this legislation and ask that you support our bills so that they are implemented citywide and statewide.

While the spirit of the legislation is preventive, it should also be used as a tool to empower children to speak up about the dangers they may be facing. Often times, young children in particular, have a harder time speaking out about what is going on around them. While parents are generally more responsible, younger children are often in carpools that are being driven by teenagers who may not be as responsible and will think nothing of having a cigarette in the presence of children. Other times, children may be in situations where they are around non-family members – whether they are family friends or neighbors - who sadly, might also light up in front of children.

By participating in hearings such as these, I hope to empower children to not be shy and to speak out when someone around them decides to light up just as when my children often reminded me to make sure my seat belt was on when they were driving for the first few times.

I call on the parents, grandparents, teachers, and concerned citizens of New York to help us raise awareness of the dangers of smoking in cars with children present to please stop smoking while your children are present or in areas where there will be in the future.

So great are the risk factors involved with children inhaling second hand smoke that nearly all vehicles produced today are *not* produced with cigarette lighters. Luckily, the national decline in smoking overall, has forced car makers to eliminate the need to produce cigarette lighters in cars.

I appeal to every New Yorker to please consider the well-being and the health of the child travelling with them and to refrain from smoking in their presence. Just as safe as we are in making sure their seat belts are on and their car seats tight, we must also protect them from smoke and environmental factors that could cause irreversible damage to their developing bodies.

If you'd like to quit – There are many resources available in New York to help and support you – For more information, you can call 1-866-NY-QUITS or visit NYSmokeFree.com

Thank you again for listening and joining us today.

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Testimony of American Cancer Society Cancer Action Network to the New York City Council Committee on Health
April 27, 2017 • New York, NY

Chair Johnson, members of the health committees, thank you for the opportunity to testify today. My name is Michael Davoli and I am the Director of Government Relations in Metro New York for American Cancer Society Cancer Action Network (ACS CAN), the nonprofit, nonpartisan, advocacy affiliate of the American Cancer Society. I am pleased to be able to speak on the legislation under consideration today. While my testimony will focus primarily on Intro 1138-A-2016, Intro 1544-2017, and Intro 1547-A-2017, I will also touch on Intro 1471-2017, Intro 1532-2017, Intro 5930-2017, Intro 0484-2014 and Intro 0977-2015.

Let me start by expressing that the American Cancer Society Cancer Action Network examines all policy issues by their direct impact on cancer. Here in New York City on average 78,000 people will be diagnosed with cancer each year and on average 25,000 people will lose their lives to the disease. While smoking, rates are at a historic low, on average more than 5,400 New Yorkers will be diagnosed with tobacco related cancer and more than 3,200 people will lose their lives. This includes lung, bronchus, esophagus, oral and pharynx.

The impact of tobacco use goes beyond the public health toll. The annual health care cost in government expenditures in New York State directly caused by smoking is $10.39 billion. Lower income New Yorkers who smoke suffer disproportionately due to the high cost of tobacco. New York state residents' tax burden from smoking-related healthcare government expenditure is $1,488 per household annually. Helping a lower income pack-a-day smoker quit would, on average, free up more than $1,494 per year that he or she previously spent on cigarettes. The results of this saving could be life changing for a low-income family, as lower-income smokers spend a larger portion of their income on tobacco products and related costs than higher income smokers. Reductions to other smoking-caused costs would add to this benefit, making lower-income households more secure.

We must not let up our fight against the deadly tobacco epidemic. This includes supporting increasing funding for tobacco control and cessation programming by the NYC DOHMH and examining other possible strategies, like those below, to reduce the impact that tobacco has in New York City.

Retail License Cap

ACS CAN strongly supports Intro 1547-A-2017, expanding the retail dealer license to include retailers of all tobacco products and setting caps on retail dealer licenses.

Last week ACS CAN released a new report documenting the oversaturation of New York City by licensed tobacco retail outlets. The report breaks down the number of retail outlets in each borough as well as the proximity of the retail outlets to schools and other tobacco retail outlets. I have provided copies of the report to all of you.

The results that we have included in this report are disturbing. As of October 1, 2016, there were: 8,992 licensed tobacco retail outlets citywide, including 2,725 in Brooklyn, 2,196 in Manhattan, 2,117 in Queens 1,542 in the Bronx and 412 on Staten Island.

To put those numbers in perspective, the number of licensed tobacco retail outlets citywide is: 3X more than the total number of the top 10 corporate chain stores combined (2,984), 3 ½ X more than the number of pizzerias (approximately 2,500), 3X more than the number of public, private, charter, and parochial schools (2,619) and 29 times more than the number of Starbucks (307) in New York City.

Citywide, there is a licensed tobacco retailer every five blocks or 1,312 feet; and when you factor in all the open spaces where there is no commercial or residential activity like parks, cemeteries or beaches, the number becomes even lower.

In far too many New York City neighborhoods, a child is more likely to walk past a tobacco retail outlet than a library or playground. In New York City, 6,778, over 2/3 of all licensed tobacco retail outlets are within 1,000 feet of a school. Making matters worse, over 93% or 8,442 licensed tobacco retail outlets are within 1,000 feet of another licensed tobacco retail outlet.

In some of our most vulnerable communities, tobacco is both persistent and pervasive. Significant disparities in the number of retail outlets in relation to the population are found when comparing boroughs and neighborhoods. Midtown and lower Manhattan, parts of the Bronx and most of Brooklyn are home to the highest density of tobacco retail outlets.

The five Community Districts with the highest rate of tobacco retail outlets in the Bronx are in the South Bronx, and the seven Community Districts with the highest rate of tobacco retail outlets in Brooklyn are in North and Central Brooklyn. In both the South Bronx (17 per 10K ppl) and in North (16 per 10K ppl) and Central Brooklyn (16 per 10K ppl) the rate of tobacco retailers found in the corresponding community districts is significantly higher than the borough. (10 per 10K ppl). Meanwhile, smoking rates in each of these neighborhoods rank near the top in the city.

Cigarette smoking disproportionately affects the health of people with lower income, lower levels of educational achievement and those who live at or below the poverty level. Recent studies demonstrate that living near tobacco outlets makes it harder for smokers to quit and that teens who live in areas with higher tobacco outlet density are more likely to have tried smoking, and more likely to think that more adults smoke. In dense urban neighborhoods, tobacco retail outlets often feature signs that promote tobacco products and pricing. Sidewalks are littered with cigarette butts and city residents and visitors' ability to breathe smoke-free air is compromised.

Widespread availability of tobacco in our communities dangerously normalizes tobacco use. Each year in New York state, 22,500 youth under the age of 18 become regular daily smokers and 31.6 million packs of cigarettes are bought or smoked by New York youth. The cost, accessibility and limits on where tobacco may be used play a significant role in smoking rates. While requirements for minimum prices and restrictions on tobacco use have significantly driven down smoking rates, the continued widespread and unfettered availability of tobacco in New York City is a major factor contributing to the number of youth who become smokers each year. The tobacco industry spends enormous sums of money in New York State to market its products in places where young people shop, like retail stores near schools.

Establishing a cap on the number of tobacco retail outlets will reduce the number of outlets where community members can access or be exposed to deadly tobacco. In addition to improving health of the entire population, establishing a cap protects low income communities and communities of color that have disproportionately high numbers of tobacco retail outlets in their neighborhoods, as well as disproportionately higher smoking rates. Through a process of attrition of stores with licenses that are either revoked through normal processes, or by licenses that are not renewed, a cap will gradually reduce the number of tobacco retail outlets.

Reducing the number of locations where tobacco can be legally purchased will also help drive down illegal tobacco sales. Limiting the legal locations will allow law enforcement to focus their efforts on a smaller number of outlets and ultimately drive down illegal tobacco sales.

Similar approaches have been successfully adopted in various communities including San Francisco, Chicago and Philadelphia. While reducing the number of licensed tobacco retail outlets is not a silver bullet and will not end all tobacco use, by establishing a cap on the number of licensed tobacco retail outlets, New York City can reduce the impact of tobacco retail outlets and end the oversaturation of New York City.

Pharmacy Restriction

ACS CAN strongly supports Intro 1131-A-2016—A Local Law to restrict the sale of tobacco products in pharmacies. Tobacco-free pharmacies reduce access to all tobacco products, which will help prevent kids from forming a lifelong addiction as well as help support those who are coming to the pharmacy for help quitting. Pharmacies are in the business of improving health; however, they represent nearly 5 percent of cigarette sales.

Cigarette sales declined by 17 percent between 2005-2009, but increased in pharmacies by 23 percent during the same timeframe. It is a contradiction for pharmacies to be a facilitator of health and wellness while selling cigarettes and tobacco products. Selling these products side-by-side helps to normalize tobacco use, and serves to further obscure the deadliness of these products. The CVS Pharmacy chain acknowledged this in 2015 when it voluntarily gave up tobacco sales at all its stores nationwide. Research shows that pharmacists and the public support removing tobacco products from pharmacies.

A 2014 survey showed two-thirds of Americans support prohibiting tobacco sales in pharmacies, including nearly half of smokers. As I stated earlier in my testimony, New York City is oversaturated with licensed tobacco retail outlets. If we are to further drive down smoking rates, we must begin by reducing the number of licensed tobacco retail outlets and their density in New York City.

Prohibiting tobacco sales in pharmacies reduces the density of tobacco retail outlets. Cities in Massachusetts and California that have prohibited the sale of tobacco products in pharmacies saw a three times greater reduction in tobacco retail outlet density than cities that did not. Another study predicted that prohibiting tobacco sales in pharmacies in North Carolina found that it would reduce retail outlets in the state by over 1,000 and reduce density by 13.9 percent. Over 150 municipalities around the country have prohibited tobacco sales in pharmacies.

Minimum Price/Other Tobacco Product Tax

ACS CAN strongly supports Intro 1544-2017, a Local Law to establish price floors and minimum package sizes for tobacco products and shisha, and establish a tax on tobacco products other than cigarettes. Significantly increasing the cost of tobacco reduces tobacco consumption. Regular, significant increases in the retail price of cigarettes reduces the number of people who begin smoking and increases the number of smokers who quit. Studies have shown that for every 10 percent increase in the price of cigarettes, there is a 4 percent reduction in overall cigarette consumption and a 6.5 percent reduction in youth consumption. Low-income adults, youth, and pregnant women are especially likely to quit or reduce their smoking when the price increases. Increasing the minimum per pack price or the tax on tobacco will both accomplish this goal.

When different types of tobacco products cost different rates, lower-cost products become more readily available. Setting minimum prices on all tobacco products, including electronic cigarettes, and establishing a tax on all tobacco products at an equivalent rate will have a significant impact on tobacco use. This tax parity helps reduce tax evasion, generating more new revenue, and ensures that more tobacco users quit instead of switching to a cheaper product. ACS CAN strongly endorses increasing the minimum price of cigarettes, establishing price floors for other tobacco products and establishing a tax on other tobacco products.

Other Legislation

ACS CAN strongly supports Intro 1471-2017, a Local Law to raise the biennial fee for a Cigarette Retail Dealer License from $110 to $340. Increasing the Cigarette Retail Dealer License fee would bring it on par to similar licenses in New York City while at the same time dissuading store owners from continuing to sell tobacco.

ACS CAN strongly supports Intro 1532-2017, a Local Law to require a license to sell electronic cigarettes. Electronic cigarette use among high school students nationwide increased an astounding 900 percent from 2011 to 2015 per the U.S. Surgeon General. At the same time the electronic cigarette industry has exploded into a $3.5 Billion industry. However, no license is required to sell electronic cigarettes in New York City or State. It is imperative that New York City establish a license for electronic cigarettes and cap the number of licensed available.

ACS CAN strongly supports Intro 5930-2017, a Local Law to require rental apartment buildings, as well as co-op and condo buildings, to create a smoking policy for the building. This measure will encourage landlords to transition more private rental buildings into smoke free properties without requiring it. It is a smart, common sense approach, to encourage the private sector to adopt smoke free policies.

ACS CAN supports Intro 0484-2014, a Local Law to ban smoking in the common areas of all multiple dwellings and **Intro 0977-2015**, a Local Law to ban smoking in city-financed housing. While ACS CAN generally supports policies that promote smoke free housing, including these proposals, we believe that it is critical that New York City expand the promotion of and access to tobacco cessation resources to help smokers quit.

In conclusion

The American Cancer Society Cancer Action Network looks forward to working with the City Council, the Office of the Mayor, the Department of Health and Mental Hygiene and all stakeholders in New York City on these and other efforts in the fight against the deadly tobacco epidemic.

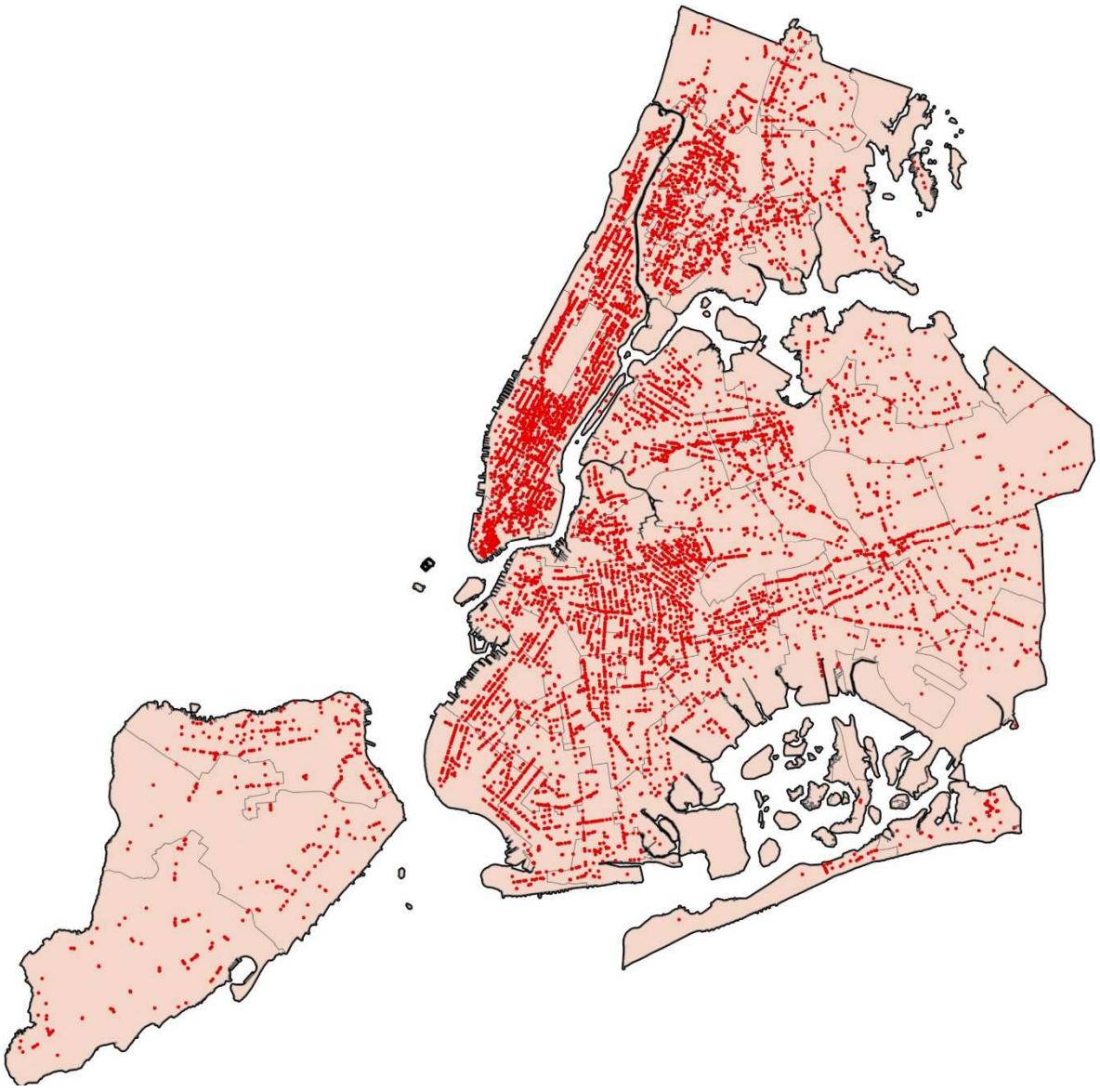
During today's hearing, you will undoubtedly hear from tobacco and electronic cigarette industry representatives, tobacco retail outlet owners and electronic cigarette users warning of the dire consequences of New York City adopting the proposed legislation. The same arguments that you will hear were made 50, 30, 10 and even five years ago. Their sky is falling arguments were false then and they are false now. What is true is the fact that 12,000 people will die from smoking related illness every year in New York City---that is approximately 32 people every day. In a four-year period, approximately 38,000 New Yorkers died from smoking illness. That's almost two times the capacity of Madison Square Garden.

We must not let up. We must do more if we are to defeat tobacco once and for all.

####

OVERSATURATED

HOW AN OVERSATURATION OF LICENSED TOBACCO RETAIL OUTLETS IN NEW YORK CITY IS IMPACTING PUBLIC HEALTH



American Cancer Society Cancer Action Network

Acknowledgements

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ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. ACS CAN works to encourage elected officials and candidates to make cancer a top national priority. ACS CAN gives ordinary people extraordinary power to fight cancer with the training and tools they need to make their voices heard.

Download the full report at:

www.acscan.org/ny

For more information:
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OVERSATURATED

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EXECUTIVE SUMMARY

The following report examines existing public data in regards to the health of New Yorkers, tobacco use in New York City and the oversaturation of licensed tobacco retail outlets in New York City, and presents detailed recommendations from the American Cancer Society Cancer Action Network (ACS CAN) on how to best address the oversaturation.

The Problem:
Between 2005-2014 the five leading causes of premature death in New York City were cancer, heart disease, unintentional injury, diabetes and chronic lower respiratory diseases. While many factors lead to these causes of premature death, no single factor contributes to premature deaths in New York City more than the use of tobacco. Tobacco use is the number one cause of preventable death in New York City, killing approximately 12,000 people each year.

In addition to lung and bronchus cancer, smoking causes more than a dozen different types of cancer. While lung and bronchus cases do not account for the largest percentage of cancer cases, they do result in more cancer deaths than cancers at any other site. Nearly 80 percent of cases of lung and bronchus cancer are tobacco-related. This is especially troubling since these cases are preventable by simply not using tobacco.

The impact of tobacco use goes beyond the toll it takes on public health. New York state residents' annual tax burden from smoking-related government spending on healthcare is $1,488 per household.

In an effort to turn the tide on lung and bronchus cancer and other smoking-related illnesses, New York City has led a successful effort for more than a decade to reduce smoking rates. By increasing the price of tobacco products, implementing comprehensive smoke-free and tobacco-free policies and funding evidence-based, citywide tobacco use prevention and cessation programs, New York City has driven smoking rates to historic lows and protected our communities from secondhand smoke.

Despite these efforts, 14.3 percent of residents (approximately 950,000 people) still smoke, and significant disparities persist by education, household income, race and ethnicity, housing status and other demographics. Significant disparities in smoking rates are also found when comparing boroughs and neighborhoods.

Recent studies demonstrate that close proximity to tobacco stores make it harder for smokers to quit and that teens who live in areas with higher tobacco outlet density are more likely to have tried smoking, and more likely to think that more adults smoke.

Currently, there are nearly 9,000 licensed tobacco retail outlets citywide. Across the five boroughs, licensed tobacco retail outlets can be found on nearly every corner and every block. In dense urban neighborhoods, tobacco retail outlets often feature signs that

promote tobacco products and pricing. Sidewalks are littered with cigarette butts and city residents and visitors' ability to breathe smoke-free air is compromised.

Significant disparities in the number of retail outlets in relation to the population are also found when comparing boroughs and neighborhoods. Midtown and lower Manhattan, parts of the Bronx and a majority of Brooklyn are home to the highest density of tobacco retail outlets.

The Youth Factor

In far too many New York City neighborhoods, a child is more likely to walk past tobacco retail outlets than libraries or playgrounds. There is approximately one licensed tobacco retail outlet for every 196 children in New York City. Meanwhile there is approximately one playground for every 1,765 children and one public library for every 8,613 children in New York City.

Widespread availability of tobacco in our communities dangerously normalizes tobacco use. Each year in New York state, 22,500 youth under the age of 18 become regular daily smokers and 31.6 million packs of cigarettes are bought or smoked by New York youth.

The cost, accessibility and limits on where tobacco may be used play a significant role in smoking rates. While requirements for minimum prices and restrictions on tobacco use have been in effect for some time, the continued widespread and unfettered availability of tobacco in New York City is a major factor contributing to the number of youth who become smokers each year.

The tobacco industry spends enormous sums of money in New York State to market its products in places where young people shop, like retail stores near schools. More than two-thirds of licensed tobacco retail outlets are within 1,000 feet of a school in New York City. The overwhelming majority of licensed tobacco retail outlets are within 1,000 feet of another licensed tobacco retail outlet, exacerbating the impact that tobacco has on our neighborhoods.

The Solutions

There are many approaches to reducing the oversaturation of tobacco retail outlets. Research and experiences in other municipalities have shown the best approaches are:

- Cap and gradually reduce the number of tobacco retail licenses available in a community;
- Set a minimum distance between tobacco retail outlets and schools, other youth service entities and other licensed tobacco retail outlets;
- Restrict sales in pharmacies and other health service entities.

Establishing a cap on the number of tobacco retail outlets and restricting the location and type of retail outlets permitted to sell tobacco will reduce the number of outlets where community members can access or be exposed to deadly tobacco. In addition to improving health for everyone, establishing these types of restrictions on licensed tobacco retail outlets protects low income communities and communities of color that often have

a disproportionately high number of tobacco retail outlets in their neighborhoods, as well as disproportionately higher smoking rates. Similar approaches have been successfully adopted in various communities including San Francisco, Chicago and Philadelphia.

While reducing the number and density of licensed tobacco retail outlets is not a silver bullet and will not end all tobacco use, municipalities looking for ways to further reduce tobacco use can look at both research and practical examples for how to use licensing and zoning rules to reduce the impact of tobacco retail outlets.

FINDINGS

FINDING: Tobacco use is the number one cause of preventable death and disease in New York City, killing approximately 12,000 people each year.[1]

FINDING: Lung and bronchus cases account for 10.8 percent of cancer cases and 22.1 percent of cancer deaths in New York City. Between 2009-2013 there were 4,255 cases of lung and bronchus cancer in New York City and 2,752 deaths from of lung and bronchus cancer.[2] Nearly 80 percent of cases of lung and bronchus cancer are tobacco related.[3]

FINDING: Citywide, nearly 80 percent of smokers are either non-daily smokers (41.4 percent) or light daily smokers (37.5 percent), while heavy smokers make up only 21.1 percent of smokers.[4] See page 46 for definitions of each type.

FINDING: As of October 1, 2016, there were 8,992 licensed tobacco retail outlets citywide, including 1,542 in the Bronx, 2,725 in Brooklyn, 2,196 in Manhattan, 2,117 in Queens and 412 on Staten Island[5]

FINDING: The number of licensed tobacco retail outlets citywide is three times more than the total number of the top 10 corporate chain stores combined (2,984)[6], three and a half times more than the number of pizzerias (approximately 2,500)[7], three times more than the number of public, private, charter and parochial schools (approximately 2,619)[8] and 29 times more than the number of Starbucks (307)[9] in New York City.

FINDING: There is approximately one licensed tobacco retail outlet for every 196 children[10] in New York City. Meanwhile there is approximately one playground for every 1,765 children[11] and one public library for every 8,613[12] children in New York City.

FINDING: Citywide, there is a licensed tobacco detailer every five blocks or 1,312 feet.[13]

FINDING: There are 342 licensed tobacco retail outlets within 200 feet of a school, 2,909 licensed tobacco retail outlets within 500 feet of a school and 6,778 licensed tobacco retail outlets within 1,000 feet of a school in New York City.[14]

FINDING: There are 4,920 licensed tobacco retail outlets within 200 feet of another licensed tobacco retail outlet, 7,843 licensed tobacco retail outlets within 500 feet of another licensed tobacco retail outlet and 8,442 licensed tobacco retail outlets within 1,000 feet of another licensed tobacco retail outlet.[15]

FINDING: There are approximately 600 pharmacies in New York City that currently hold tobacco retail licenses.[16]

ACS CAN POLICY RECOMMENDATIONS

The New York City Department of Health and Mental Hygiene has achieved significant declines in youth and adult smoking rates since 2002 by implementing a five-point plan consisting of taxation, legislation, cessation, education and evaluation. Despite these historic efforts and the progress that has been made in reducing tobacco use, there remains a clear need to address the oversaturation of licensed tobacco retail outlets in New York City. ACS CAN recommends five steps that New York City should take to address this problem.

1) **Establish a cap on retail tobacco licenses:** New York City should establish a cap on the number of retail tobacco licenses in each community district at 50 percent of their current level. No new licenses should be issued in a community district until the number of licenses in that community district is at or below the newly established cap.

2) **Restrict access near youth-service entities:** New York City should prohibit new tobacco retail licenses from being issued to any new applicant located within 1,000 feet of schools, houses of worship, playgrounds, libraries and other youth-service entities.

3) **Restrict retail outlet proximity to each other:** New York City should prohibit new tobacco retail licenses from being issued to any new applicant located within 1,000 feet of a current licensed tobacco retail outlet.

4) **Restrict all tobacco sales in pharmacies:** All retail stores that contain a pharmacy or other places of business that provide any form of health service should be prohibited from selling tobacco.

5) **Include other tobacco products:** The current tobacco retail license in New York City does not cover the sale of tobacco products other than cigarettes, cigars or cigarillos. The licensing requirement should be extended to all tobacco products, including e-cigarettes.

THE HEALTH OF ALL NEW YORKERS

Premature mortality—death before the age of 65—is closely tied to poverty and a lack of access to critical services.[17] There are significantly more premature deaths among certain racial/ethnic groups and in certain neighborhoods.[18] In 2013, the age-adjusted premature mortality rate per 100,000 deaths was 276.1 for black Non-Hispanic New Yorkers, 188.2 for white Non-Hispanic New Yorkers, 160.3 for Hispanic New Yorkers, and 98.5 for Asian New Yorkers.[19]

New Yorkers of all racial/ethnic backgrounds have the leading sources of premature death in common. Between 2005-2014 the five leading causes of premature death in New York State were cancer, heart disease, unintentional injury, diabetes and chronic lower respiratory diseases. **(Figure 1)**[20]

Figure 1

Year and # of Premature Deaths	#1 Cause of Premature Death and # of Premature Deaths Age-adjusted Premature Death Rate	#2 Cause of Premature Death and # of Premature Deaths Age-adjusted Premature Death Rate	#3 Cause of Premature Death and # of Premature Deaths Age-adjusted Premature Death Rate	#4 Cause of Premature Death and # of Premature Deaths Age-adjusted Premature Death Rate	#5 Cause of Premature Death and # of Premature Deaths Age-adjusted Premature Death Rate
2014 **Total: 22,744**	Cancer 6,974 total 81 per 100,000	Heart Disease 5,241 total 60 per 100,000	Unintentional Injury 1,315 total 17 per 100,000	Diabetes 879 total 12 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 637 total 7 per 100,000

Source: New York State Department of Health, Leading Causes of Premature Death[21]

There are many different behaviors contributing to these causes of premature death. However, tobacco use contributes more to premature deaths in New York City than any other behavior.[22] Tobacco use is the number one cause of preventable death and disease in New York City, killing approximately 12,000 people each year[23]. Between 2005-2009, approximately 38,000 New Yorkers died from smoking.[24] That is almost two times the capacity of Madison Square Garden.

Health Impact of Tobacco

Smoking causes numerous diseases, including cancer, and puts smokers at a higher risk of many health problems.[25] Smoking causes heart disease, stroke, aortic aneurysm, chronic obstructive pulmonary disease (COPD)-(chronic bronchitis and emphysema), diabetes, osteoporosis, rheumatoid arthritis, age-related macular degeneration and cataracts, and worsens asthma symptoms in adults. Smokers have a higher risk of developing pneumonia, tuberculosis, and other airway infections. In addition, smoking causes inflammation and impairs immune function.

SMOKING AND CANCER

Smoking is a leading cause of cancer and death from cancer. It causes cancers of the lung, esophagus, larynx, mouth, throat, kidney, bladder, liver, pancreas, stomach, cervix, colon and rectum, as well as acute myeloid leukemia.[26] In New York City, the four leading cancer sites are colon, lung and bronchus, female breast and prostate.

Those four cancer sites represent 48.5 percent of all new cancer cases and 46.5 percent of all cancer deaths in New York City. **(Figure 2 & 3)**[27] While lung and bronchus cases account for 10.8 percent of cancer cases, they account for 22.1 percent of cancer deaths. Between 2009-2013 there were 4,255 cases of lung and bronchus cancer in New York City and 2,752 deaths from lung and bronchus cancer.

Nearly 80 percent of cases of lung and bronchus cancer are tobacco related.[28]

Figure 2

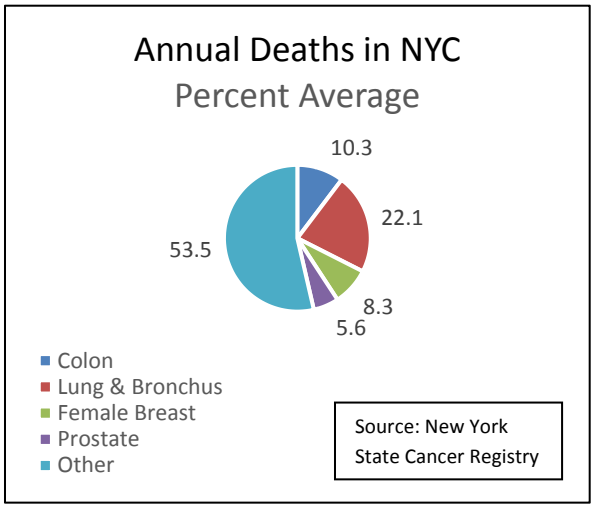
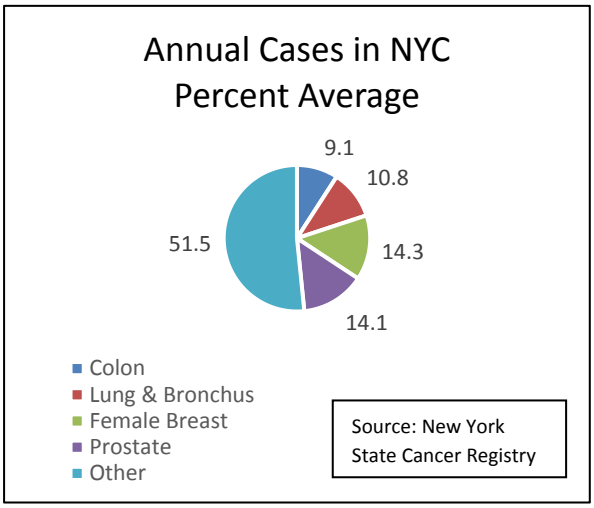


Figure 3



ECONOMIC IMPACT OF TOBACCO

The impact of tobacco use goes beyond the public health toll. The annual health care cost in government expenditures in New York State directly caused by smoking is $10.39 billion.[29] Lower income New Yorkers who smoke suffer disproportionately due to the high cost of tobacco. New York state residents' tax burden from smoking-related healthcare government expenditure is $1,488 per household annually. **(Figure 4)**[30]

Helping a lower income pack-a-day smoker quit would, on average, free up more than $1,494[31] **(Figure 4)** per year that he or she previously spent on cigarettes. The results of this saving could be life changing for a low income family, as lower-income smokers spend a larger portion of their income on tobacco products and related costs than higher-income smokers. Reductions to other smoking-caused costs would add to this benefit, making lower-income households more secure.

Figure 4

Source: Campaign For Tobacco Free Kids[32]

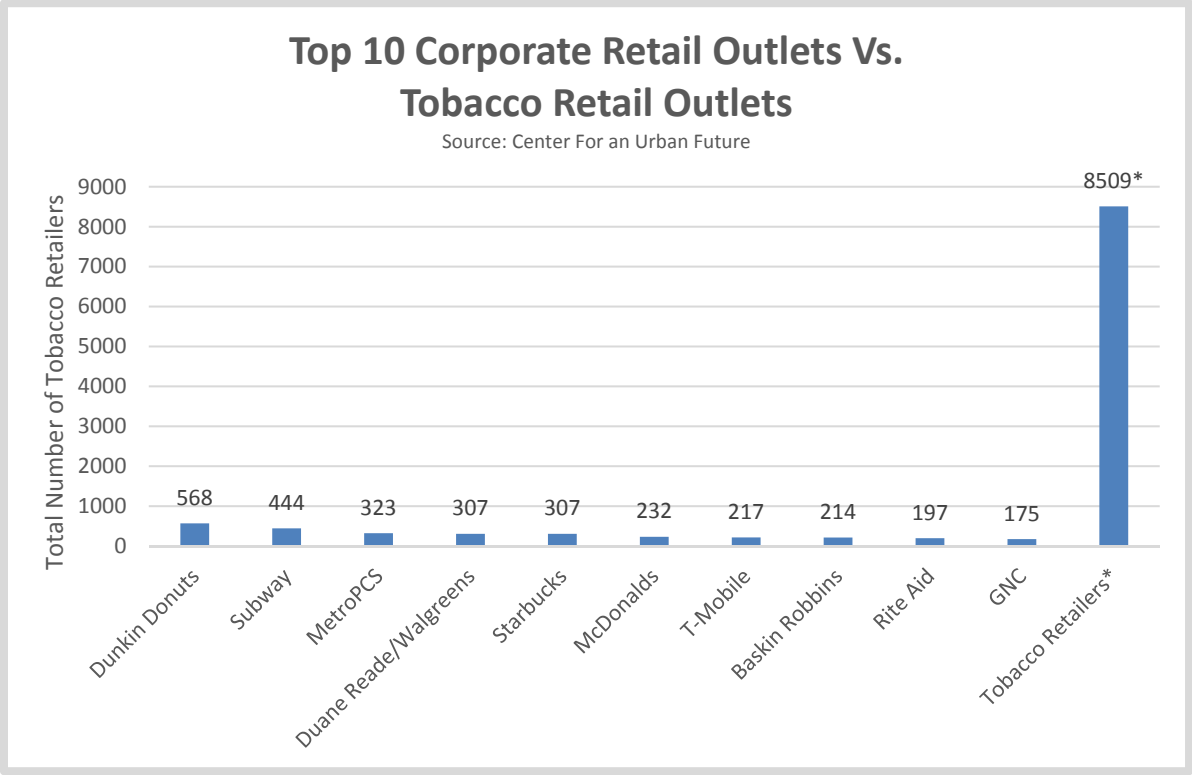
THE OVERSATURATION OF TOBACCO RETAIL OUTLETS IN NEW YORK CITY

Millions of New Yorkers are surrounded by tobacco due to the overwhelming number of places where tobacco can be purchased in the five boroughs. There are currently 8,992 licensed tobacco retail outlets citywide,[33] including 1,542 in the Bronx, 2,725 in Brooklyn, 2,196 in Manhattan, 2,117 in Queens and 412 on Staten Island.[34]

To put that in perspective, the number of licensed tobacco retail outlets citywide is three times more than the total number of the top 10 corporate chain retail outlet stores combined (2,984[35]), three and a half times more than the number of pizzerias (approximately 2,500)[36], three times more than the number of public, private, charter and parochial schools (approximately 2,619)[37] and 29 times more than the number of Starbucks (307[38]) in New York City. **(Figure 5)**

The oversaturation of tobacco retail outlets in New York City makes it harder for New Yorkers to quit smoking, and encourages youth to start smoking.

Figure 5



**This total does not include the* *Duane Reade/Walgreens/Rite Aid stores selling tobacco since they are included in a separate column.*

THE OVERSATURATION OF TOBACCO RETAIL OUTLETS IN NEW YORK CITY

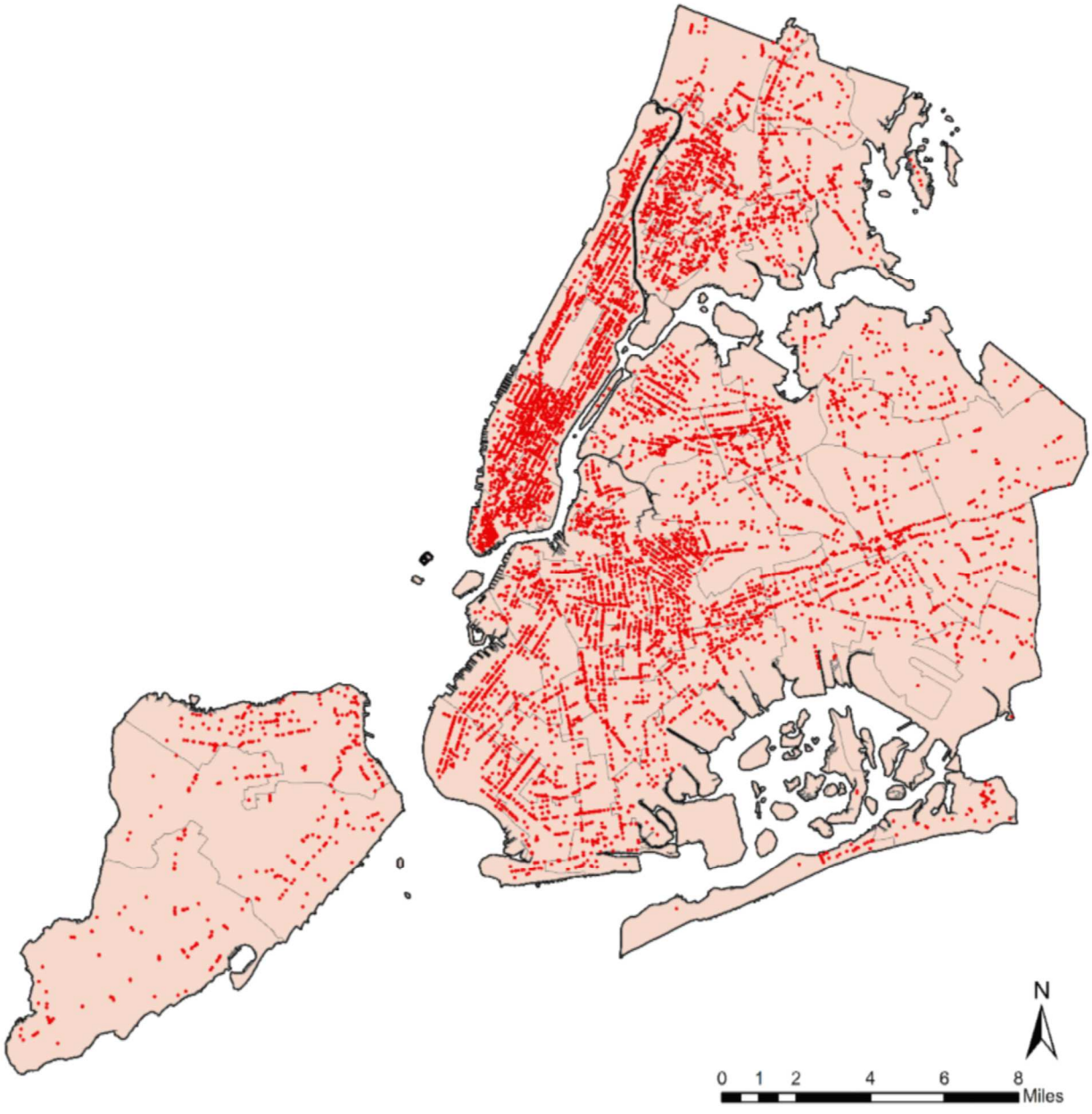
The maps

The following pages include maps showing every licensed tobacco retail store in New York City plotted based on their registered address. The numbers on the borough maps mark City Council districts. High resolution maps are available at www.acscan.org/oversaturated.

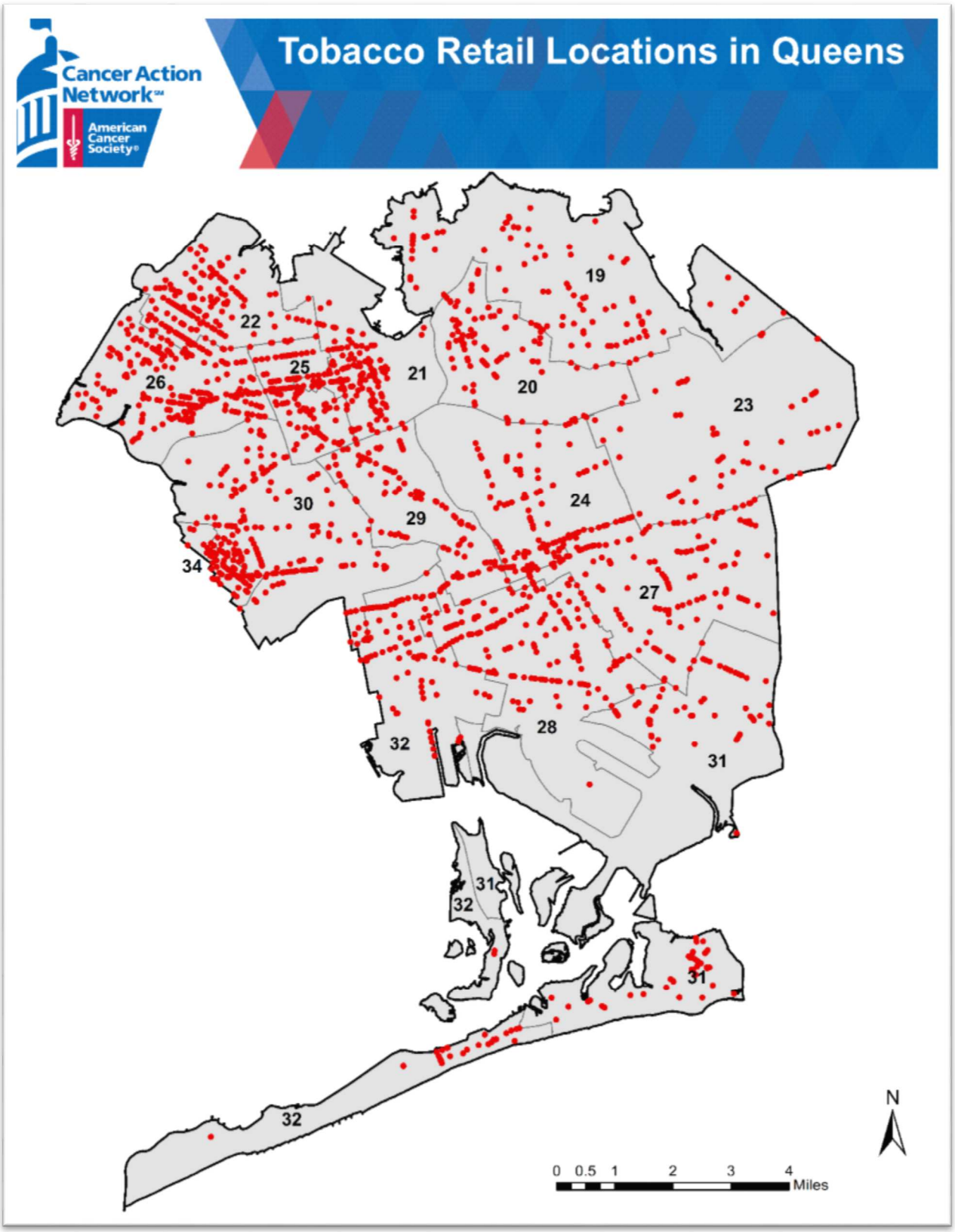
Included here are:

- New York City
- Manhattan
- Queens
- Bronx
- Brooklyn
- Staten Island

Tobacco Retail Locations in New York City



Tobacco Retail Locations in Manhattan


Cancer Action Network
American Cancer Society
Tobacco Retail Locations in Queens
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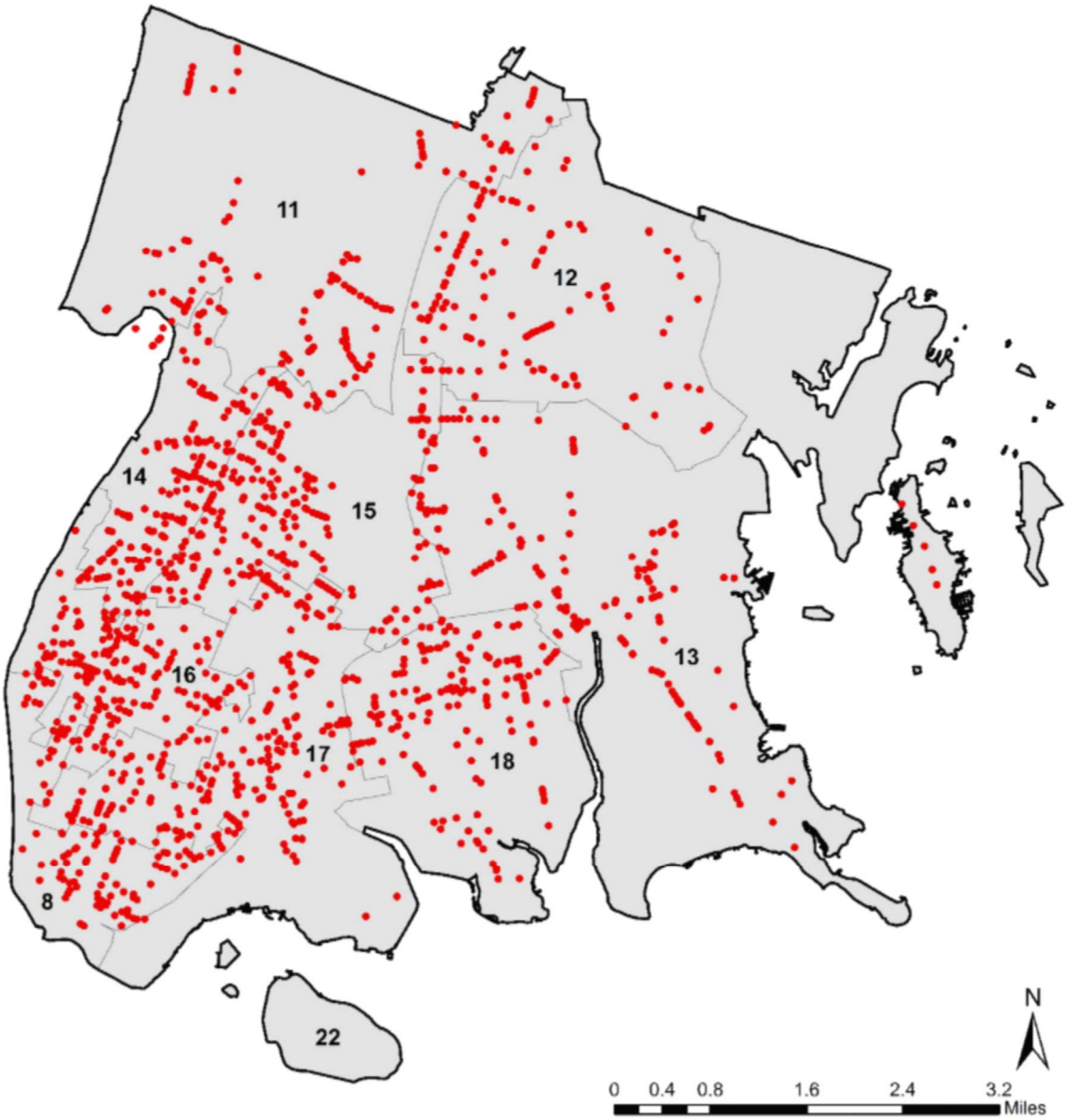
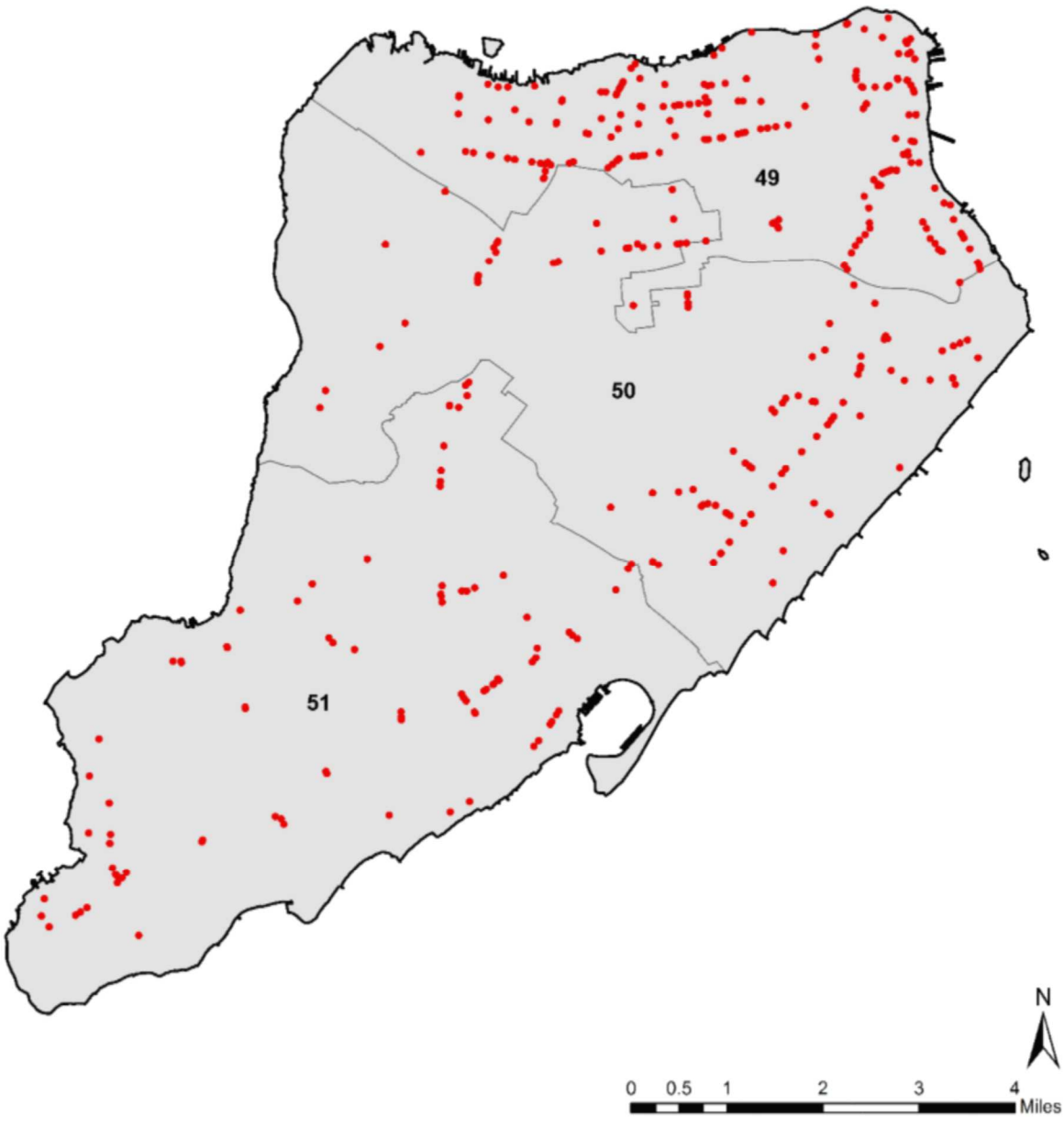
Tobacco Retail Locations in the Bronx



Tobacco Retail Locations in Brooklyn

Tobacco Retail Locations on Staten Island



TOBACCO RETAIL DENSITY

Across the five boroughs, licensed tobacco retail outlets can be found on nearly every corner and every block. Reducing the density of retail outlets will help reduce tobacco use by requiring customers to make a greater effort to find and obtain tobacco products.

In dense urban neighborhoods, tobacco retail outlets often feature signs that promote tobacco products and pricing, streets are littered with cigarette butts, and residents and visitors' ability to breath clean, smoke-free air is compromised. Retail outlets licensed to sell tobacco are rife with advertisements paid for by tobacco companies and provide easy access to purchase tobacco.

When examining tobacco retail density across New York City, trends become clear. Midtown and lower Manhattan, parts of the Bronx and a majority of Brooklyn are home to the highest density of tobacco retail outlets.

Borough Level

New York City is divided into five distinct boroughs. Each borough features unique characteristics that impact their retail climate.

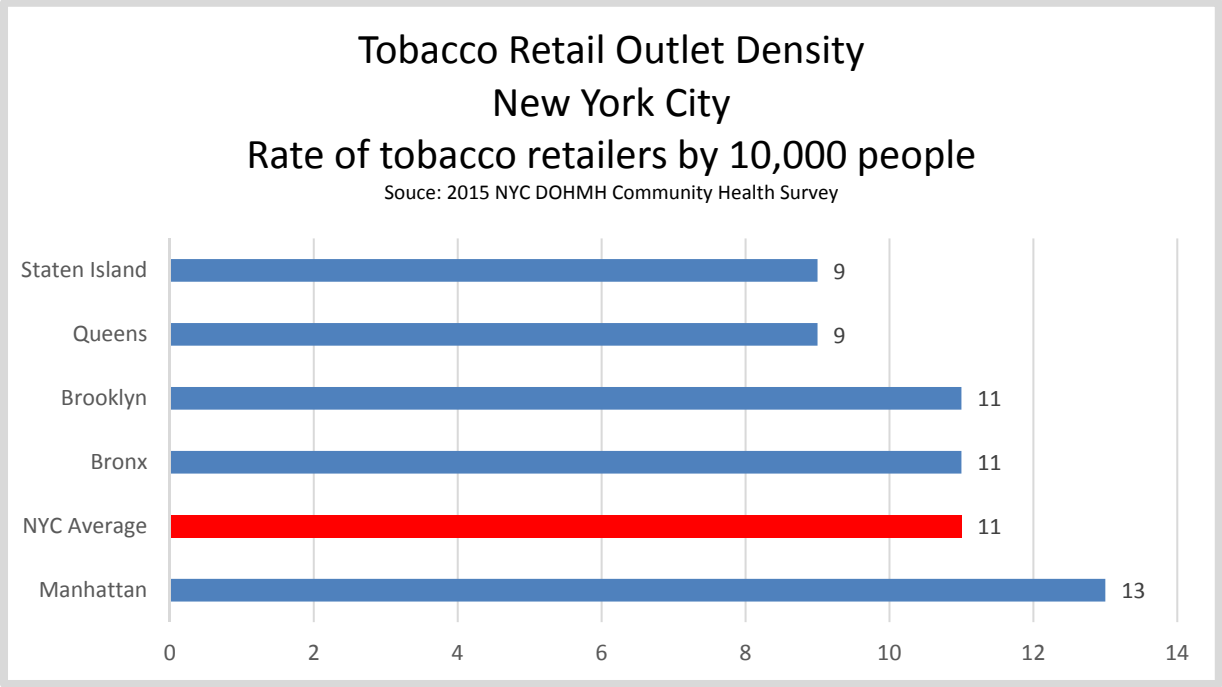
Staten Island and Queens have significantly lower population densities than other boroughs, with only 8,112 and 21,460 people respectively per square mile. By comparison, Manhattan has 72,033 people per square mile, followed by 37,137 people per square mile in Brooklyn and 34,653 people per square mile in the Bronx.[39]

Manhattan leads the city in the rate of tobacco retail outlets with 13 per 10,000 people, with the Bronx (11 per 10,000 people), Brooklyn (11 per 10,000 people), Queens (9 per 10,000 people) and Staten Island (9 per 10,000 people) following. **(Figure 6)**[40]

In addition to population density, transportation options play a significant role in how tobacco retail outlet density impacts smoking rates. Unlike the other four boroughs, but like many suburbs, Staten Island residents rely more on automobiles and less on public transit and walking to get around on a daily basis.[41] Staten Island has more cars per capita than any other borough in New York City.[42] As a result, tobacco retail outlet density may contribute less to smoking rates on Staten Island than in the other boroughs.

Areas with higher population density, more public transit options and higher walkability scores are more likely to be impacted by tobacco retail density.

Figure 6



High Risk Neighborhoods

The New York City Department of Health and Mental Hygiene has identified several neighborhoods in the south Bronx, East and Central Harlem, and North and Central Brooklyn as high health risk neighborhoods. High risk neighborhoods are neighborhoods in need of extra attention to promote health equity and reduce health disparities. With that designation comes targeted resources, programs, and attention to the health needs of those communities.[43]

Community District Level

In both the South Bronx and in North and Central Brooklyn the rate of tobacco retail outlets found in the corresponding community districts is significantly higher than the borough as a whole. The five community districts with the highest rate of tobacco retail outlets in the Bronx are in the South Bronx, and the seven community districts with the highest rate of tobacco retail outlets in Brooklyn are in North and Central Brooklyn. Smoking rates in each of these neighborhoods rank at the top in the city.

There are currently 59 community districts in New York City, including 12 in Manhattan, 12 in the Bronx, 18 in Brooklyn, 14 in Queens and 3 on Staten Island.

Midtown Manhattan (62 per 10,000 people) and the Financial District (25 per 10,000 people) have a disproportionate rate of retail outlets compared to the number of residents. Hunts Point and Longwood (17 per 10,000 people), Greenwich Village and Soho (17 per 10,000 people) and Clinton and Chelsea (17 per 10,000 people) lead the city in more residential neighborhoods. **(Figures 7-11)**[44]

Figure 7

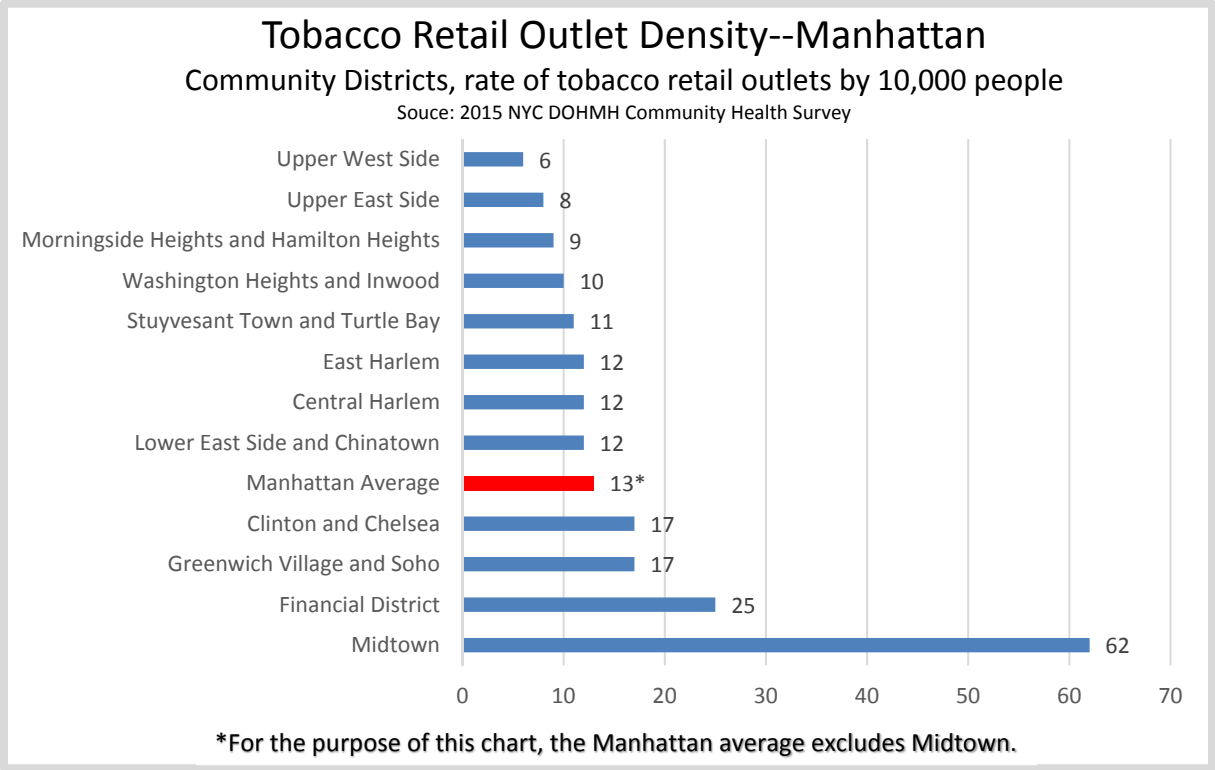


Figure 8

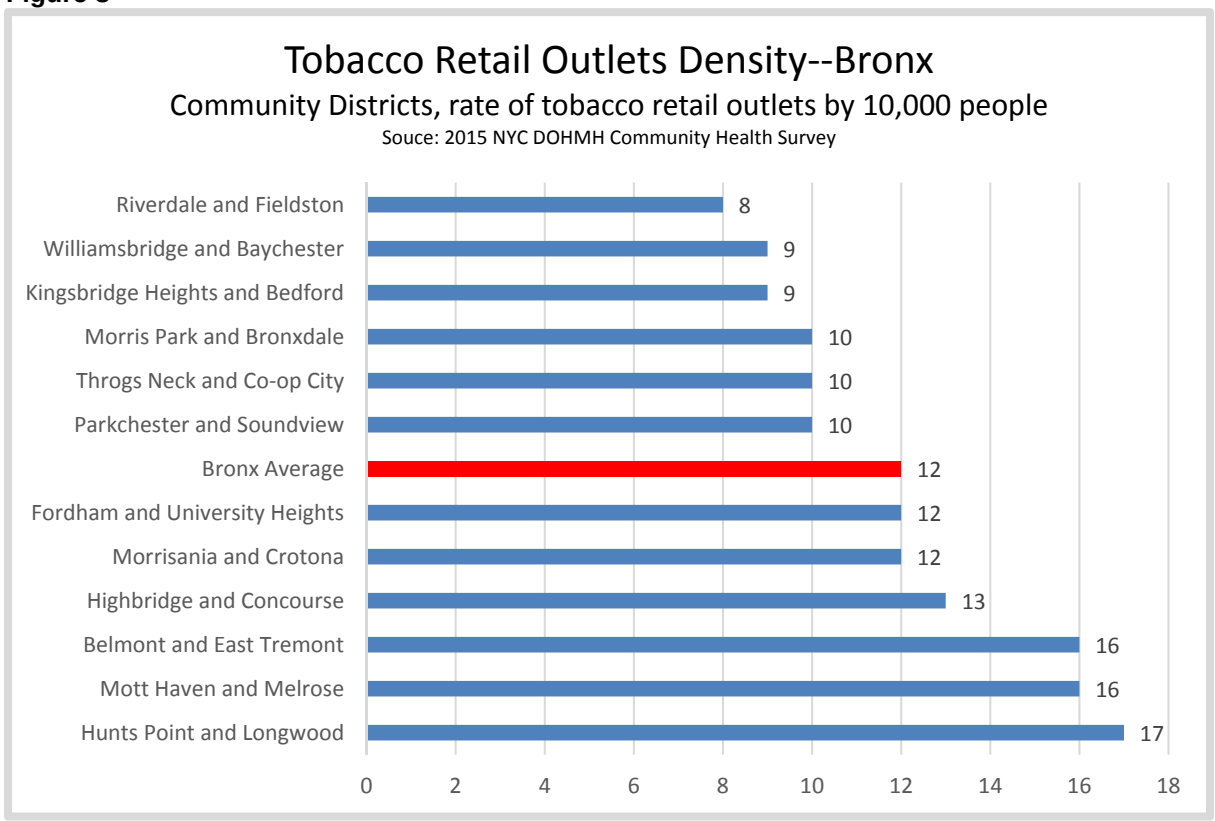


Figure 9

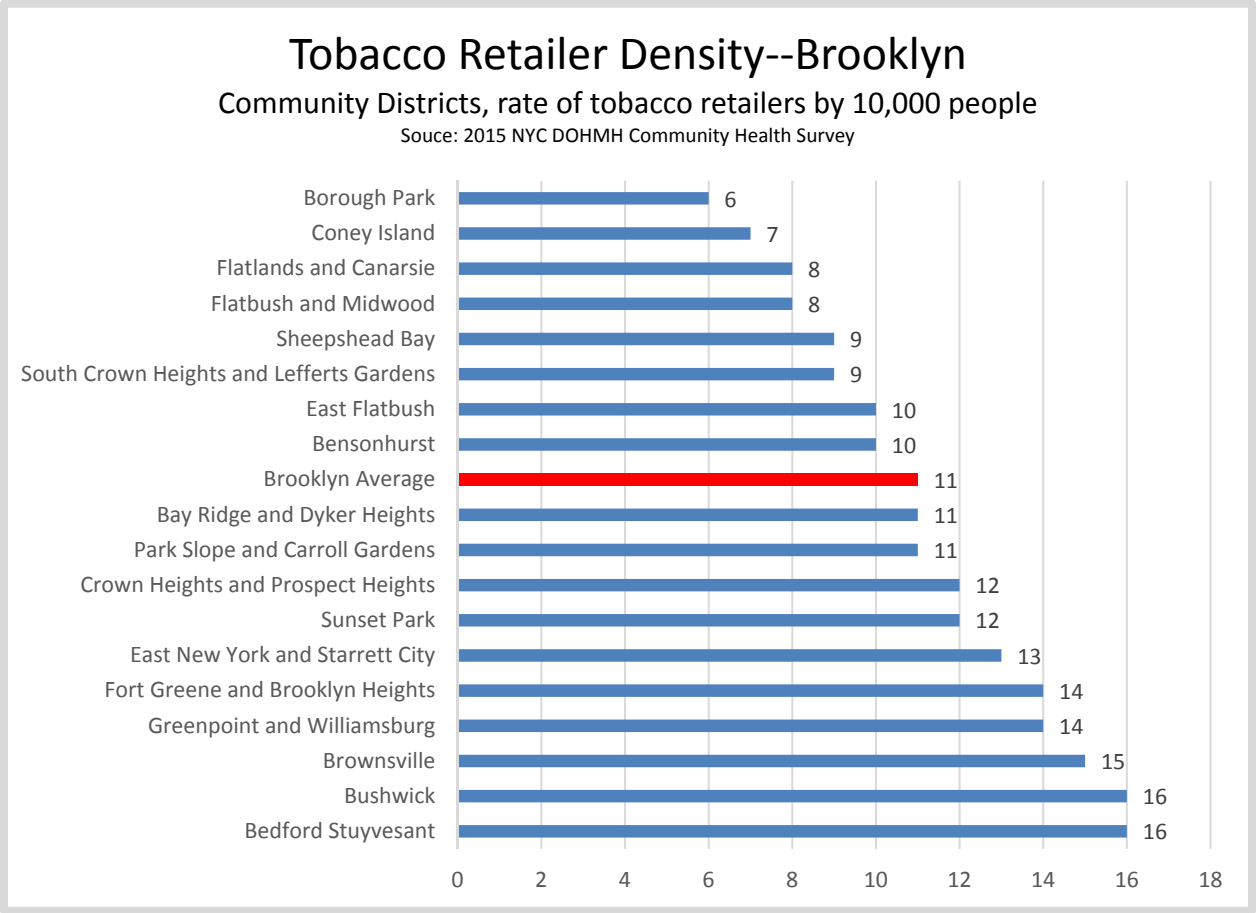


Figure 10

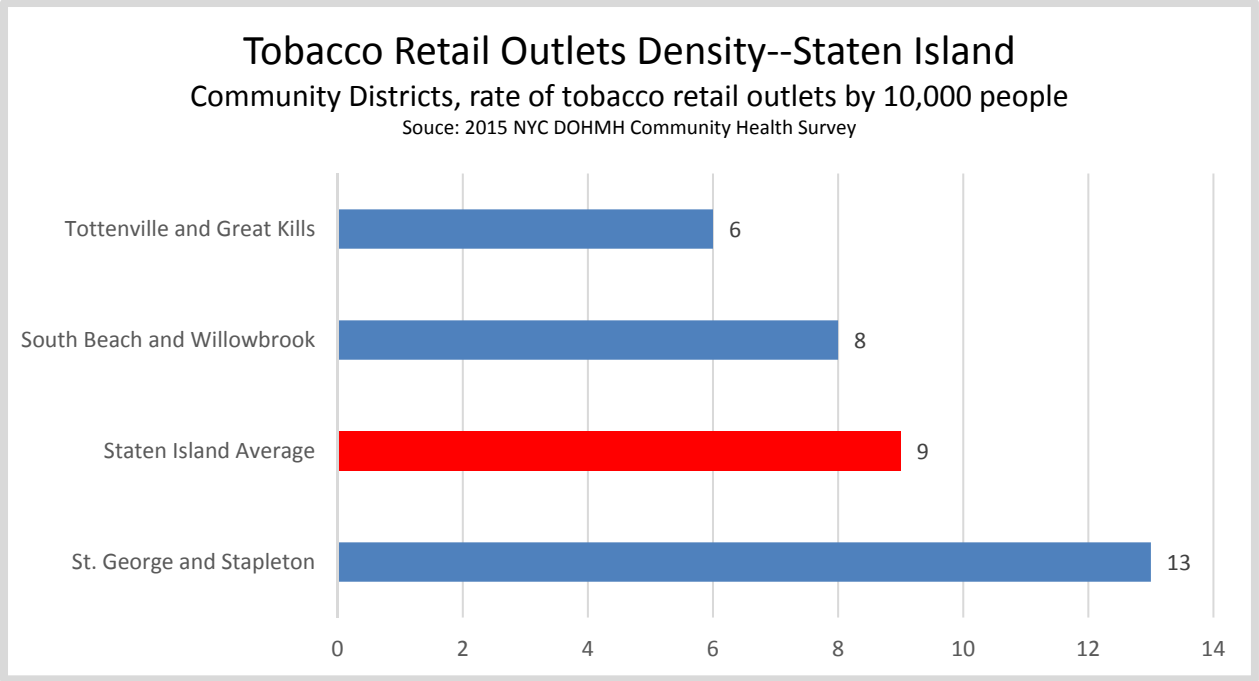
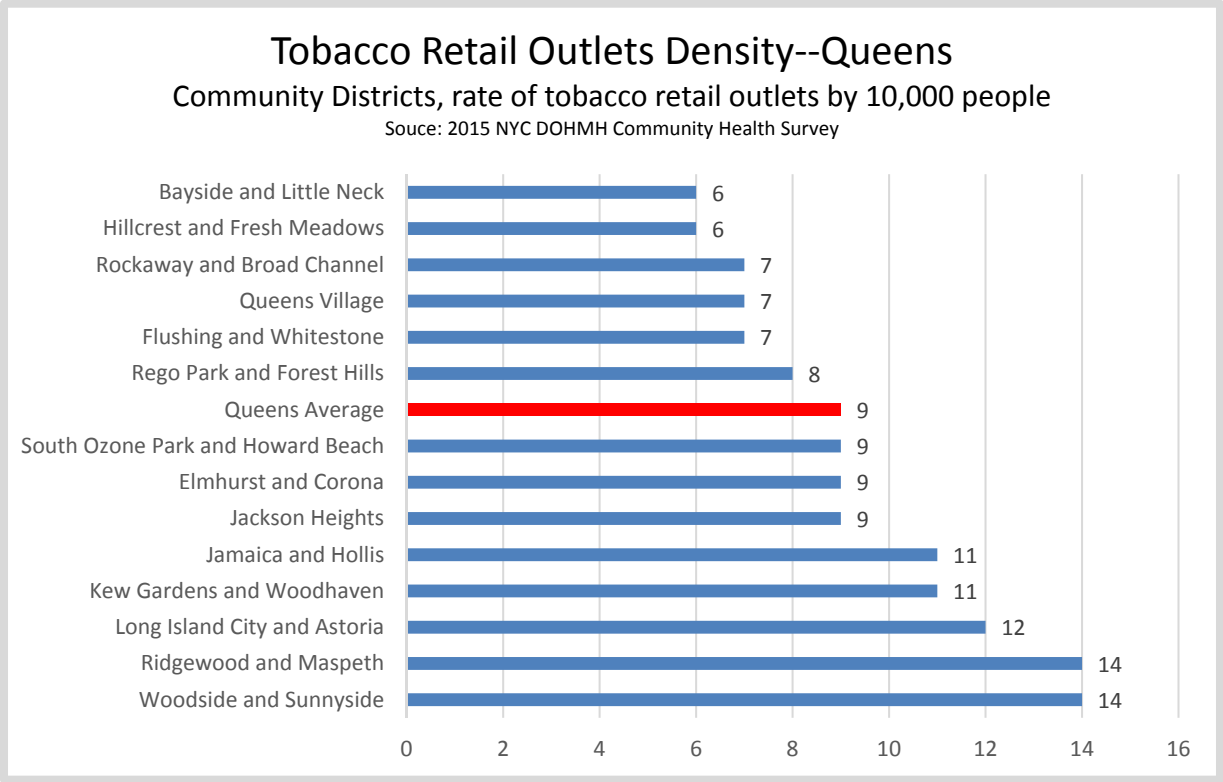


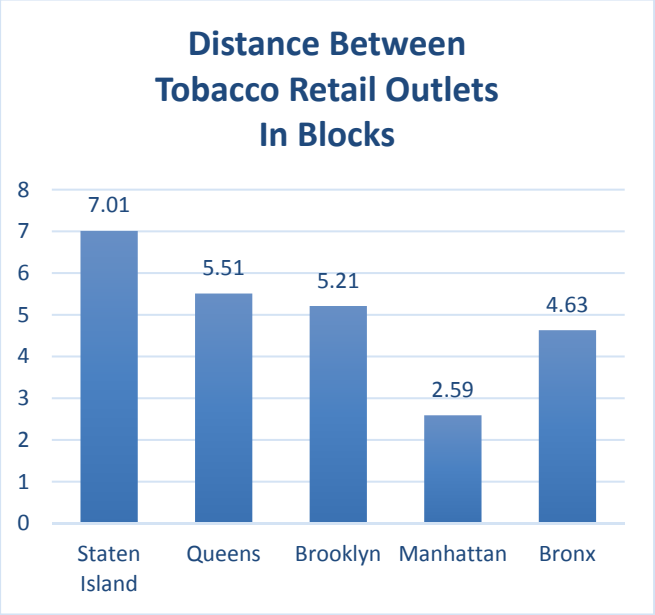
Figure 11


Tobacco Retail Outlets Density--Queens
Community Districts, rate of tobacco retail outlets by 10,000 people
Souce: 2015 NYC DOHMH Community Health Survey
Bayside and Little Neck
Hillcrest and Fresh Meadows
Rockaway and Broad Channel
Queens Village
Flushing and Whitestone
Rego Park and Forest Hills
Queens Average
South Ozone Park and Howard Beach
Elmhurst and Corona
Jackson Heights
Jamaica and Hollis
Kew Gardens and Woodhaven
Long Island City and Astoria
Ridgewood and Maspeth
Woodside and Sunnyside
6
6
7
7
7
8
9
9
9
9
11
11
12
14
14
0
2
4
6
8
10
12
14
16

PROXIMITY TO OTHER TOBACCO RETAIL OUTLETS

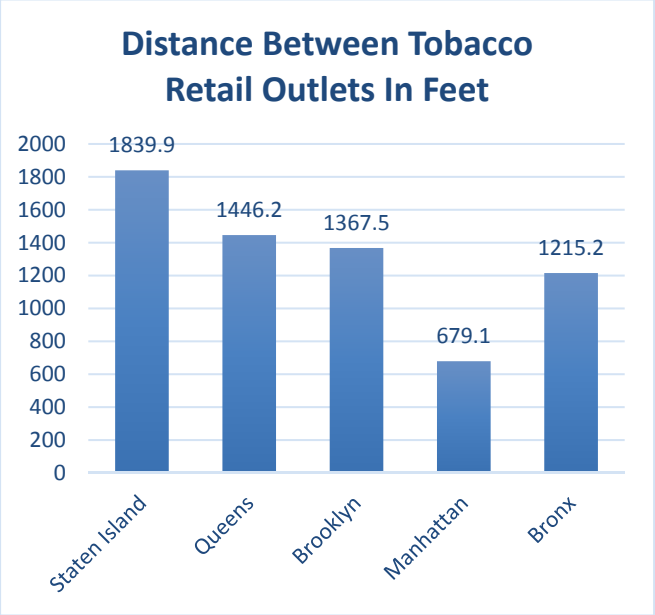
Citywide, there is a licensed tobacco retail outlet every **five blocks or 1,312 feet. (Figure 12 & 13)**[45] When accounting for city parks, beaches, cemeteries and other open spaces where no retail outlet stores exist, the distance between licensed tobacco retail outlets is even less.

Figure 12



Analysis by: Aleksey Bilogur, CUNY Baruch[46]

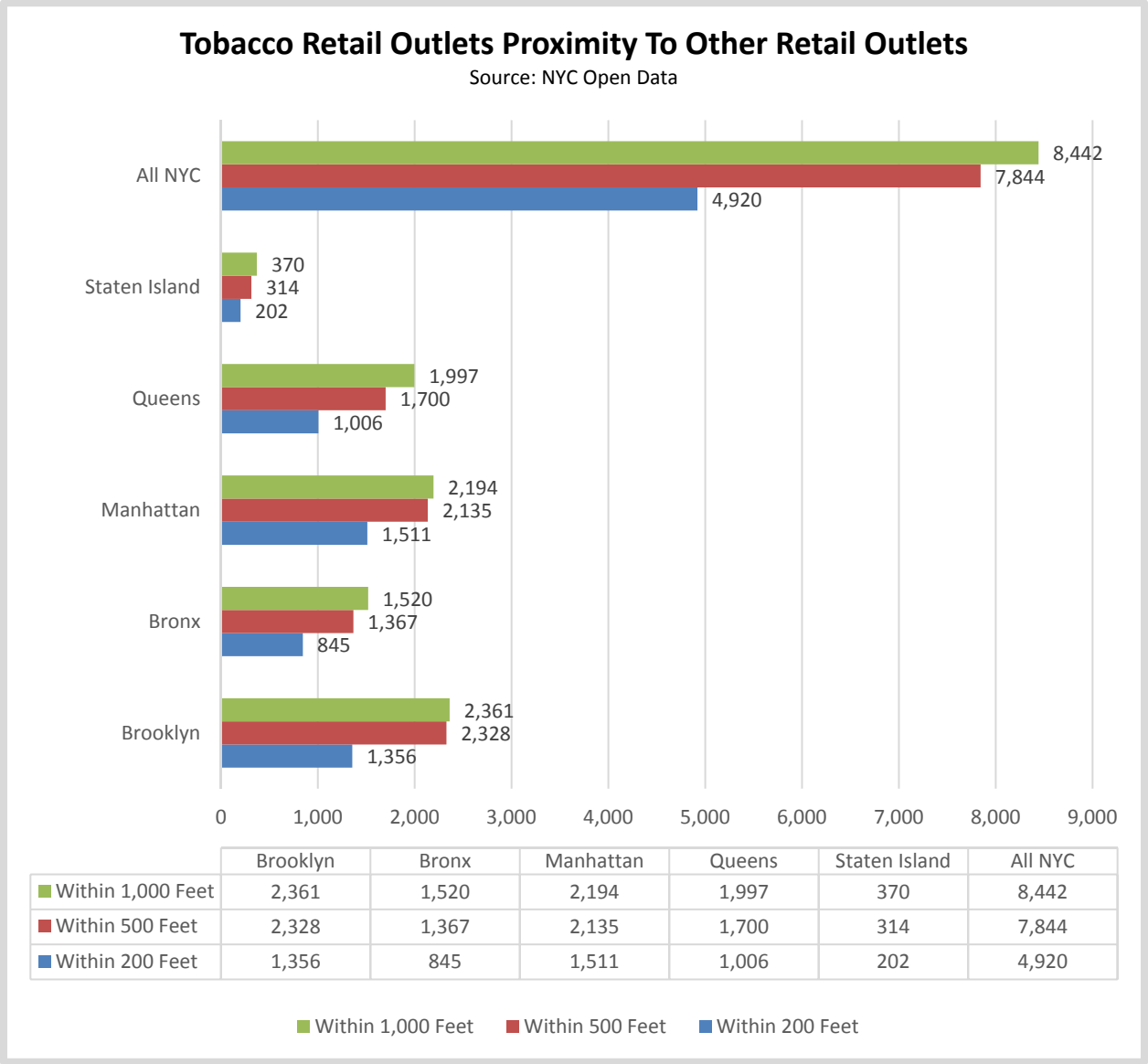
Figure 13



Analysis by: Aleksey Bilogur, CUNY Baruch[47]

There are 4,920 licensed tobacco retail outlets within 200 feet of another retail outlet, 7,844 licensed tobacco retail outlets within 500 feet of another retail outlet and 8,442 licensed tobacco retail outlets within 1,000 feet of another retail outlet. Citywide, only 221 licensed tobacco retail outlets are more than 1,000 feet apart. [48] The maximum distance between licensed tobacco retail outlets citywide is 9,730 feet (1.84 miles) in the Far Rockaways (Breezy Point). **(Figure 14)**[49]

Figure 14



	Brooklyn	Bronx	Manhattan	Queens	Staten Island	All NYC
Within 1,000 Feet	2,361	1,520	2,194	1,997	370	8,442
Within 500 Feet	2,328	1,367	2,135	1,700	314	7,844
Within 200 Feet	1,356	845	1,511	1,006	202	4,920

Alcohol Versus Tobacco Retail Outlet Density Restrictions: A Comparison

The New York State Alcoholic Beverage Control Law[50] prohibits certain licenses from being issued if the location of the establishment is within a 500 feet radius of certain other establishments with on-premises liquor licenses. The restrictions apply in cities, towns or villages with a population of 20,000 or more. No similar restriction exists in relation to tobacco and youth despite the significant negative impact that tobacco has on health.

PROXIMITY TO OTHER TOBACCO RETAIL OUTLETS

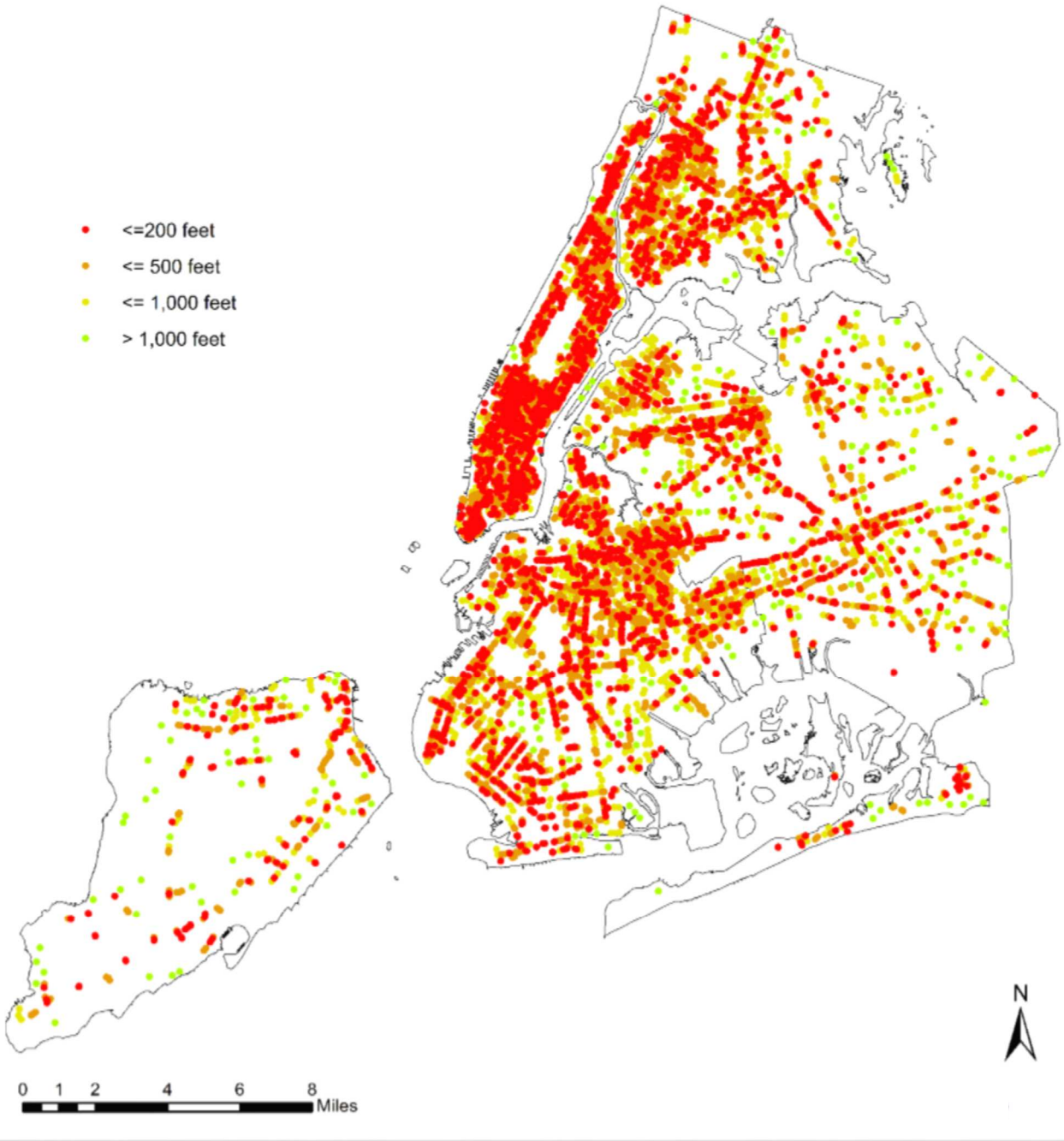
The maps

The following pages include maps showing every licensed tobacco retail dealer in New York City plotted based on their registered address along with their proximity to other licensed tobacco retail outlets High resolution maps are available at www.acscan.org/oversaturated.

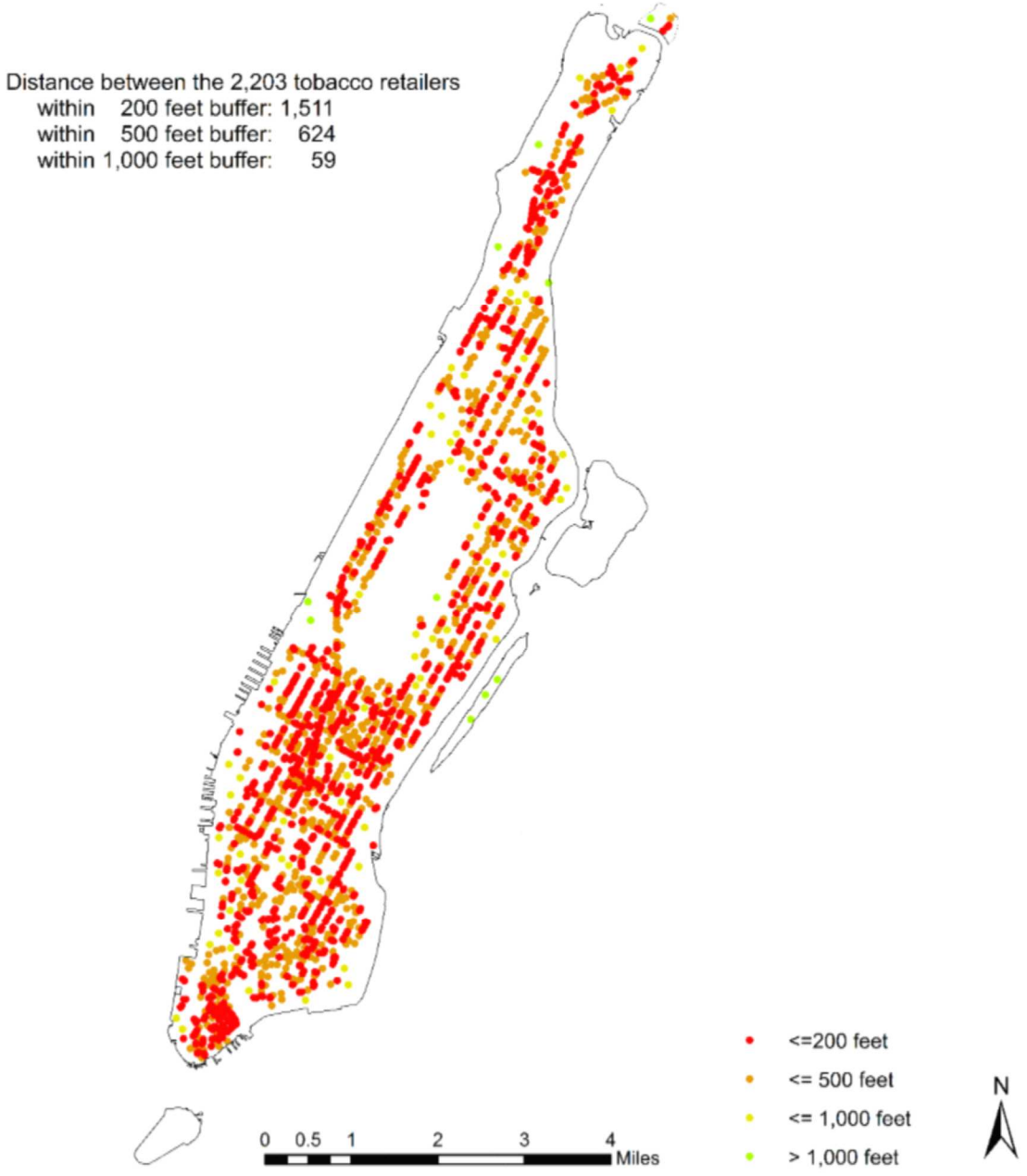
Included here are:

- New York City
- Manhattan
- Queens
- Bronx
- Brooklyn
- Staten Island

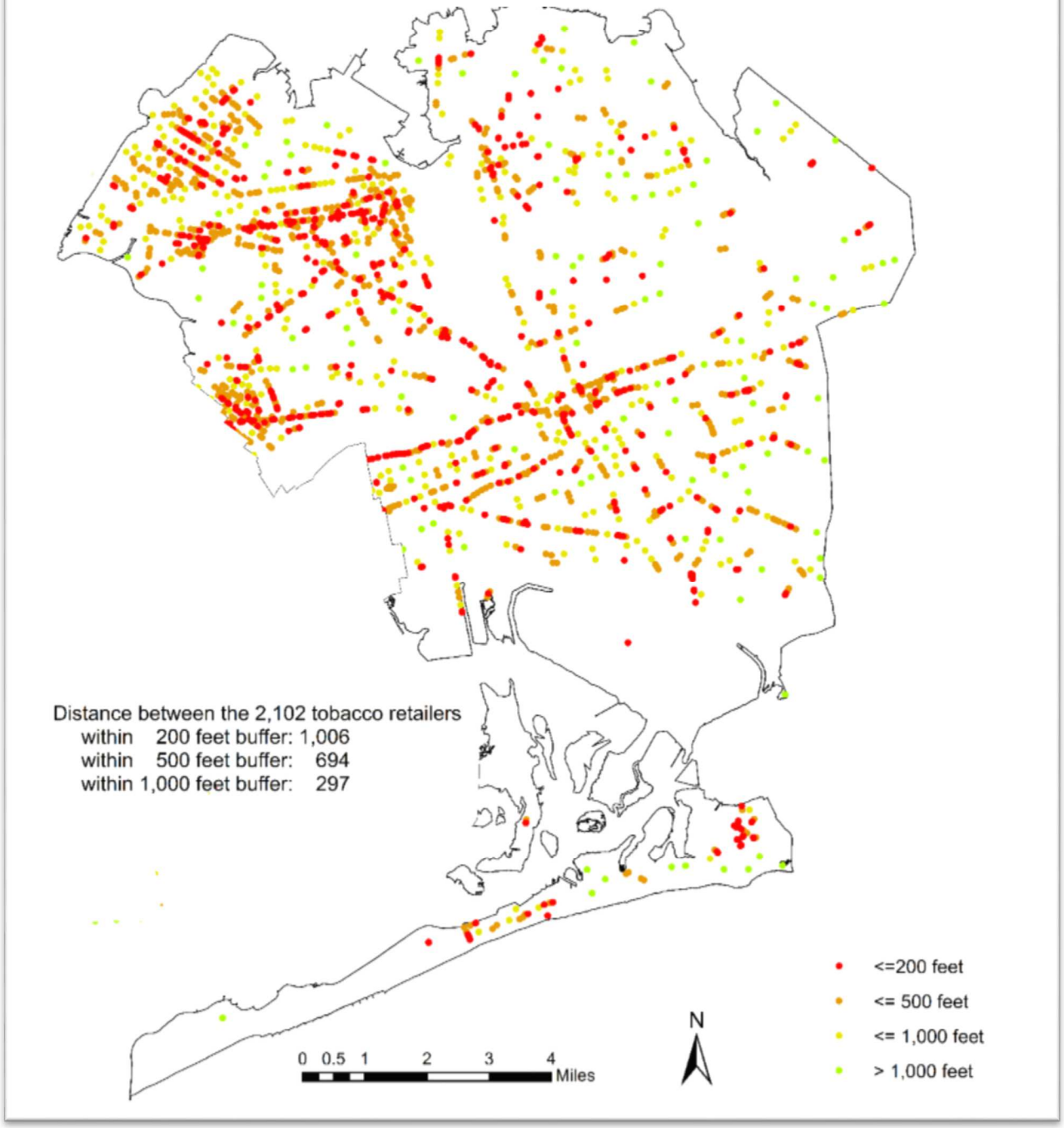
Distances Between Tobacco Retail Locations



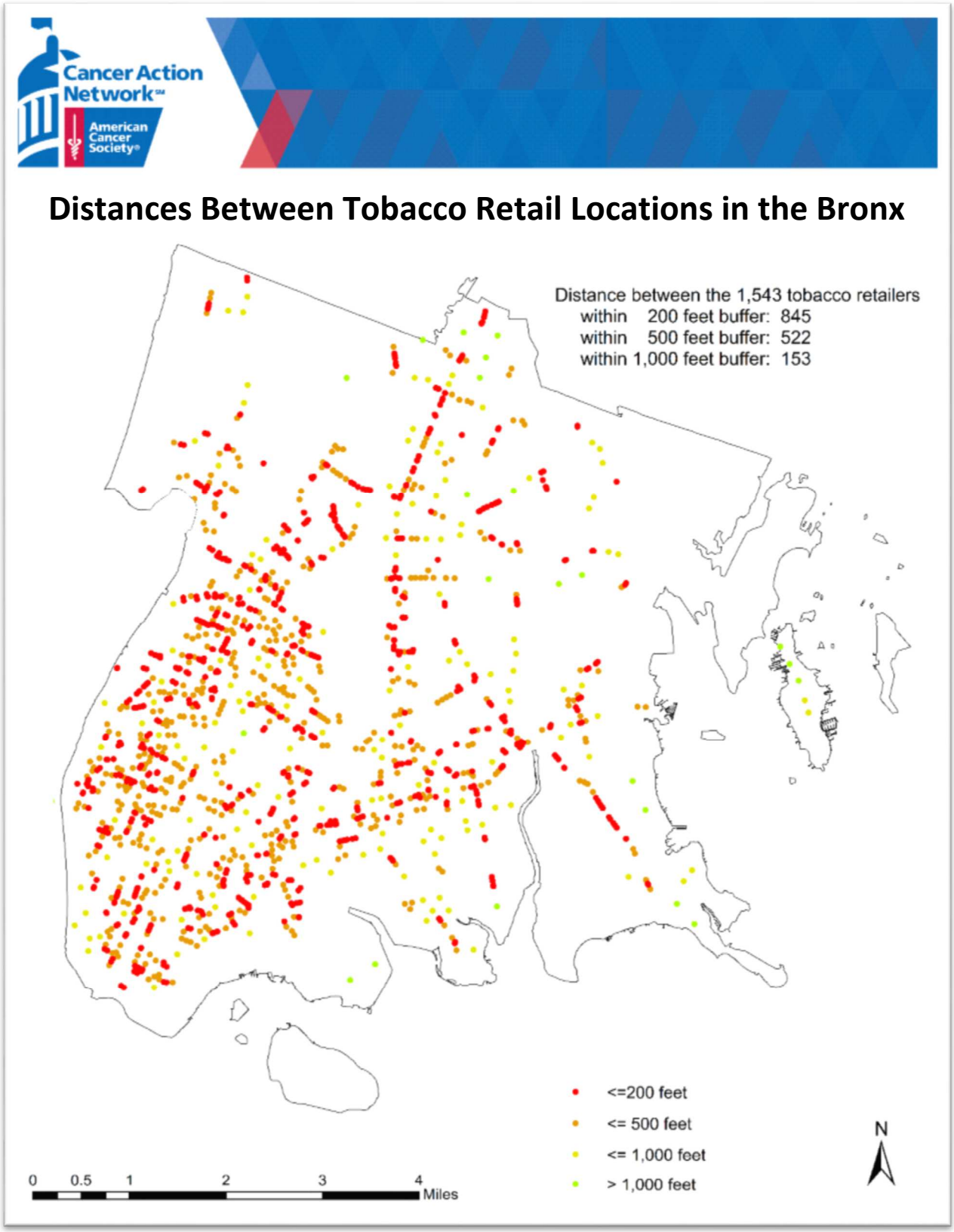
Distances Between Tobacco Retail Locations in Manhattan



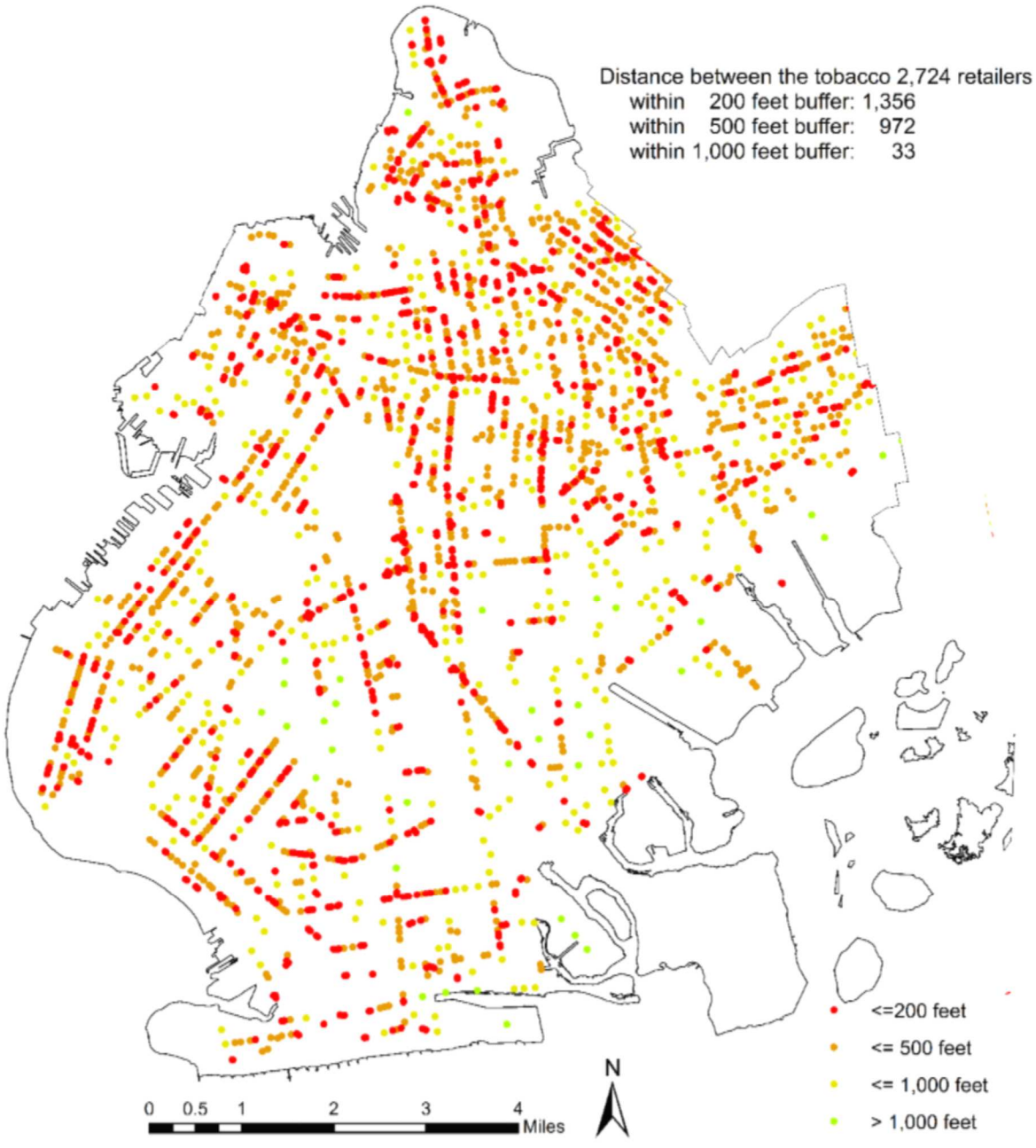
Distances Between Tobacco Retail Locations in Queens



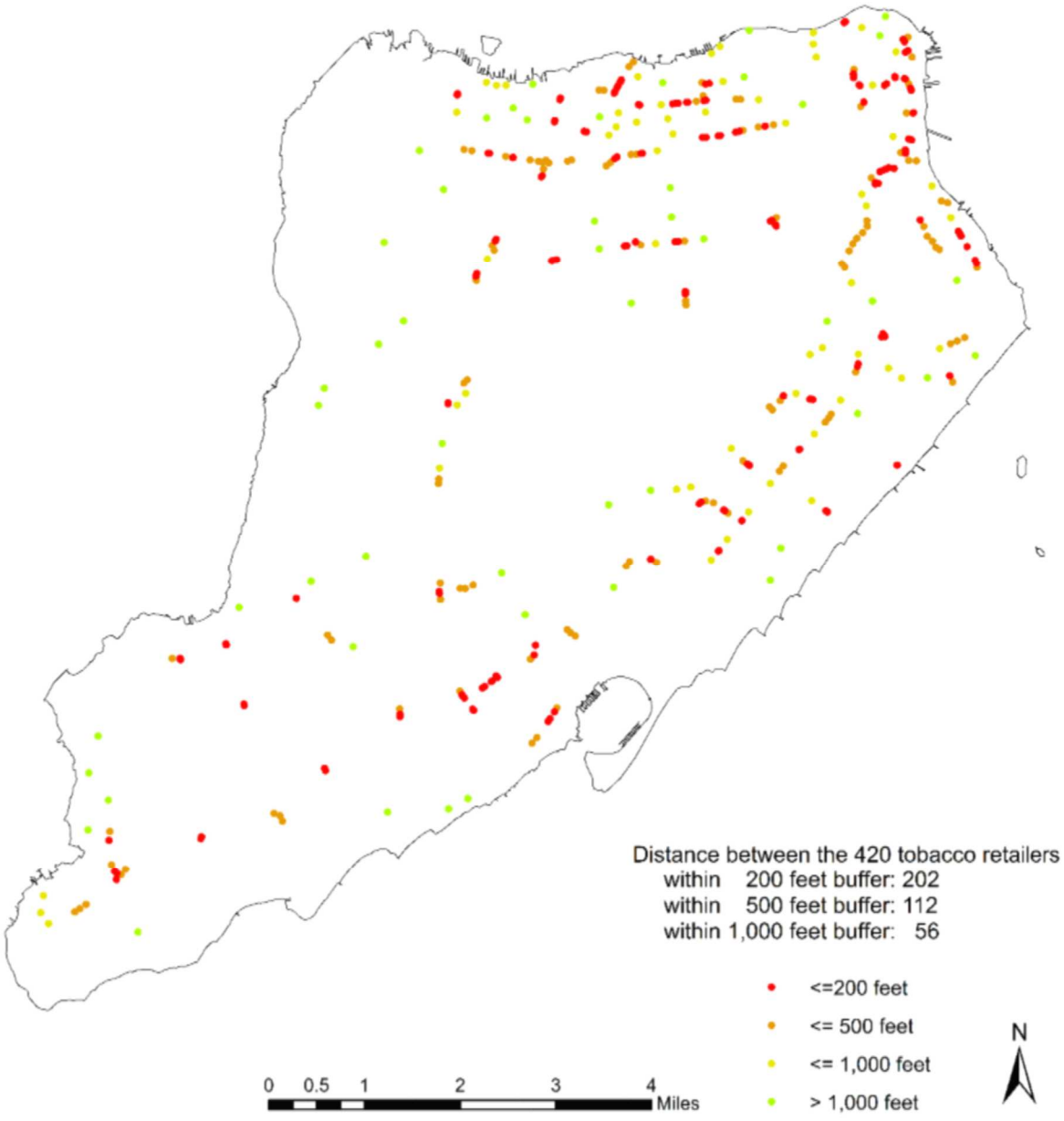
Distances Between Tobacco Retail Locations in the Bronx



Distances Between Tobacco Retail Locations in Brooklyn



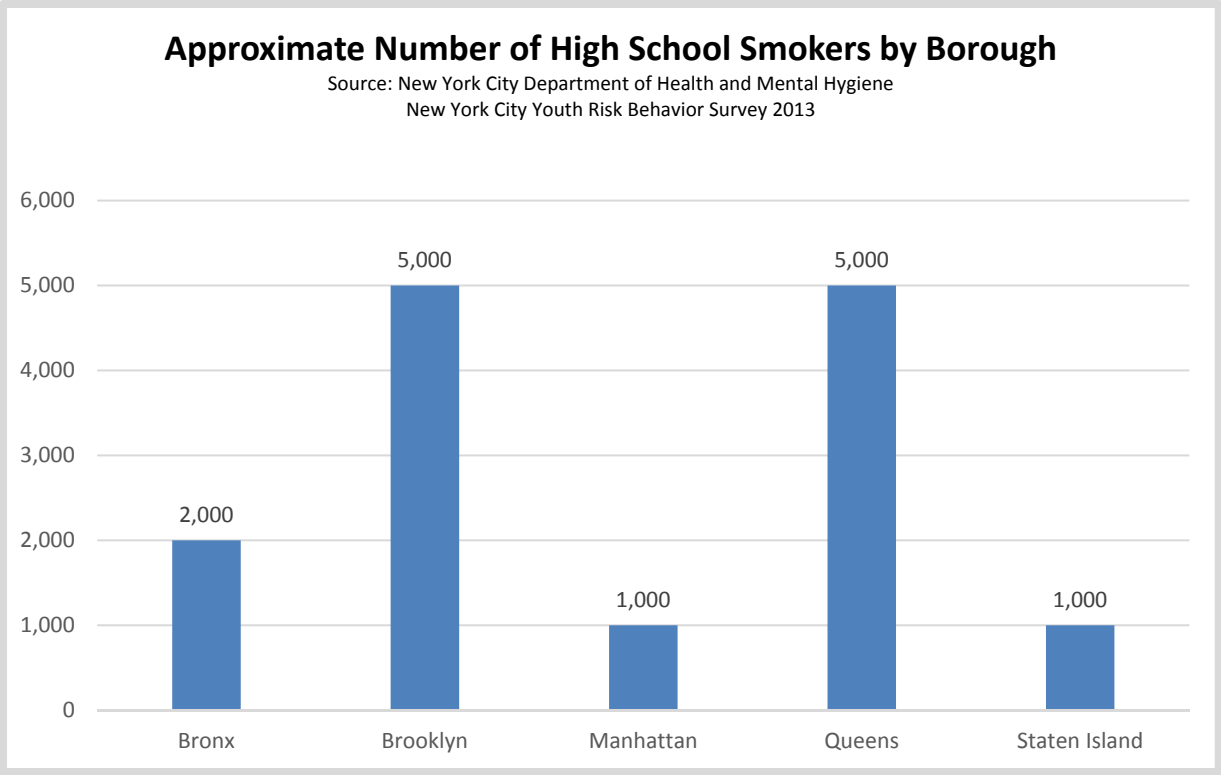
Distances Between Tobacco Retail Locations on Staten Island



TOBACCO RETAIL OUTLETS AND SCHOOLS

According to Tobacco Free New York State, each year in New York state, 22,500 youth become regular daily smokers, and 31.6 million packs of cigarettes are bought or smoked by youth under the age of 18.[51] Approximately 15,000 public high school students smoke cigarettes (**Figure 15)**[52]**,** one-third of whom will die prematurely as a direct result of smoking.[53] Every day, the tobacco industry spends over $500,000 in New York state to market its deadly products.[54] Tobacco companies place most of their advertising where young people shop – in convenience stores, where 75 percent of New York State teens shop at least once per week.[55] The more tobacco retail outlets there are near schools, the more likely children are to smoke.[56] More than one in three New York City high school students who smoke obtain their cigarettes from a neighborhood retail outlet.[57]

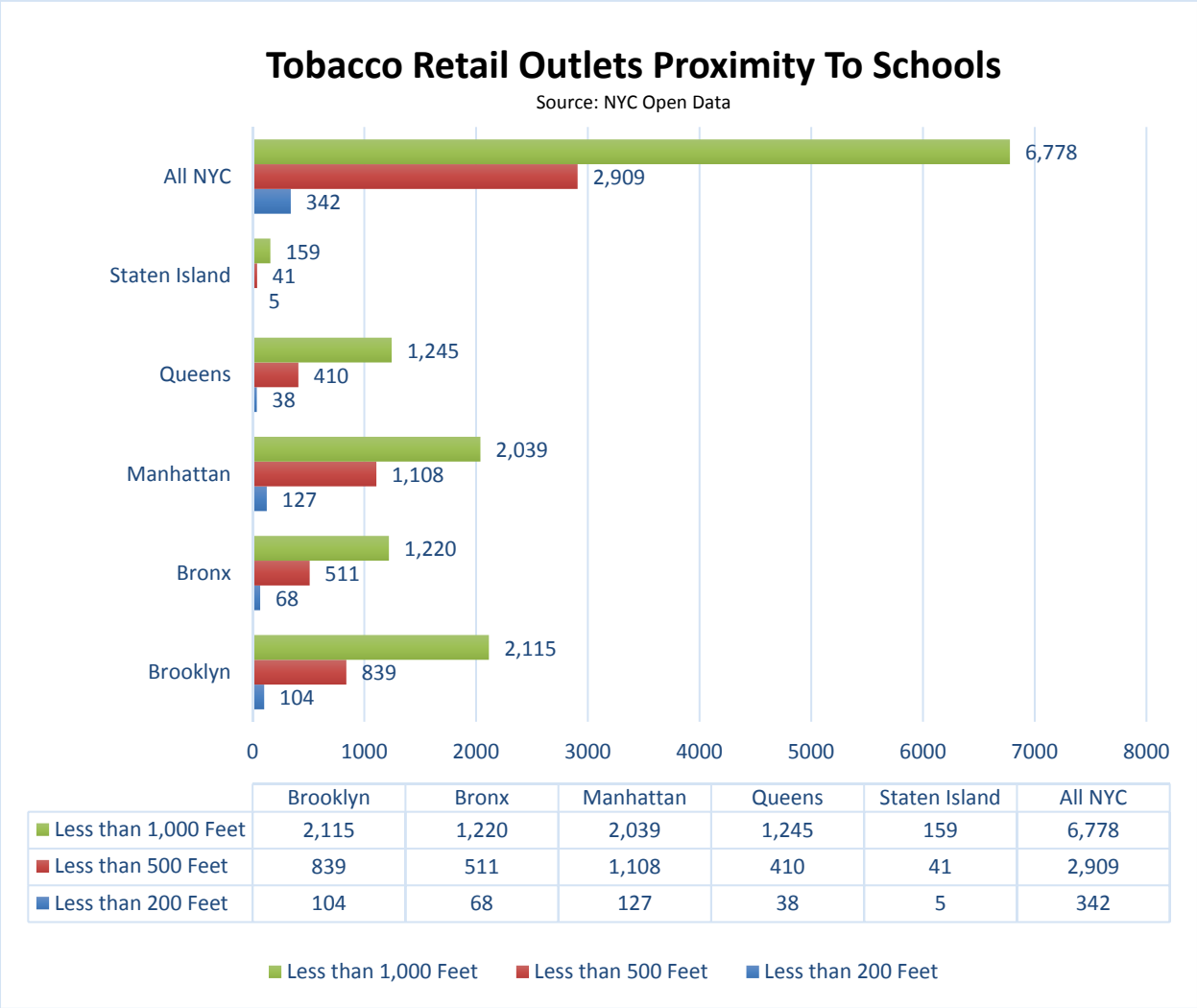
Figure 15



Youth in New York City are more likely to find tobacco retail outlets than libraries[58] or playgrounds[59] in their neighborhoods. There is approximately one licensed tobacco retail outlet for every 196 children[60] in New York City. Meanwhile, there is approximately one playground for every 1,765 children[61] and one public library for every 8,613[62] children in New York City.

In New York City there are 342 licensed tobacco retail outlets within 200 feet of a school, 2,909 licensed tobacco retail outlets within 500 feet of a school and 6,778 licensed tobacco retail outlets within 1,000 feet of a school. **(Figure 16)**[63]

Figure 16



	Brooklyn	Bronx	Manhattan	Queens	Staten Island	All NYC
Less than 1,000 Feet	2,115	1,220	2,039	1,245	159	6,778
Less than 500 Feet	839	511	1,108	410	41	2,909
Less than 200 Feet	104	68	127	38	5	342

Alcohol Versus Tobacco and Youth Retail Outlet Restrictions: A Comparison

The New York State Alcoholic Beverage Control Law[64] prohibits certain licenses from being issued if the location of the establishment is on the same street and within 200 feet of a building that is used exclusively as a school, church, synagogue or other place of worship. This restriction applies to any retail establishment where liquor will be sold for on-premises consumption and any retail establishment where liquor or wine will be sold for consumption off the premises. No similar restriction exists in relation to tobacco and youth despite the significant negative impact that tobacco has on health.

TOBACCO RETAIL LOCATIONS AND SCHOOLS

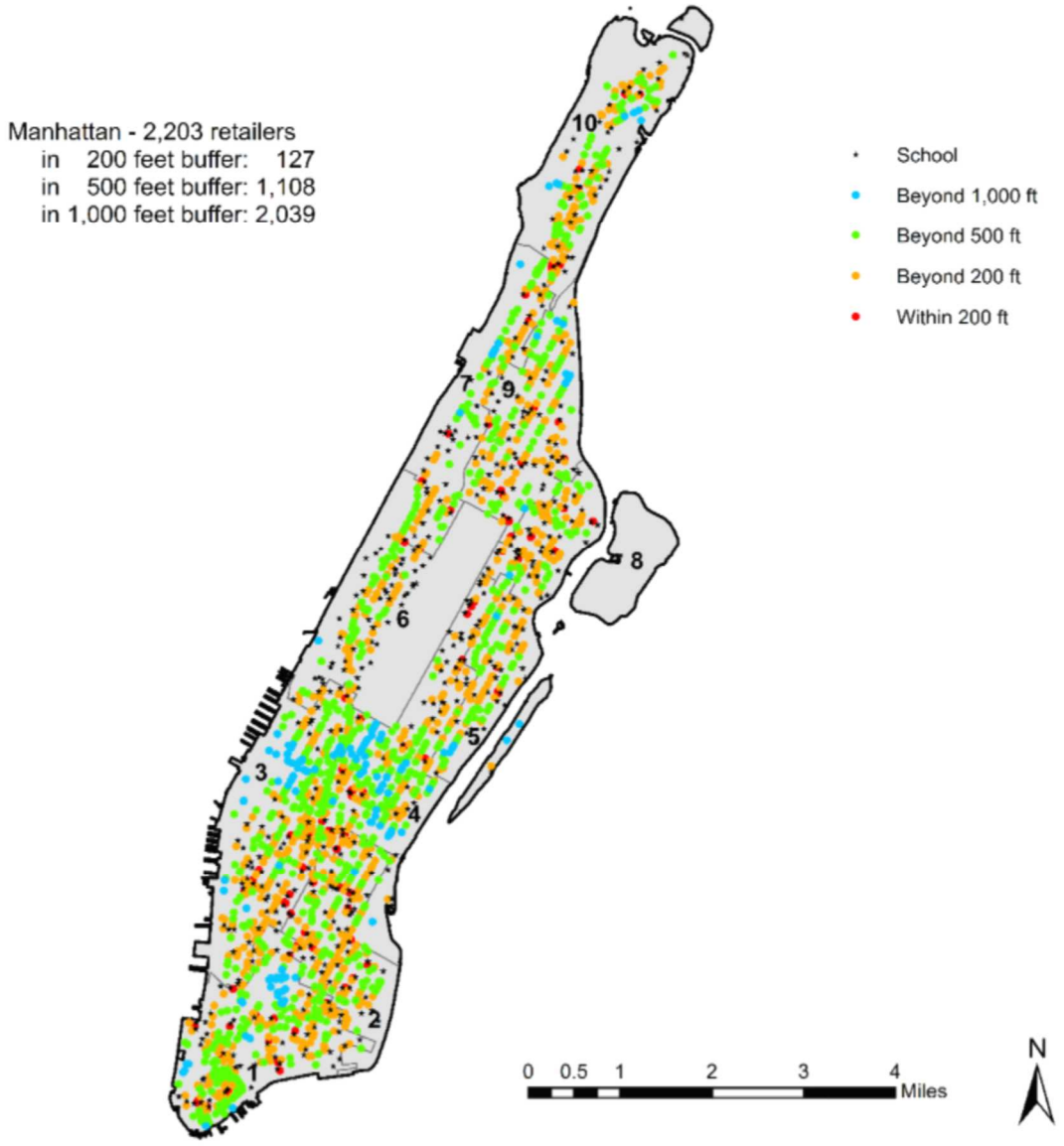
The maps

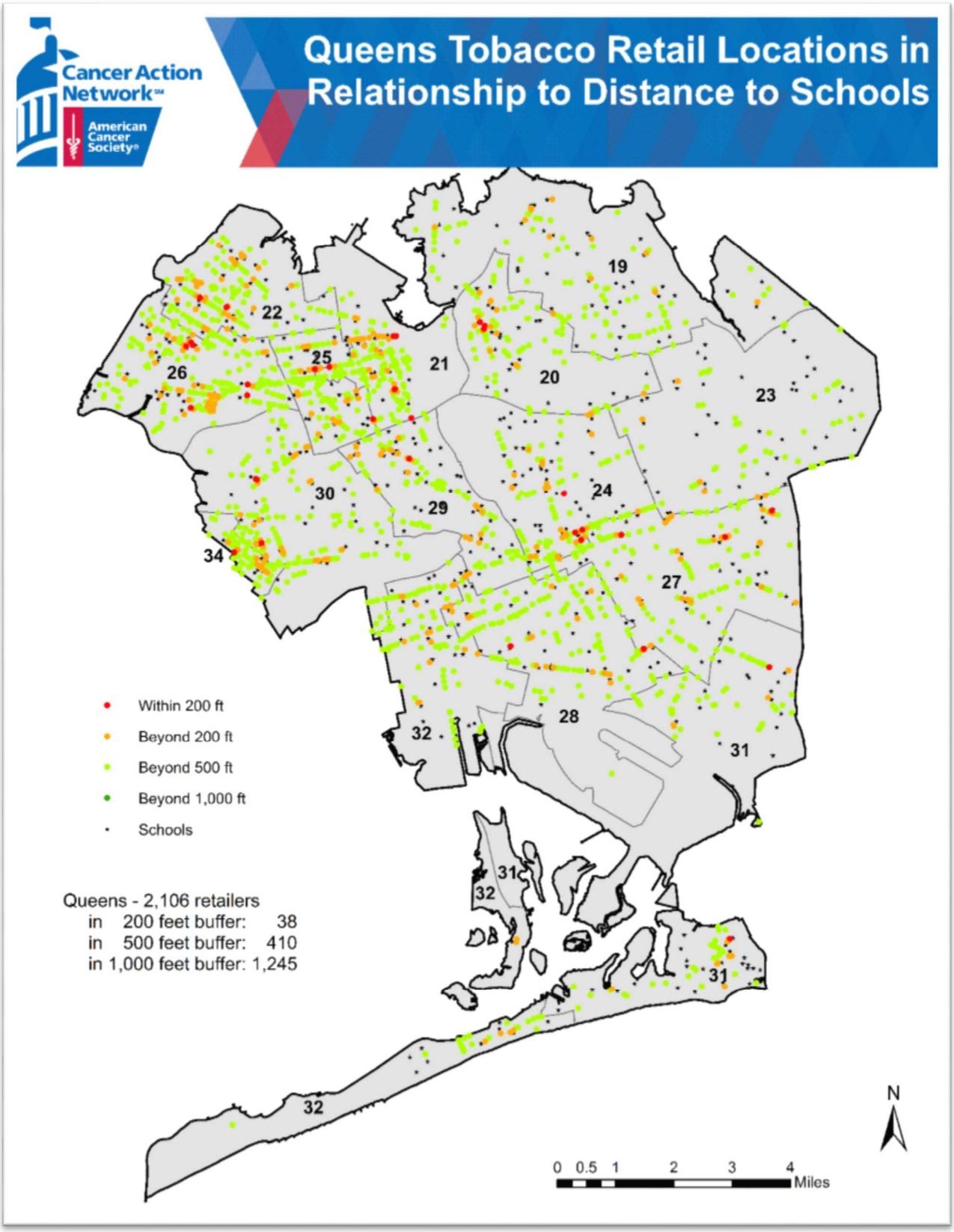
The following pages include maps showing every licensed tobacco retail dealer in New York City and every New York City public school plotted based on their registered address. The numbers on the borough maps are of City Council districts. High resolution maps are available at www.acscan.org/oversaturated.

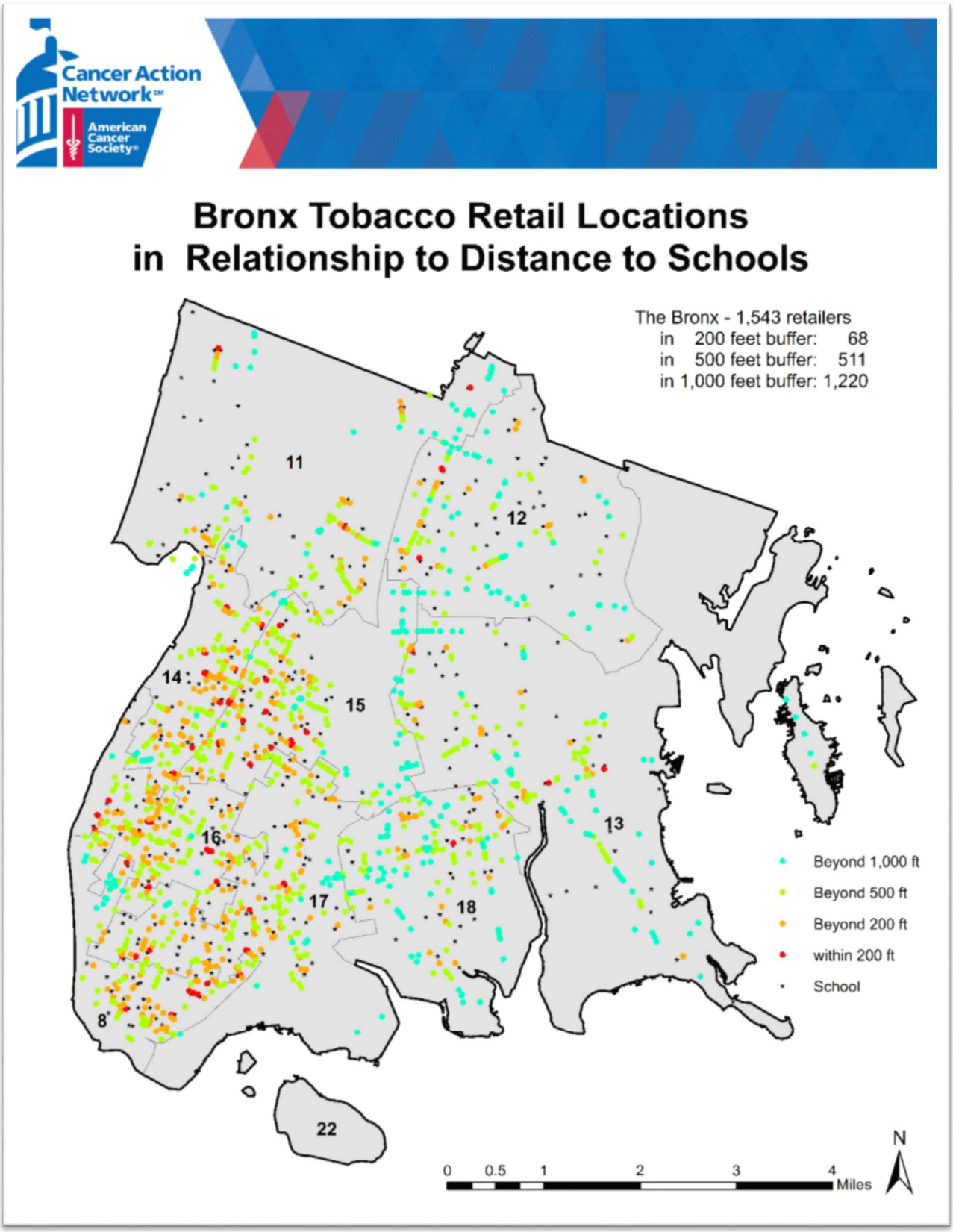
Included here are:

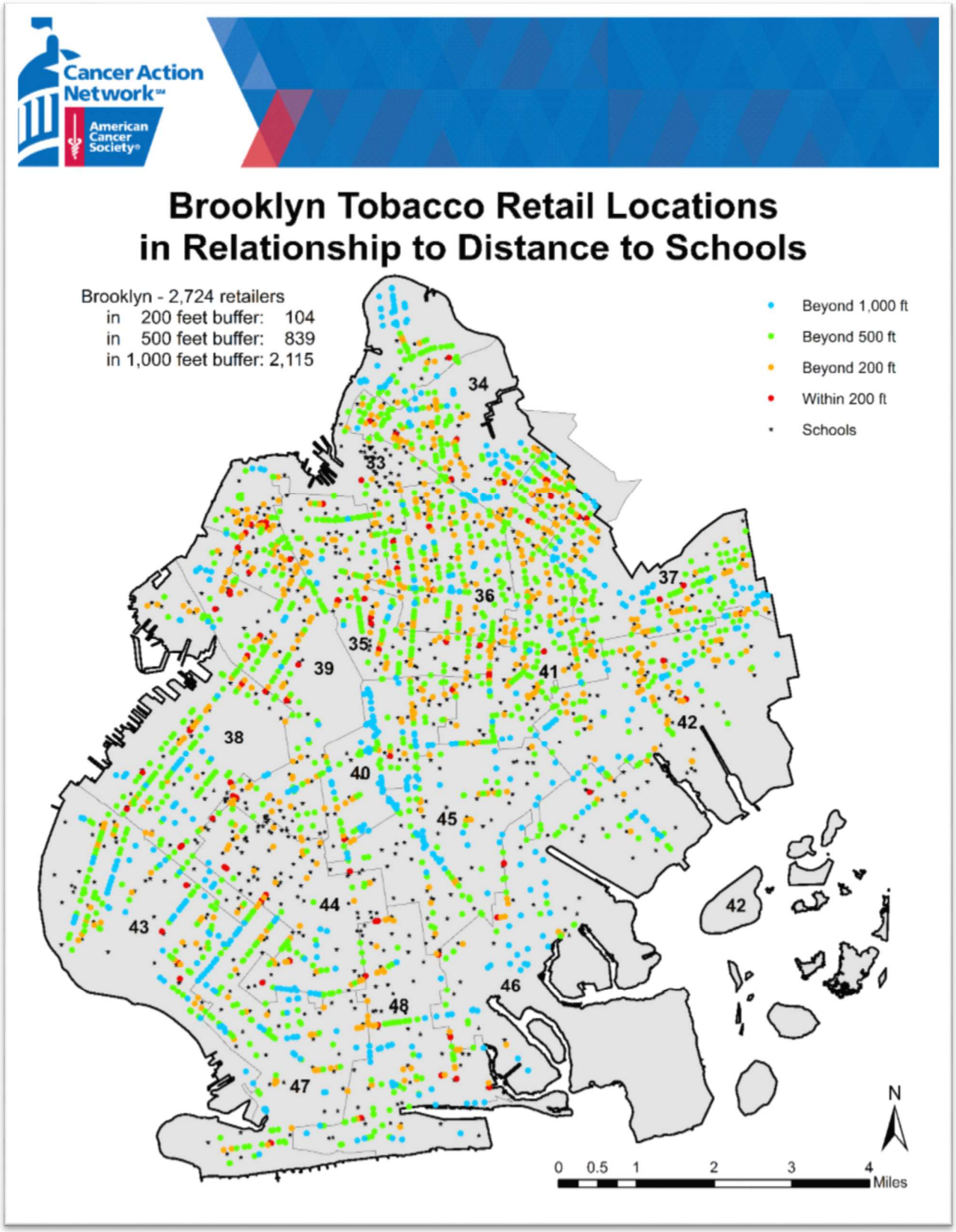
- Manhattan
- Queens
- Bronx
- Brooklyn
- Staten Island

Manhattan Tobacco Retail Locations in Relationship to Distance to Schools

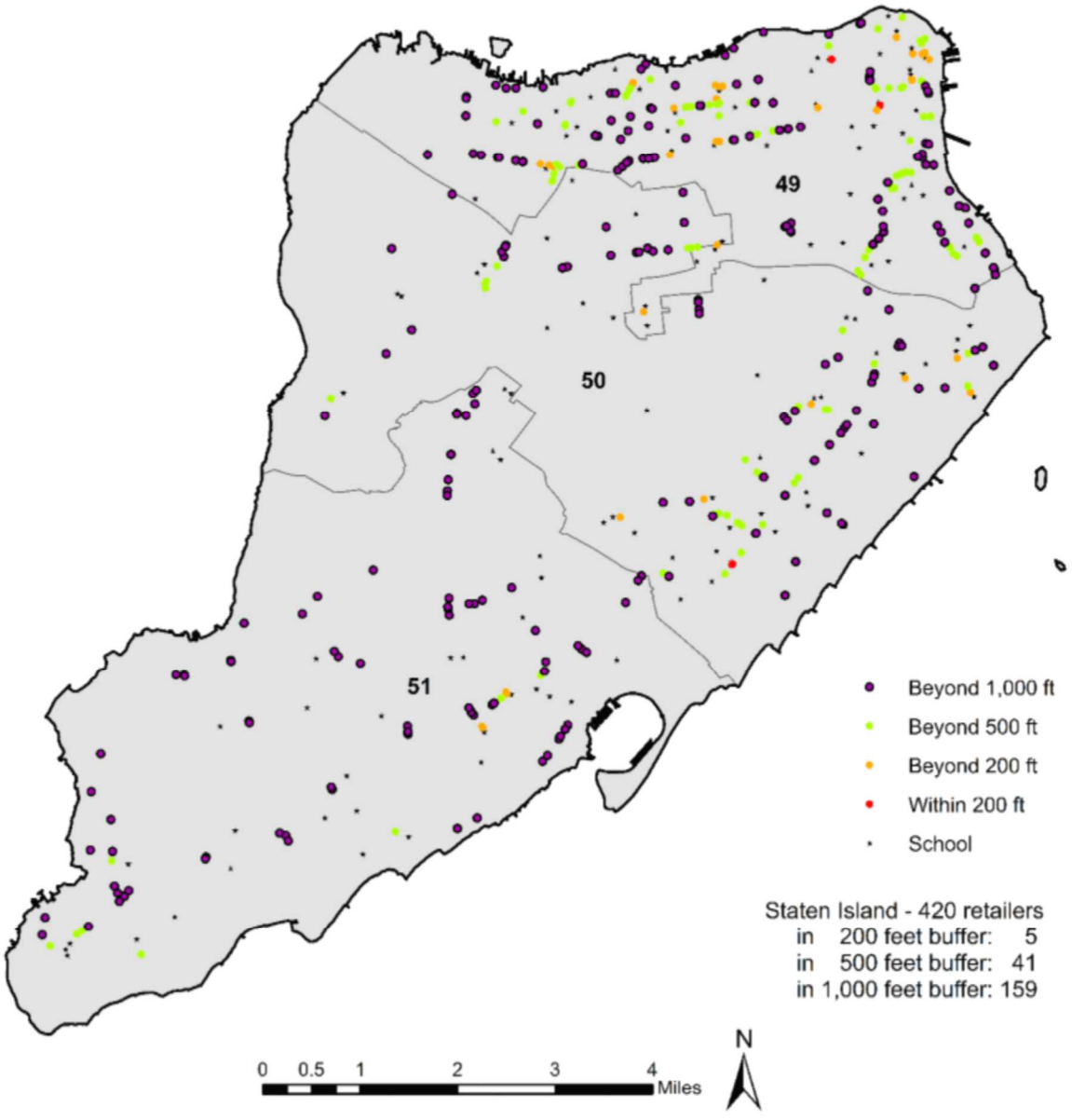



Cancer Action Network
American Cancer Society
Queens Tobacco Retail Locations in Relationship to Distance to Schools
19
22
25
21
20
26
23
30
29
24
34
27
28
32
31
31
32
31
32
Within 200 ft
Beyond 200 ft
Beyond 500 ft
Beyond 1,000 ft
Schools
Queens - 2,106 retailers
in 200 feet buffer: 38
in 500 feet buffer: 410
in 1,000 feet buffer: 1,245
N
0 0.5 1 2 3 4
Miles


Cancer Action Network℠
American Cancer Society®
Bronx Tobacco Retail Locations
in Relationship to Distance to Schools
The Bronx - 1,543 retailers
in 200 feet buffer: 68
in 500 feet buffer: 511
in 1,000 feet buffer: 1,220
11
12
14
15
13
16
17
18
8
22
Beyond 1,000 ft
Beyond 500 ft
Beyond 200 ft
within 200 ft
School
0 0.5 1 2 3 4
Miles
N


Cancer Action Network
American Cancer Society
Brooklyn Tobacco Retail Locations
in Relationship to Distance to Schools
Brooklyn - 2,724 retailers
in 200 feet buffer: 104
in 500 feet buffer: 839
in 1,000 feet buffer: 2,115
Beyond 1,000 ft
Beyond 500 ft
Beyond 200 ft
Within 200 ft
Schools
34
33
37
36
35
39
41
42
38
40
45
42
44
43
46
48
47
N
0 0.5 1 2 3 4
Miles

Staten Island Tobacco Retail Locations in Relationship to Distance to Schools

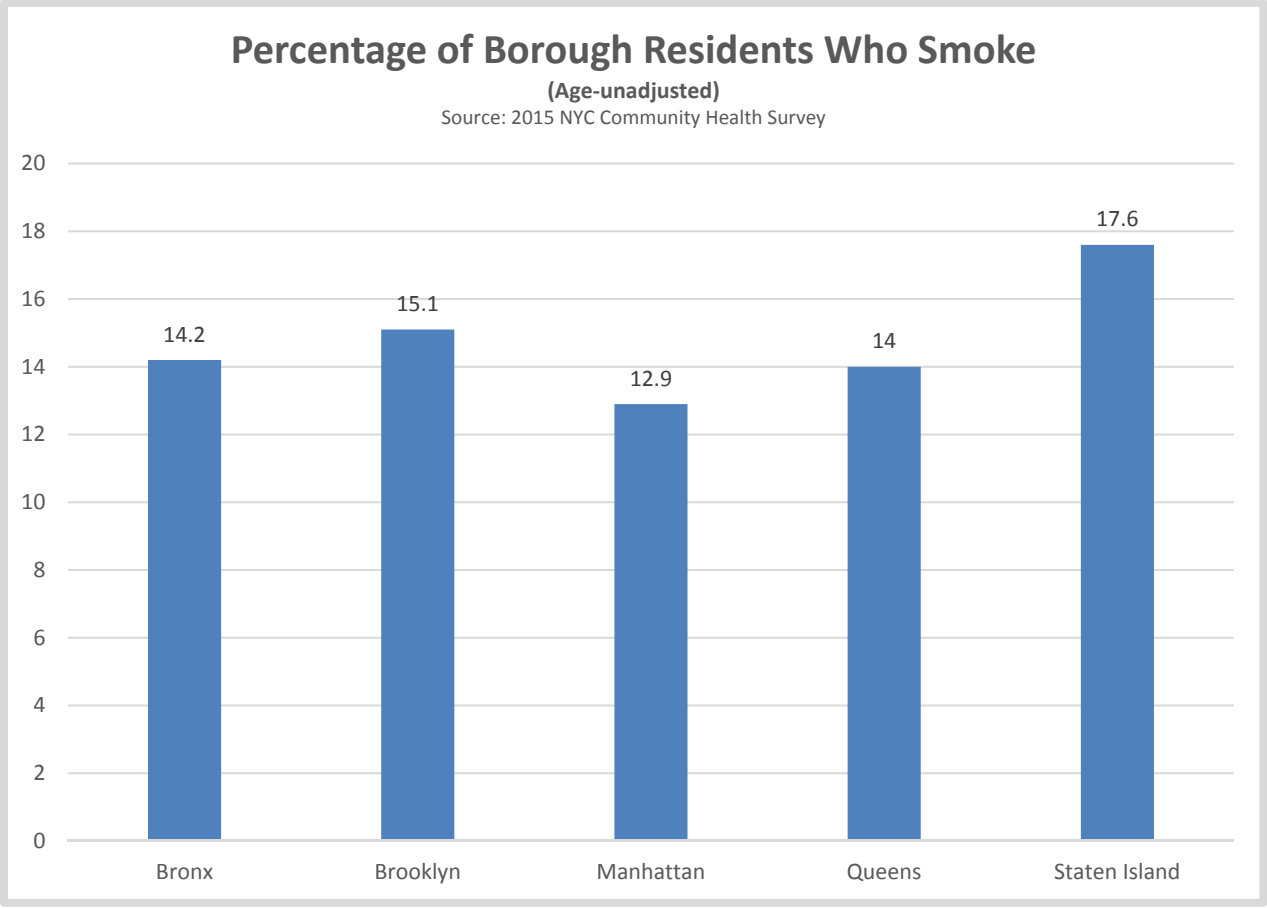


TOBACCO USE IN NEW YORK CITY

Since 2002 smoking rates in New York City have declined by 33 percent, dropping from a three-year average of 21.6 percent between 2000-2002 to a three-year average of 14.7 percent between 2013-2015.[65] Currently the smoking rate stands at 14.3 percent.[66] Approximately 950,000 adults[67] smoke cigarettes.[68] In addition, more than 200,000 children are exposed to secondhand smoke at home.[69]

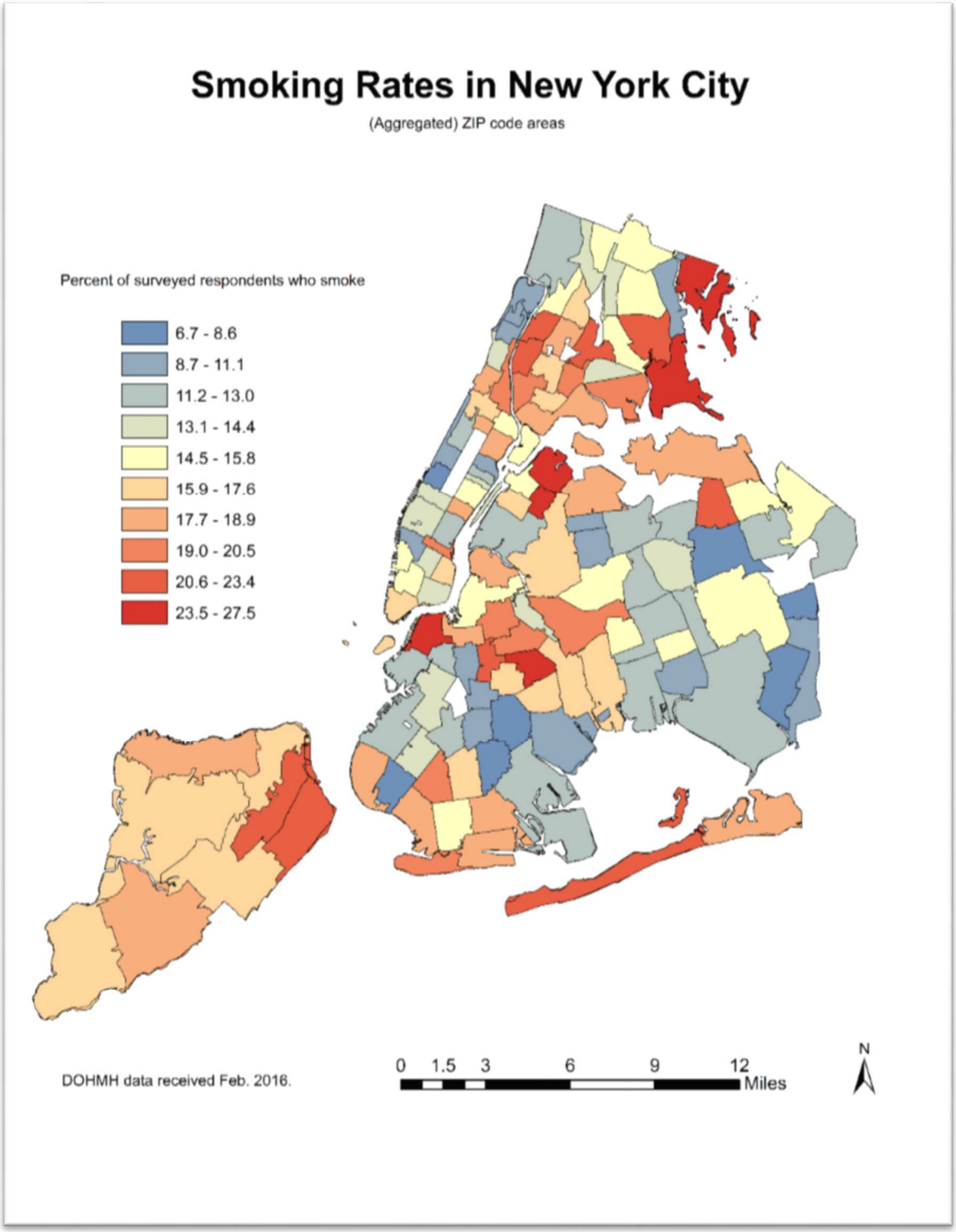
When looking at the five boroughs individually the differences in smoking rates may not seem substantial.[70] However, smoking rates on an aggregated zip code level tell a very different and more troubling story. While Brooklyn and Staten Island have the highest smoking rates, significant differences exist within each borough. These disparities are an especially daunting challenge that must be addressed. **(Figure 17)**[71]

Figure 17



The below map includes aggregate zip codes with smoking rates according to the New York City Department of Health and Mental Hygiene. **(Figure 18)**

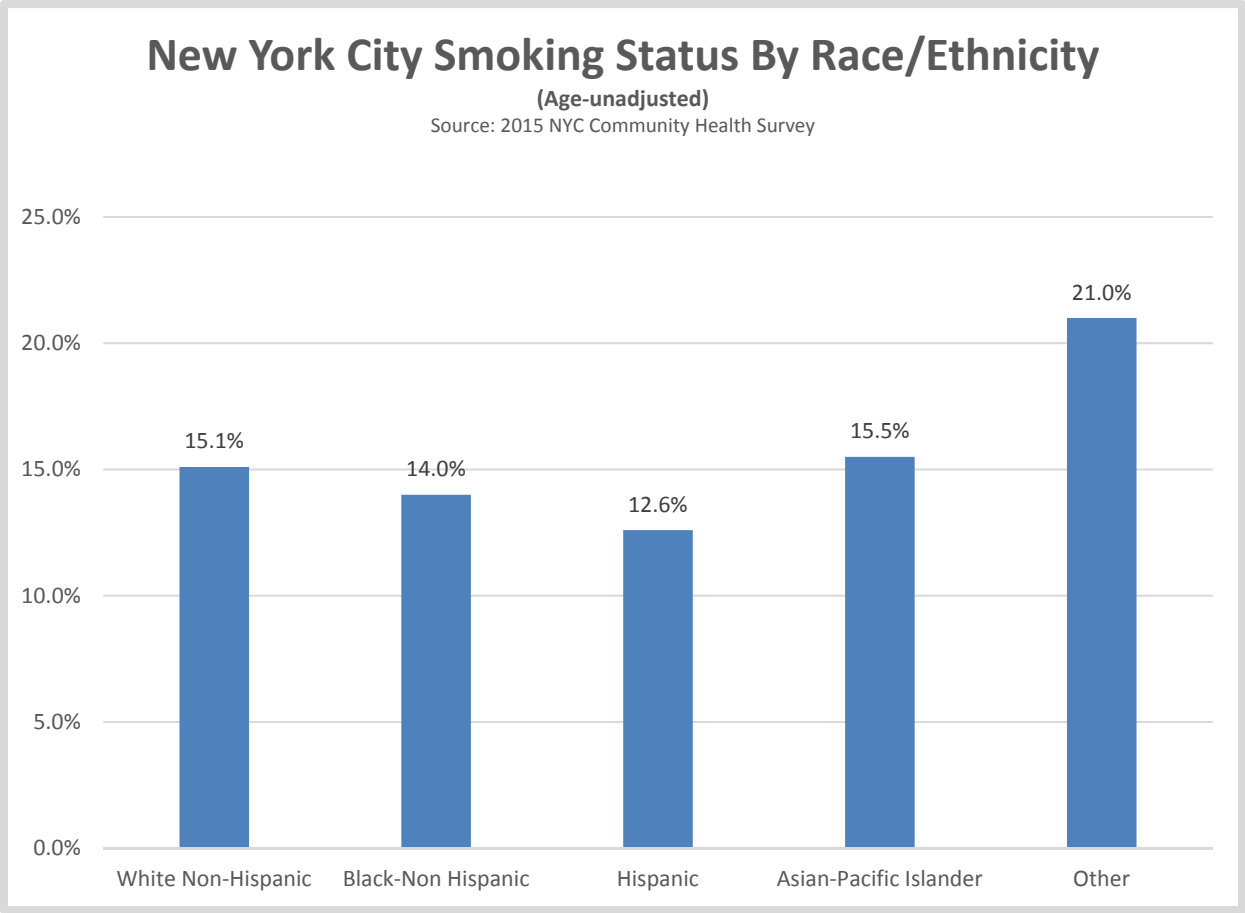
Figure 18



DISPARITIES IN TOBACCO USE

Although cigarette smoking has declined significantly in New York City since 2002, disparities in tobacco use remain across various groups. While different racial and ethnic groups smoke at similar rates (**Figure 19)**[72], significant disparities exist by educational level and socioeconomic status across New York City.

Figure 19

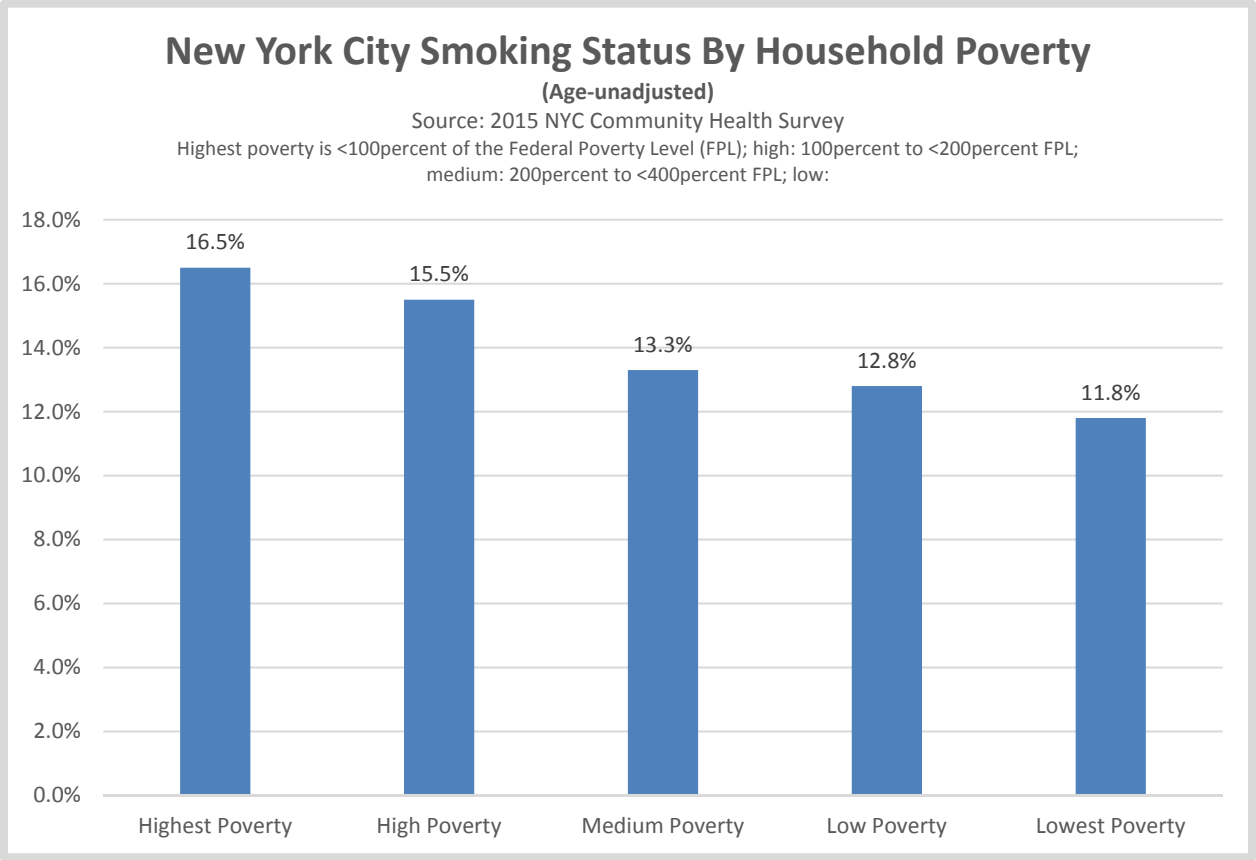


According the U.S. Centers for Disease Control and Prevention, adults who have lower levels of educational attainment, who are unemployed or who live at, near or below the U.S. federal poverty level are considered to have low socioeconomic status (SES).[73]

Cigarette smoking disproportionately affects the health of people with low SES.[74] Lower-income individuals who also smoke cigarettes suffer more from diseases caused by smoking than those with higher incomes. Secondhand smoke exposure is also higher among people living below the poverty line and those with less education. People of low SES are just as likely to attempt quitting, but are less likely to actually succeed in quitting smoking cigarettes. Tobacco companies often target advertising campaigns toward low-income neighborhoods and communities

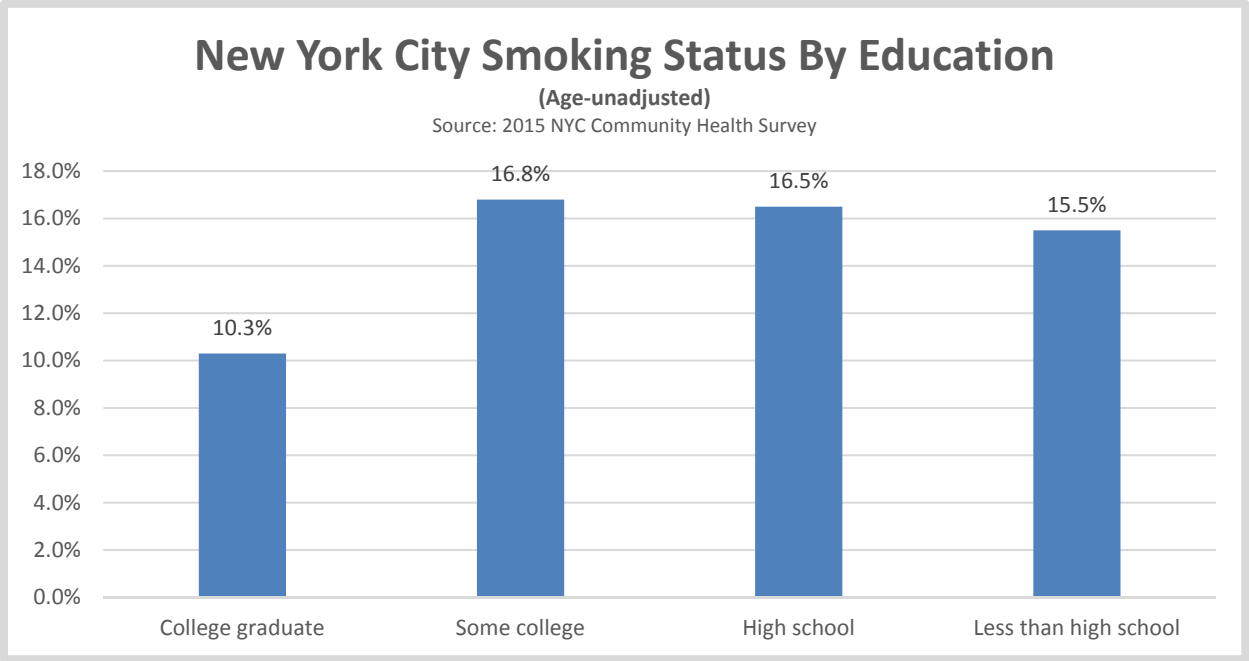
Smoking Rates by Categories That Define Lower Socioeconomic Status[75]
New Yorkers with the lowest income/highest level of poverty have a smoking rate of 16.5 percent while New Yorkers with the highest income/lowest poverty have a smoking rate of only 11.8 percent. **(Figure 20)[76]**

Figure 20



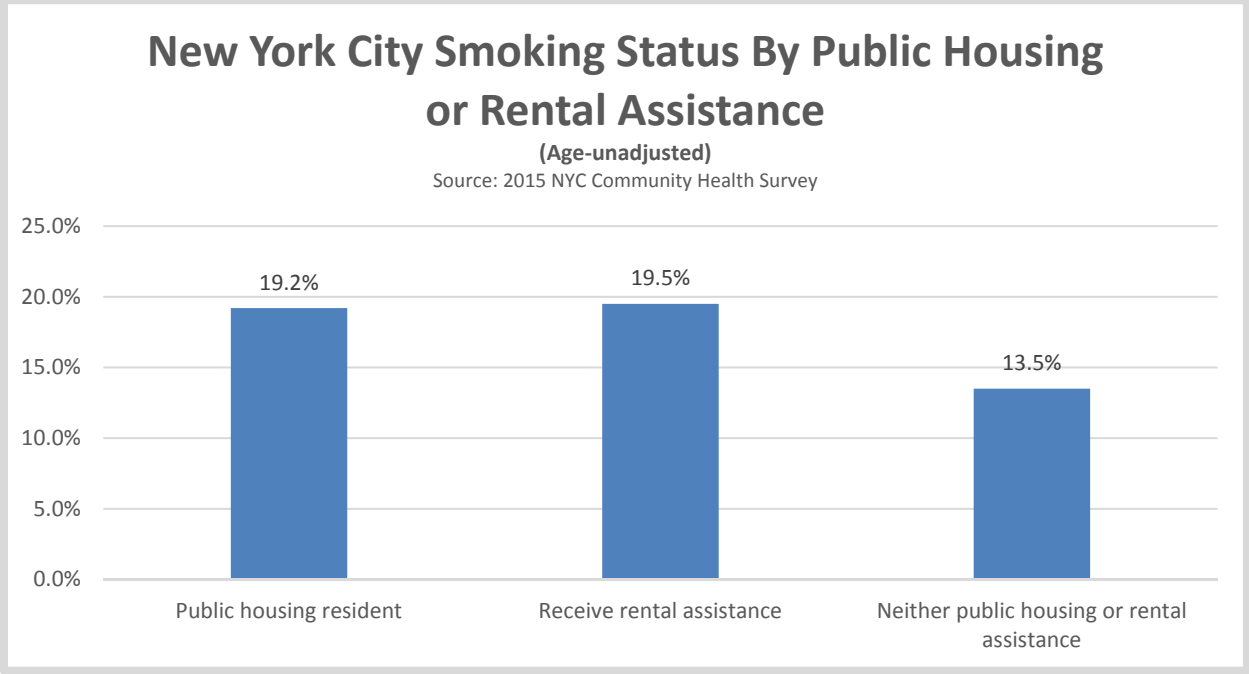
New Yorkers with less than a high school education have a smoking rate of 15.5 percent while New Yorkers with a college degree have a smoking rate of only 10.3 percent. **(Figure 21)**[77]

Figure 21



New Yorkers who live in public housing (19.2 percent) or receive rental assistance (19.5 percent) are also significantly more likely to smoke than New Yorkers who do not live in public housing or receive rental assistance (13.5 percent). **(Figure 22)**[78]

Figure 22



Type of Smoking Behavior[79]

There are three different types of smoking behavior tracked by the New York City Department of Health and Mental Hygiene: non-daily smoker, light daily smoker and heavy daily smoker. People who smoke more than 10 cigarettes a day are considered heavy daily smokers. Those who smoke between one and 10 cigarettes a day are considered light daily smokers, and all other smokers are considered non-daily smokers, according to the New York City Department of Health and Mental Hygiene.

Citywide, 41.4 percent of smokers are non-daily smokers, 37.5 percent are light daily smokers and 21.1 percent of smokers are heavy daily smokers. **(Figure 23)**[80] That means nearly 80 percent of smokers are either non-daily smokers or light daily smokers.[81] The same is true in four out of five boroughs. Only on Staten Island are heavy daily smokers nearly as common as non-daily or light daily smokers. **(Figures 24-28)**[82]

Figure 23

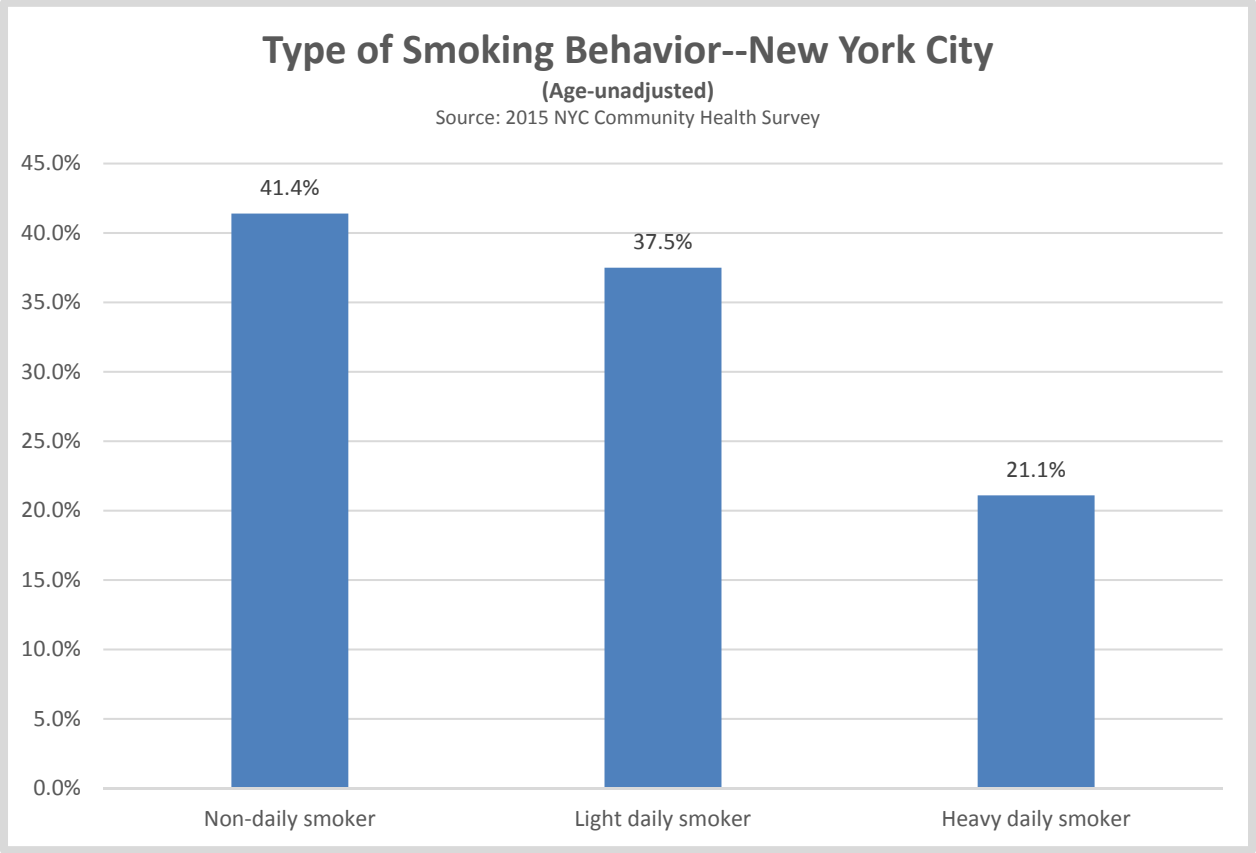


Figure 24

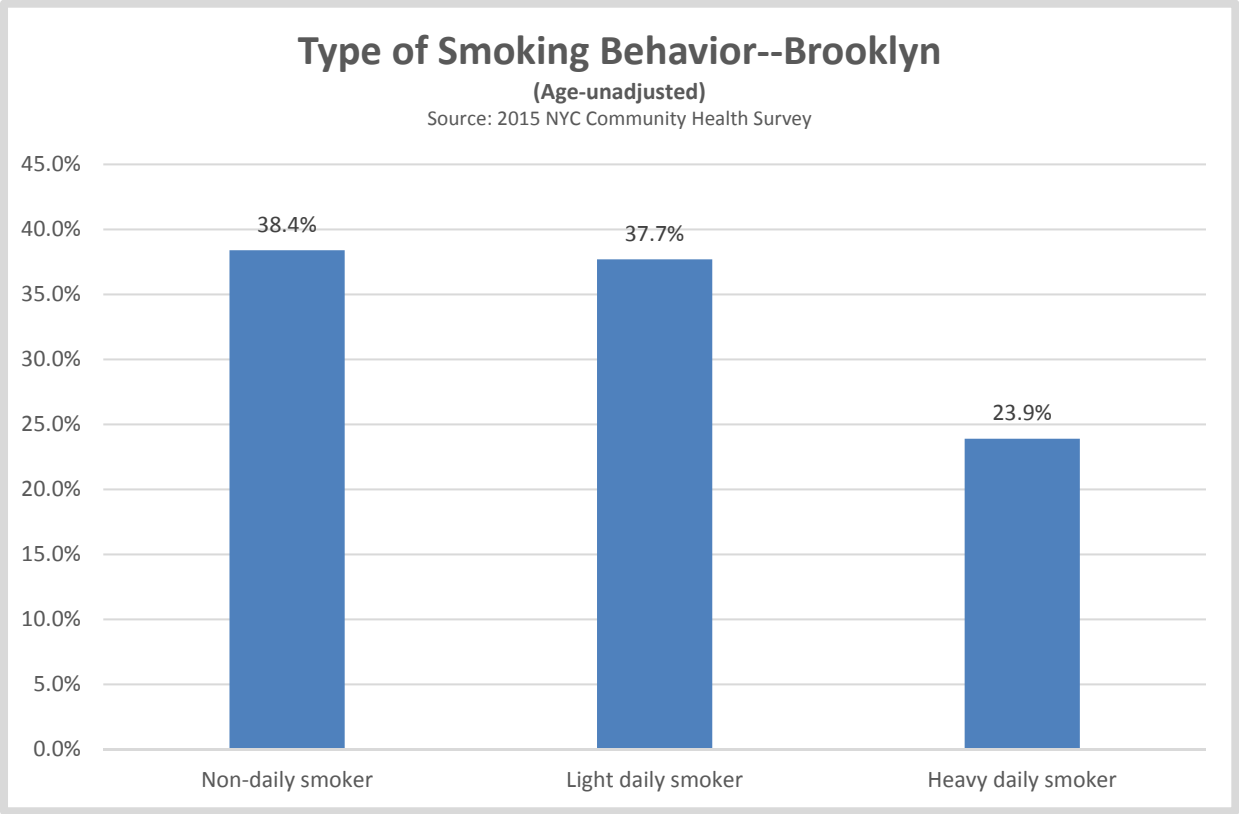


Figure 25

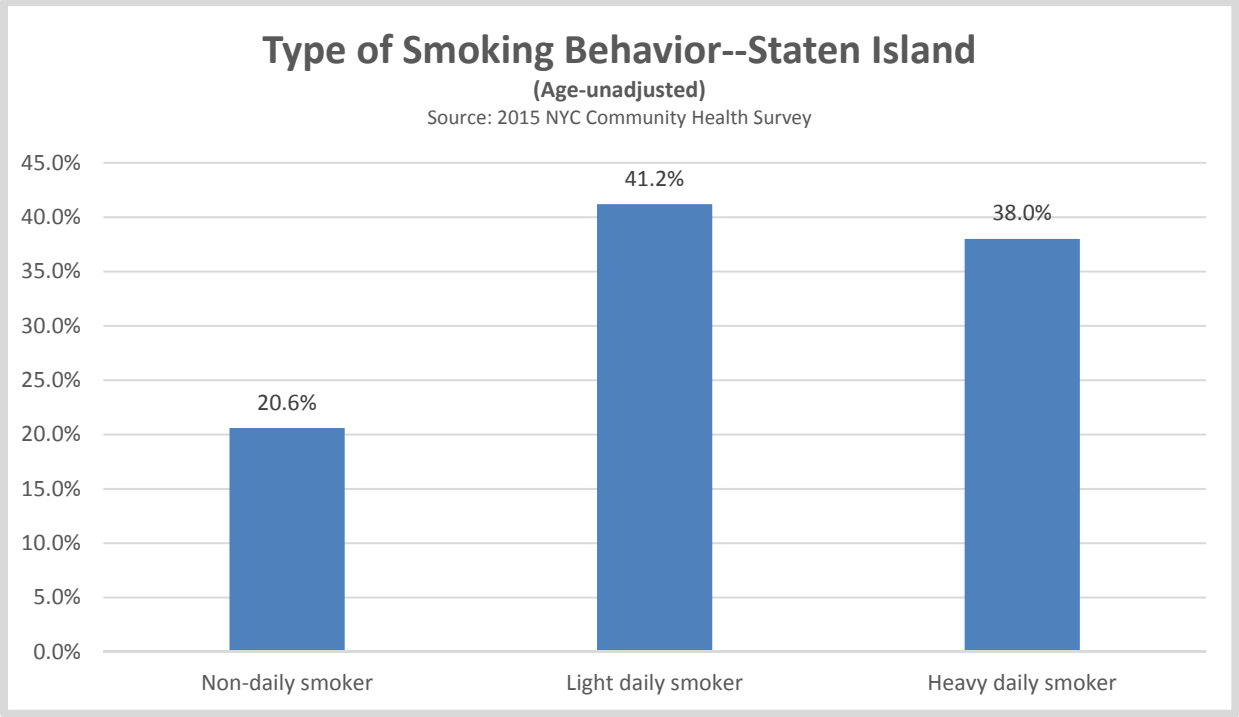


Figure 26

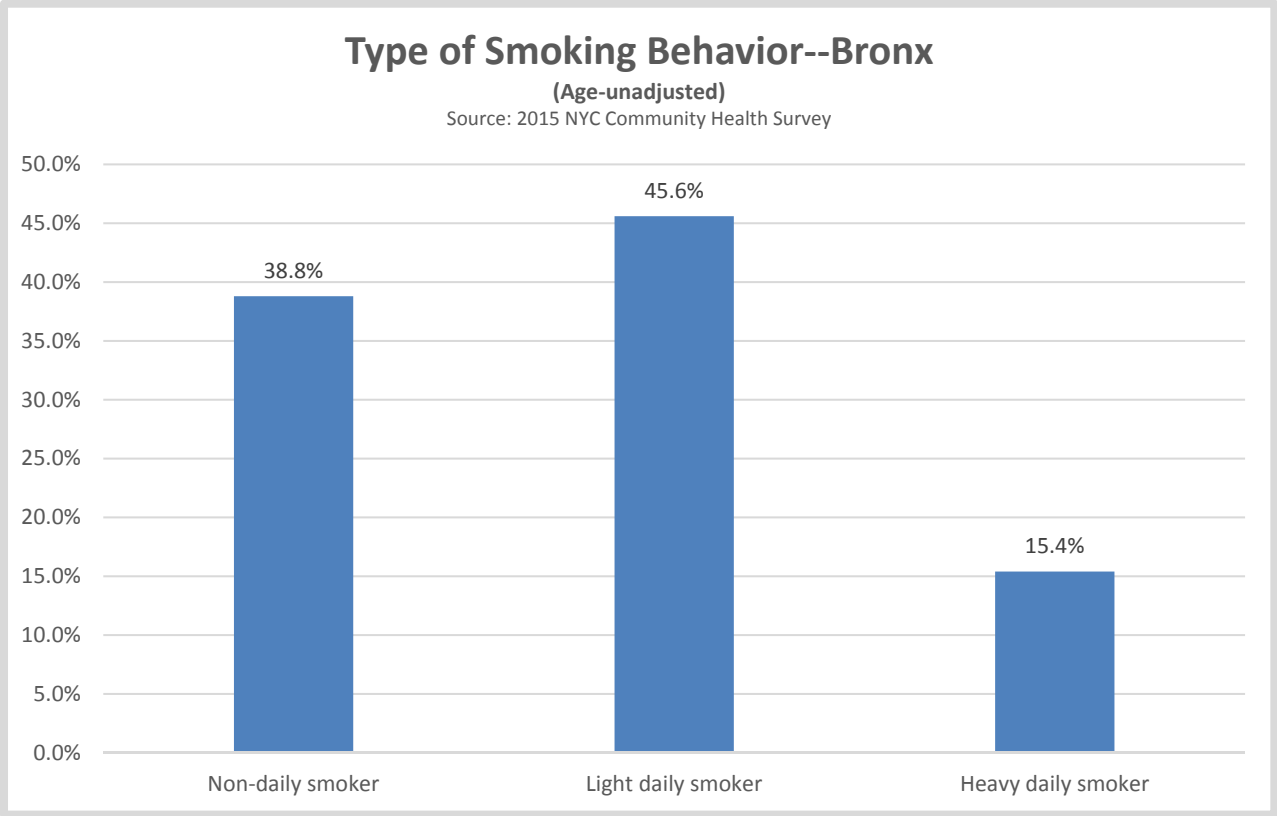


Figure 27

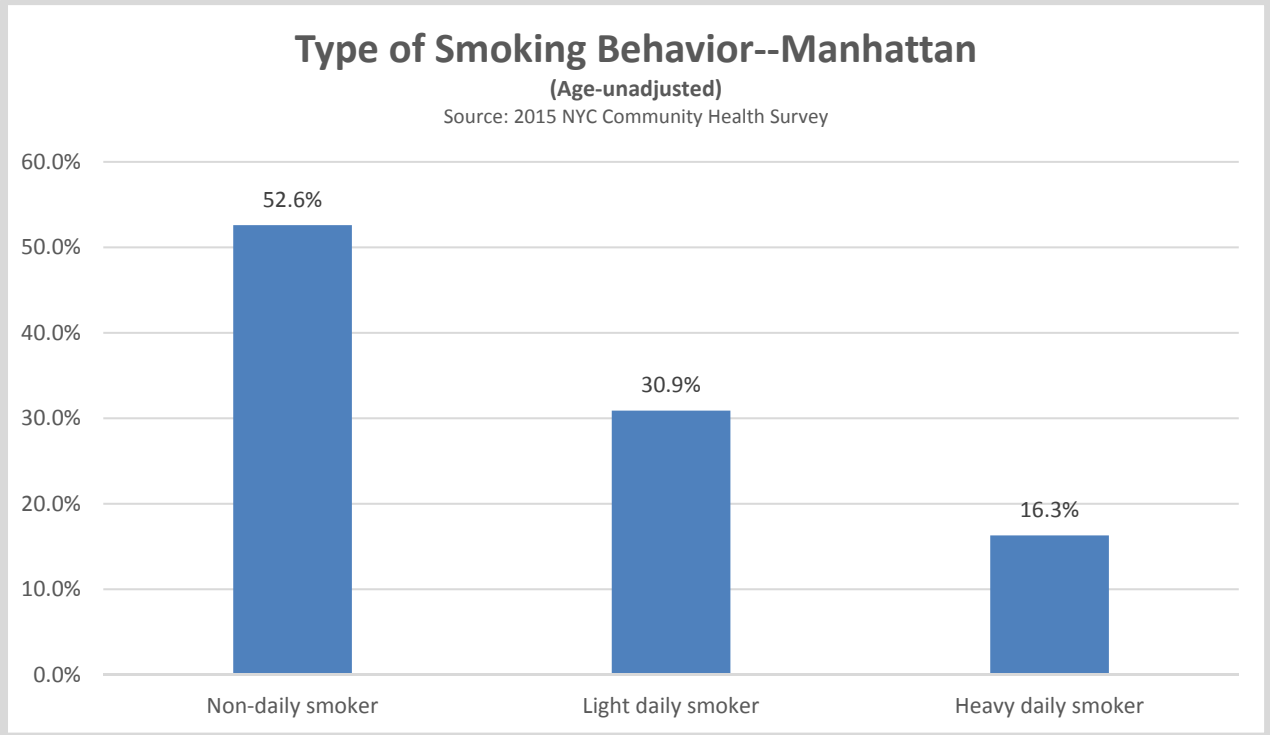
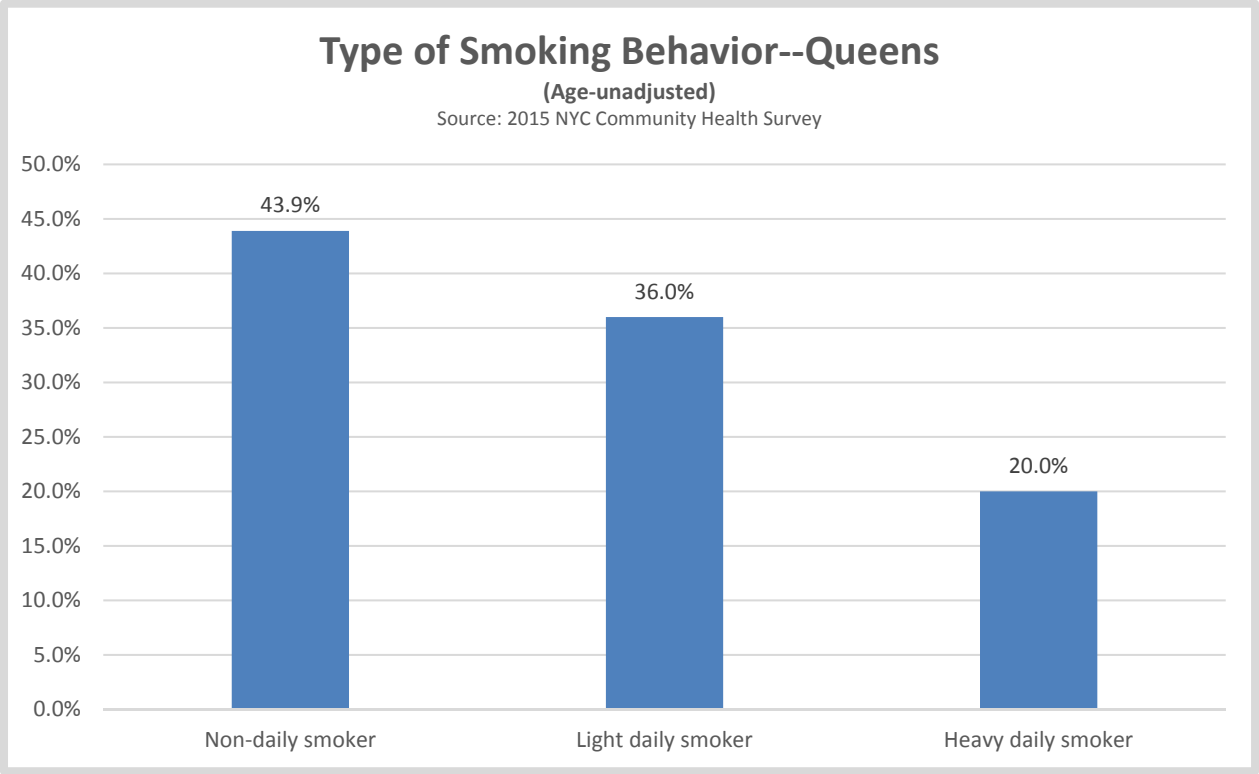


Figure 28


Type of Smoking Behavior--Queens
(Age-unadjusted)
Source: 2015 NYC Community Health Survey
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
43.9%
36.0%
20.0%
Non-daily smoker
Light daily smoker
Heavy daily smoker

NEW YORK CITY ACTION

The New York City Department of Health and Mental Hygiene launched an aggressive, comprehensive tobacco control plan starting in 2002 consisting of five components: taxation, legislation, cessation, education and evaluation.[83] The result has been a decline in smoking rates by 33 percent since 2002.

Taxation:
New York City raised its cigarette tax in 2002 from $0.08 to $1.50 per pack. The increase brought the price per pack to almost $7. New York state increased its cigarette tax by $1.25 in 2008. The increase brought the total cost per pack to approximately $8.50. The federal tax on cigarettes was increased by $.62 in 2009, bringing the New York City total cost per pack to approximately $9.20. New York State added a $1.60 to its cigarette tax in 2010. The total tax on a pack of cigarettes in New York City is $5.85, second only to Chicago, where a combined state and local tax is $6.16 per pack. City, state and federal cigarette taxes have resulted in the average price for a pack of cigarettes being approximately $11.20 as of 2013.[84]

Legislation:
The Smoke-Free Air Act (SFAA) of 2002 made virtually all workplaces in New York City smoke-free, including restaurants and bars. In 2009, the SFAA was expanded to restrict smoking in all outdoor areas on hospital grounds and within 15 feet of hospital entrances and exits. Also in 2009, the New York City Council passed legislation restricting the sale of flavored non-cigarette tobacco products. To further protect against secondhand smoke exposure, the SFAA was expanded in 2011 mandating that all public parks, beaches and pedestrian plazas be smoke-free.

In 2013, a three-piece tobacco control package was passed by the New York City Council and signed into law by Mayor Michael Bloomberg that included prohibiting the sale of tobacco products to anyone under the age of 21, new rules on tobacco enforcement and a prohibition on the indoor use of electronic cigarettes. The tobacco enforcement legislation increased penalties for retail outlets that evade tobacco taxes or sell tobacco without a license, prohibits retail outlets from redeeming coupons, mandates a minimum price for cigarettes and little cigars, and requires cheap cigars and cigarillos be sold in packages of at least four and little cigars to be sold in packages of 20.

Cessation, Education and Evaluation:
Between 2006 and 2016, the New York City Department of Health and Mental Hygiene conducted media campaigns depicting the health consequences of smoking and testimonial ads from sick or dying smokers, encouraged calls to 311 and the New York State (NYS) Smokers' Quitline, and promoted a nicotine replacement therapy giveaway. The result was more than 750,000 calls from smokers looking to quit and 500,000 courses of nicotine patches, gum and lozenges given out to smokers looking to quit.[85] An annual Community Health Survey and a bi-annual Youth Risk Behavior Survey allows the New York City Department of Health and Mental Hygiene to continuously evaluate the results of its efforts to curb tobacco use in New York City.

RESEARCH AND BEST PRACTICES

While New York City has utilized the primary best practices in tobacco control, one underutilized approach is addressing the oversaturation of tobacco retail outlets.

By reducing the density of tobacco retail outlets, New York City can reduce the oversaturation of tobacco and ultimately reduce tobacco use. Research shows that requiring tobacco users to make a greater effort to find and obtain tobacco products will lead to a decrease in tobacco use, especially among youth.[86]

Consumers are cost-sensitive to tobacco prices, meaning that they will purchase fewer cigarettes as the cost increases.[87] By reducing the density of tobacco retail outlets, customers will need to spend more time and money to purchase tobacco, which will ultimately reduce customers' tobacco use overall.[88]

There are different approaches to reducing the impact that an oversaturation of tobacco retail outlets has on the health of a community. Research and experiences in other municipalities have shown the best approaches are to:

- Cap and gradually reduce the number tobacco retail licenses available in a community;
- Set a minimum distance that tobacco retail outlets must be from schools, other youth service entities and other licensed tobacco retail outlets; and
- Restrict sales in pharmacies and other health service entities.

Cap and reduce:
Establishing a cap on the number of tobacco retail outlets will reduce the number of outlets where community members can access or be exposed to deadly tobacco. In addition to improving health of the entire population, establishing a cap protects low-income communities and communities of color that have disproportionately high numbers of tobacco retail outlets in their neighborhoods, as well as disproportionately higher smoking rates. Through a process of attrition of stores with licenses that are either revoked through normal processes, or by licenses that are not renewed, a cap will gradually reduce the number of tobacco retail outlets.

The National Academies of Sciences, Engineering, and Medicine, a national advisory body on health policy, has called for regulations to reduce the number and density of tobacco outlets as an important prevention approach.[89]

Data indicates that the concentration of tobacco outlets within neighborhoods where the tobacco industry uses deliberate marketing strategies targeting low income and racially/ethnically diverse communities is directly related to the likelihood of smoking.[90] The industry does this targeting through price discounts, culturally customized ad content, promotional giveaways and product placement.

In 2014, the San Francisco Board of Supervisors unanimously voted to cap the number of retail outlets that can sell tobacco in San Francisco. The policy established a cap on

the number of available licenses in each of the city's supervisory districts that was the equivalent to half of their original total.[91]

San Francisco projects that under the new policy it will take a decade for the number of tobacco retail licenses to be reduced to at or below the new cap per district. However, the impact of the policy on the number of licenses across the city and in each district is already noticeable in the data. The number of tobacco retail outlet licenses in San Francisco decreased by 8 percent in the first 10 months since the density policy took effect. All supervisorial districts have seen decreases in the number of tobacco retail outlet licenses. The districts with the highest number of retail outlet licenses before the policy went into effect have seen the greatest declines. District 6, which has one of the highest density of retail outlets, has lost 13 percent of its tobacco retail outlet licenses in the same time period.[92]

In December 2016, the Philadelphia Board of Health approved a cap on the number of retail licenses that specifically targets residential neighborhoods. Starting in February 2017, one sales permit per 1,000 people will be available. The Philadelphia retail policy also prohibits new tobacco retail outlets within 500 feet of schools.[93]

Proximity restrictions:
Prohibiting tobacco sales near schools can help reduce youth exposure to tobacco both by removing access to the product and by eliminating the accompanying advertising. Studies have shown tobacco advertising to be more prevalent in stores where adolescents are likely to shop and in stores located near schools.[94]

Tobacco retail outlets are an important marketing channel for reaching and attracting potential new users. Exposure to promotional activities and marketing has been shown to affect tobacco use initiation rates among adolescents, particularly when the stores are close to schools.[95] Youth who live or go to schools in neighborhoods with the highest density of tobacco retail outlets or with the highest density of retail tobacco advertising have higher smoking rates compared to youth who attend school or live in neighborhoods with fewer or no tobacco outlets.[96]

Restricting the proximity of tobacco retail outlets to each other reduces the density of tobacco retail outlets and ultimately of tobacco marketing. Marketing of tobacco products is prevalent at tobacco retail outlets. Thus, a high density of tobacco retail outlets means a concentration of tobacco marketing, exposing children, youth and adults to environmental cues which encourage tobacco use.[97] Additionally, high densities of tobacco retail outlets are linked to increased adult smoking rates.[98]

Prohibiting tobacco sales within 1,000 feet of schools could reduce disparities in tobacco retail outlet density. Density is often higher in low-income and minority neighborhoods.[99] One study found that prohibiting tobacco sales within 1,000 feet of schools would not only reduce density across the board, but would nearly eliminate existing disparities in tobacco retail outlet density between neighborhoods.[100]

Several localities have had success prohibiting tobacco retail outlets near schools. In 2010, Santa Clara County, California, passed an ordinance prohibiting any new tobacco retail outlets from opening within 1,000 feet of a school or 500 feet of another tobacco retail outlet. Nearly one third of retail outlets in the unincorporated areas decided to end their tobacco sales as result, and 73 percent reported that they would support prohibiting tobacco sales within 1,000 feet of a school to reduce tobacco use among youth.[101]

In 2013, Chicago prohibited the sale of all flavored tobacco products including menthol within 500 feet of schools. In 2009, New Orleans limited the sale of tobacco within 300 feet of schools.

Prohibiting tobacco sales in pharmacies:
Tobacco-free pharmacies reduce access to all tobacco products, which will help prevent kids from forming a lifelong addiction as well as help support those who are coming to the pharmacy for help quitting.

Pharmacies are in the business of improving health; however, they represent nearly 5 percent of cigarette sales.[102] Cigarette sales declined by 17 percent between 2005-2009, but increased in pharmacies by 23 percent during the same timeframe.[103] It is a contradiction for pharmacies to be a facilitator of health and wellness while selling cigarettes and tobacco products. Selling these products side-by-side helps to normalize tobacco use, and serves to further obscure the deadliness of these products. The CVS Pharmacy chain acknowledged this in 2015 when it voluntarily gave up tobacco sales at all of its stores nationwide.

Research shows that pharmacists and the public support removing tobacco products from pharmacies. A 2014 survey showed two-thirds of Americans support prohibiting tobacco sales in pharmacies, including nearly half of smokers.[104]

Prohibiting tobacco sales in pharmacies reduces the density of tobacco retail outlets. Cities in Massachusetts and California that have prohibited the sale of tobacco products in pharmacies saw a three times greater reduction in tobacco retail outlet density than cities that did not.[105] Another study predicted that prohibiting tobacco sales in pharmacies in North Carolina found that it would reduce retail outlets in the state by over 1,000 and reduce density by 13.9 percent.[106]

Over 150 municipalities around the country have prohibited tobacco sales in pharmacies.[107]

ACS CAN POLICY RECOMMENDATIONS

Municipalities looking to further reduce tobacco use can look at both research and practical examples for how to use licensing and zoning rules to reduce the impact of tobacco retail outlets.

Restricting the number and location of tobacco retail outlets will have a greater impact on municipalities where the intensity of smokers is lower. Non-daily or light daily smokers are more likely to be discouraged from smoking by policies that make it more difficult to access tobacco.

Since more than 80 percent of smokers in New York City are either non-daily smokers or light daily smokers, a policy that would reduce availability of tobacco would have a significant impact on smoking rates in New York City.

There is a clear need to address the oversaturation of licensed tobacco retail outlets in New York City. Based on the retail climate in New York City, specific New York City demographics and the best available research, ACS CAN recommends five steps that New York City should take to address this problem:

1) **Establish a cap on licenses:** New York City should establish a cap on the number of retail tobacco licenses in each Community District at 50 percent of their current level. No new licenses should be issued in a Community District until the number of licenses in that Community District is at or below the newly established cap.

2) **Restrict access near youth-service entities:** New York City should prohibit new tobacco retail licenses from being issued to any new applicant located within 1,000 feet of schools, houses of worship, playgrounds, libraries and other youth-service entities.

3) **Restrict retail outlet proximity to each other:** New York City should prohibit new tobacco retail licenses from being issued to any new applicant located within 1,000 feet of a current licensed tobacco retail outlet.

4) **Restrict all tobacco sales in pharmacies:** All retail stores that contain a pharmacy or other places of business that provide any form of health service should be prohibited from selling tobacco.

5) **Include other tobacco products:** The current tobacco retail license in New York City does not cover the sale of tobacco products other than cigarettes, cigars or cigarillos. The licensing requirement should be extended to all tobacco products, including e-cigarettes and hookah.

CONCLUSION

Despite a 33 percent decline in the smoking rate in New York City in the past decade and a half, there is still much more work to be done in the fight against this deadly product. New York City could make significant progress in reducing premature deaths while dramatically reducing racial/ethnic disparities in mortality rates by tackling the oversaturation of tobacco retail outlets in New York City. While New York City has been a global leader in the fight for public health, the death toll from tobacco demands New York City do more.

New Yorkers do not need any more tobacco retail outlets. It is currently too easy to access deadly tobacco products. By ending the oversaturation of tobacco in our neighborhoods we can drive down smoking rates and save lives.

As a result of New York City's high population density and the high number of non-daily and light daily smokers, a policy reducing the number and location of licensed tobacco retail outlets in New York City would have a significant impact on smoking rates and the overall health of New York City residents, commuters and visitors to New York City.

While reducing the number and density of licensed tobacco retail outlets is not a silver bullet and will not on its own end all tobacco use, the following actions will go a long way toward improving public health and should be strongly considered.

ACS CAN calls on New York City leaders to immediately act on the above mentioned recommendations.

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Testimony

In Support of

Int 0977-2015 - A Local Law to amend the administrative code of the city of New York, in relation to banning smoking in city-financed housing.
Int 1131-2016 - A Local Law to amend the administrative code of the city of New York, in relation to the sale of tobacco products in pharmacies
Int 1471-2017 - A Local Law to amend the administrative code of the city of New York, in relation to increasing retail cigarette dealer license fee
Int 1532-2017 - A Local Law to amend the administrative code of the city of New York, in relation to licensing of electronic cigarette retail dealers
Proposed Int 1544-A - A Local Law to amend the administrative code of the city of New York, in relation to the regulation of retail dealers of tobacco products and of electronic cigarettes, the establishment of price floors and minimum package sizes for tobacco products and shisha, and the establishment of a tax on tobacco products other than cigarettes
Int 1547-2017 - A Local Law to amend the administrative code of the city of New York, in relation to expanding the retail dealer license to include retailers of tobacco products and setting caps on retail dealer licenses
T2017-5930 - A Local Law to amend the administrative code of the city of New York, in relation to disclosure of smoking policies for class A multiple dwellings

Submitted by:
American Heart Association / American Stroke Association
Robin Vitale, Vice President, Health Strategies

April 27, 2017

Members of the Committee on Health:

On behalf of the American Heart Association / American Stroke Association (AHA), I am thrilled to be here today to support the city's continued efforts against tobacco addiction. The AHA is our nation's largest, voluntary-led, science-based organization focused on the prevention and treatment of cardiovascular diseases and stroke. Approximately 80% of diagnoses involving these chronic diseases could be prevented if Americans improved their lifestyles and adopted healthier behaviors.[1]

In the last 50 years, 20 million Americans have died prematurely due to tobacco-caused illnesses. When the chemical cocktail from smoking tobacco or breathing in

[1] http://www.cdc.gov/vitalsigns/HeartDisease-Stroke/index.html

secondhand smoke hits the bloodstream, it damages arteries throughout the body, the heart, and the brain. Clots in arteries are more likely to form as a result, causing a heart attack or stroke.1 Smoking also lowers the level of HDL or 'good' cholesterol, raises heart rate, and replaces oxygen in the blood with carbon monoxide. In short, smoking wreaks havoc on the cardiovascular system.[2]

And the toll is not just on our health but on the health of our economy. Smoking has been estimated to cost the U.S. economy between $289 billion and $333 billion per year, including workplace productivity losses of $151 billion, and direct medical expenditures between $133 billion and $176 billion.[3]

For these reasons, the AHA advocates for policies that serve to reduce access to tobacco, limit exposure to secondhand smoke and generally promote awareness about the dangers of tobacco use. While our city has often lead the way in pioneering health policies, there is always more work to be done until every New Yorker is able to steer clear of nicotine addiction. Empirical research establishes the need for a comprehensive, multi-pronged approach to tobacco control, including measures that change social and cultural norms about tobacco use, limit tobacco accessibility and restrict smoking. As we continue to lose approximately 12,000 city residents to tobacco-related illness every year, the city has a responsibility to pursue more solutions against this health risk.[4]

Smoke Free Housing

Research continues to show that smoke-free policies in the home reduce second-hand smoke exposure for all residents, can increase cessation among smokers, and can decrease relapse in former smokers.[5][6][7][8][9]

Even if people living in multi-unit housing have a smoke-free policy for their own home, they may still suffer incursions from others in the complex. Research has documented the transfer of second-hand smoke in the air and transfer of second-hand smoke constituents through heating,

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[2] Barnoya J. Glantz SA. Cardiovascular Effects of Secondhand Smoke Nearly as Large as Smoking *Circulation.* 2005;111:2684-2698.

[3] US Department of Health and Human Services. 50 Years of Progress: A Report of the Surgeon General, 2014. 2014. Available at: http://www.surgeongeneral.gov/library/reports/50-years-of-progress/50-years-of-progress-bysection.html.

[4] http://www1.nyc.gov/site/doh/health/health-topics/smoking.page

[5] Hyland A, Higbee C, Travers MJ, et al. Smoke-free homes and smoking cessation and relapse in a longitudinal population of adults. Nicotine Tob Res. 2009; 11(6):614–618.

[6] Mills A, Messer K, Gilpin E, Pierce J. The effect of smoke-free homes on adult smoking behavior: a review. Nicotine Tob Res. 2009; 11(1):1131–1141.

[7] King, B. A., Mahoney, M. C., Cummings, K. M., & Hyland, A. J. Intervention to promote smoke-free policies among multiunit housing operators. *Journal of public health management and practice: JPHMP*. 2011. *17*(3), E1.

[8] Pizacni BA, Maher JE, Rohde K, et al. Impact of a No-Smoking Policy in Public Housing Apartments. *Journal of Clinical Outcomes Measurement*, 2012. 19(6): 245-50.

[9] Pizacani, B. A., Maher, J. E., Rohde, K., Drach, L., & Stark, M. J. Implementation of a smoke-free policy in subsidized multiunit housing: effects on smoking cessation and secondhand smoke exposure. *Nicotine & Tobacco Research*, 2012. *14*(9), 1027-1034.

ventilation, air conditioning systems and other connections between units.[101112] As many as half of multi-unit housing residents report that smoke has entered their unit from elsewhere in the building or complex and detectable levels of nicotine have been documented in multi-unit buildings where smoking is permitted.[1314151617] In 2009, the U.S. Department of Housing and Urban Development encouraged smoke-free policies in public housing to prevent the migration of second-hand smoke between housing units in an attempt to lower exposure especially among the most vulnerable tenants including the elderly, children, and people with chronic illnesses.[18] Studies on the health impact of second-hand smoke are robust. No level of second-hand smoke exposure is safe.[19] Thus it is appropriate for tenants and building managers to work together toward a smoke-free environment for all residents.

While advocating for comprehensive smoke-free policies, the American Heart Association wants to assure that smokers are not denied access to public housing as they can abide by policies which allow for outdoor smoking areas. A well-funded cessation program can complement this strategy to support this tenant population in the effort to reduce smoking rates in the building.

Tobacco Free Pharmacies

The American Heart Association advocates banning tobacco sales in health care institutions including pharmacies. Similarly, the American Pharmaceutical Association has long held that tobacco should not be sold in pharmacies; it is incongruent to place tobacco products right near tobacco cessation aids. Removing tobacco products is another step in our longstanding efforts to denormalize tobacco products.

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[10] Bohac DL, Hewett MJ, Hammond SK, Grimsrud DT. Secondhand smoke transfer and reductions by air sealing and ventilation in multiunit buildings: PFT and nicotine verification. Indoor Air 2011; 21(1):36–44.
[11] Kraev TA, Adamkiewicz G, Hammond SK, Spengler JD. Indoor concentrations of nicotine in low-income, multiunit housing: associations with smoking behaviours and housing characteristics. Tob Control 2009;18:438–44.
[12] King BA, Travers MF, Cummings KM, Mahoney MC, Hyland AJ. Secondhand smoke transfer in multiunit housing. Nicotine Tob Res 2010;12(11):1133– 41.
[13] Hennrikus, D., Pentel, P., & Sandell, S. Preferences and practices among renters regarding smoking restrictions in apartment buildings. *Tobacco Control*, 2003. *12*, 189–194.
[14] Hewett, M., Sandell, S., Anderson, J., & Niebuhr, M. Secondhand smoke in apartment buildings: Renter and owner or manager perspectives. *Nicotine & Tobacco Research*, 2007. *9*(Suppl. 1), S39–S47.
[15] King, B. A., Travers, M. J., Cummings, K. M., Mahoney, M. C., & Hyland, A. J. Prevalence and predictors of smoke-free policy implementation and support among owners and managers of multiunit housing. *Nicotine & tobacco research*, 2010. *12*(2), 159-163.
[16] Hood, N. E., Ferketich, A. K., Klein, E. G., Pirie, P., & Wewers, M. E. Associations between self-reported in home smoking behaviours and surface nicotine concentrations in multiunit subsidised housing. *Tobacco control*. 2012; 0:1–6.
[17] Matt, G. E., Quintana, P. J., Zakarian, J. M., Fortmann, A. L., Chatfield, D. A., Hoh, E., et al., When smokers move out and non-smokers move in: residential thirdhand smoke pollution and exposure. *Tobacco Control*, 2011.*20*(1), e1-e1.
[18] King, B. A., Travers, M. J., Cummings, K. M., Mahoney, M. C., & Hyland, A. J. Prevalence and predictors of smoke-free policy implementation and support among owners and managers of multiunit housing. *Nicotine & tobacco research*, 2010. *12*(2), 159-163.
[19] U.S. Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General—Executive Summary.*

Pharmacies and drug stores offer health-promoting products and services just down the aisle from displays of tobacco products.[20] In fact, one study found that 55 percent of tobacco-selling pharmacies displayed over the-counter cessation products right next to the cigarettes.[21] This has been an important point of contention with many pharmacies arguing that addicted smokers need access to cessation products at the point of purchase for tobacco products so that they may be encouraged to quit. Many public health groups, on the other hand, have argued that having tobacco products right next to cessation resources will only serve to entice the addict to continue their addiction to the tobacco product.

Since 1970, The American Pharmaceutical Association has held the position that mass display of cigarettes in pharmacies is in direct contradiction to the role of a pharmacy as a public health facility and multiple surveys of pharmacists since that time have shown that a vast majority of pharmacists would prefer not selling tobacco products.[22] More recently, in 2010, the American Pharmacists Association urged pharmacies to stop selling tobacco and pushed state pharmacy boards to discontinue issuing and renewing licenses of pharmacies that sell these products.

In 2014, CVS Caremark announced it would become the first national retail pharmacy chain to phase out sales from tobacco over the next year, saying the potential profits were not worth the cost to public health. In 2016, two-thirds of US adults reported that they are strongly or somewhat in favor of banning tobacco sales at pharmacies.[23] And CVS Caremark's decision to stop selling tobacco products has made an impact. A year after its announcement, cigarette sales dropped across all retailers in 13 states. The average smokers in states where CVS had a large presence bought 5 fewer packs of cigarettes, totaling about 95 million fewer packs sold during an 8-month period.[24]

The American Heart Association continues to be a strong advocate for tobacco-free pharmacies. We look forward to all city licensed retail pharmacies removing this danger to our health.

Retail Licenses

According to city data, there are approximately 9000 licensed cigarette retailers within 300 square miles in our boroughs. It is difficult to find a city block that does not have a licensed tobacco retailer located on it, particularly in our more vulnerable neighborhoods. A recent study by our colleagues in the American Cancer Society Cancer Action Network found that There is approximately one licensed tobacco retail outlet for every 196 children in New York City, and those children are more likely to see tobacco for sale every day than to have access to a playground or library.[25]

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[20] Hudmon K.S., C.M. Fenlon, R.L. Corelli, A.V. Prokhorov, and S.A. Schroeder. Tobacco sales in pharmacies: time to quit. Tobacco Control Journal 2006;15(1):35-8.

[21] Fincham J.E. An unfortunate and avoidable component of American pharmacy: tobacco. Am J Pharm Educ. 2008;72(3):57.

[22] Robinson G. Chain Drugstore Polices and Attitudes about Tobacco Sales and Promotions, Phase II - Executive Summary; California Medical Association Foundation, Pharmacy Partnership Project. San Francisco , CA : CMA Foundation, Pharmacy Project, 2000.

[23] www.ajpmonline.org/article/S0749-3797(16)30246-X/fulltext

[24] www.cvshealth.com/sites/default/files/impact%20of%20the%20CVS%20Tobacco%20Sales%20Removal%20on%20Smoking%20Cessation.pdf

[25] https://www.acscan.org/sites/default/files/Oversaturated%20Report%20for%20publication_0.pdf

Evidence shows that it is more difficult for smokers to quit, particularly in low-income areas when they reside in close proximity to a tobacco retailer. And children exposed to tobacco retailers can double the risk of tobacco use initiation.[26]

Communities adopt tobacco retailer licensing laws as one way to ensure compliance with tobacco laws and to combat the public health problems associated with tobacco use. The same argument holds true for the need to monitor compliance of laws involving electronic cigarettes. The fees connected to the license registration are a necessary tool to fund the needed oversight and management of the license program. It is appropriate to assess these fees periodically to ensure that the costs involved are commensurate for current operation needs.

Increasing the Price of Tobacco and Nicotine

No tobacco product is considered safe to use. Smokeless tobacco has been associated with an increased risk for fatal heart attacks and strokes.[27] Alarmingly, smokeless tobacco use is on the rise, with more than 10% of young adult males (aged 18–25 years) reporting use in the last 30 days. And this percentage is consistent when looking at high school-aged males, with about 9.9% reporting use of smokeless tobacco.[28]

Tobacco use in any form, including e-cigarettes, can be harmful as outlined previously.[29] E-cigarettes could fuel and promote nicotine addiction, and its acceptance has the potential of re-normalizing smoking behavior. The use of e-cigarettes may also serve as a gateway drug to other harmful substances for youth and young adults.[30] Although some e-cigarettes are marketed as a smoking cessation aid, there is no conclusive scientific evidence supporting this claim. A recent study reported that almost 20% of smokers who try e-cigarettes go on to become regular users.[31]

There is no stronger tool in the weaponry against tobacco addiction than the price-sensitivity of most smokers. Increases in cigarette prices lead to substantial reductions in cigarette smoking. A 2008 study concluded that higher prices also help reduce smoking among youth.[32] By one

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[26] Lorraine R. Reitzel, et al The Effect of Tobacco Outlet Density and Proximity on Smoking Cessation, Am J Public Health. 2011 Feb; 101(2): 315–320. doi: 10.2105/AJPH.2010.191676

[27] Piano MR, et al Impact of smokeless tobacco products on cardiovascular disease: implications for policy, prevention, and treatment. Circulation. 2010; 122(15):1520-44.

[28] U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General(http://www.cdc.gov/tobacco/data_statistics/sgr/50th-anniversary/index.htm). 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.

[29] MMWR 64(52);1403-8 (January 5, 2016) Retrieved at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6452a3.htm?s_cid=mm6452a3_w

[30] Bhatnagar, A, Whitsel, LP, Ribisl, KM, Bullen, C, Chaloupka, F, Piano, MR. ... & Benowitz, N. (2014). Electronic cigarettes a policy statement from the American Heart Association. *Circulation*, *130*(16), 1418-1436.

[31] Kralikova, E, Novak, J, West, O, Kmetova, A, & Hajek, P. (2013). Do e-cigarettes have the potential to compete with conventional cigarettes? *Chest*, *144*(5), 1609-1614.

[32] Carpenter C, et al. Cigarette taxes and youth smoking: New evidence from national, state, and local Youth Risk Behavior Surveys. Journal of Health Economics. 2008;27(2):287-299

estimate, a 10% increase in the price of a pack of cigarettes would reduce the demand by about 4% in high-income communities and about 8% in lower income communities.[33]

Thus, the American Heart Association strongly supports the effort to establish price floors and a tax on other tobacco products as a means to further encourage New Yorkers to quit their nicotine addiction.

The combination of these proposals, addressing accessibility, denormalization and price-sensitivity will provide a dramatic step toward the city's goal to reduce the number of smokers by 160,000 by 2020. A 12% smoking rate in our adult population will provide a significant boost to the American Heart Association mission to save lives from cardiovascular diseases and stroke. We are grateful for the city's persistent courage to promote public health as a top priority and we look forward to these bills being passed into law.

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[33] Curbing the epidemic: governments and the economics of tobacco control (1998) http://tobaccocontrol.bmj.com/content/8/2/196.full.

New York City Council

Committee on Health

Written Testimony of Kevin O'Flaherty

Regional Advocacy Director, Northeast

Campaign for Tobacco-Free Kids

In Support of Int 1131-2016, Int 1532-2017, Int 1544-2017, Int 1547-2017

New York, NY

April 27, 2017

Thank you for the opportunity to submit testimony on New York City's latest efforts to further reduce tobacco use, especially among kids. Actions taken by the Council over the past decade have been instrumental in reducing smoking among New York City kids and adults and have made New York City a world leader in this regard. By increasing tobacco taxes, making the City smoke-free, providing resources to help smokers to quit, reducing kids' access to candy-flavored tobacco products, adopting policies to address e-cigarettes, raising the tobacco sale age to 21 and keeping cigarette and little cigar prices high, New York City has cut youth smoking in half and reduced adult smoking by a third. However, that still leaves 900,000 smokers in the City, including 15,000 kids. We applaud the Council's recent proposals to address the continued use of tobacco among New York City residents and improve the City's health.

Tobacco companies have focused their efforts on strategic pricing of tobacco products and promotional activities at the point of sale to recruit new tobacco users, maintain current users and maximize profits. Several of today's proposals will counter these industry tactics and will make tobacco products less accessible to vulnerable populations, especially youth.

- By prohibiting the sale of tobacco products in pharmacies, the City will help to ensure that these healthcare environments are supportive of tobacco cessation while reducing the availability, appeal, and social acceptability of tobacco products.

- Because research shows that higher tobacco product prices reduce tobacco use, especially among kids, the City's proposal to implement a tax on non-cigarette tobacco products, set a price floor on all tobacco products, and require minimum package sizes for all tobacco products will make tobacco products less accessible to price-sensitive populations, especially kids.

- The City's strategy to address the oversaturation of tobacco outlets by capping the number of tobacco product retail dealer licenses will reduce tobacco use in the City through changing social norms, reducing easy access to tobacco products, and reducing exposure to tobacco industry marketing tactics at the point of sale.

- Extending the licensing requirement for tobacco products to include electronic cigarette retail dealers levels the playing field and ensures that these retailers are subject to similar requirements as other tobacco product retail dealers. Licensing also helps prevent illegal sales to minors and is an essential tool for effective enforcement.

Our testimony will focus primarily on the four proposals mentioned above.

Eliminating Tobacco Product Sales in Pharmacies

There are hundreds of thousands of tobacco retailers in the United States, including nearly 9,000 in New York City.[1] The widespread availability of tobacco products in the retail environment sends a terrible message to kids that tobacco use is normal, acceptable and appealing. Tobacco retailer density and exposure to tobacco products and marketing in the retail environment encourages youth experimentation with and initiation of tobacco use.[2] Prohibiting tobacco sales in pharmacies in New York City, a key component of the City's strategy to address the oversaturation of tobacco outlets, will

help to reduce tobacco retailer density as well as reduce the availability, appeal, and social acceptability of tobacco products. [3]

Exposure to tobacco products in the retail environment also prompts impulse purchases and undermines quit attempts.[4] Pharmacy patrons should not be exposed to tobacco products and advertising in the same place where they purchase cessation aids or medication for serious tobacco-related illnesses. Selling tobacco in pharmacies sends a mixed message to consumers about the health effects of tobacco use tobacco and compromises pharmacists' commitment to protecting their patients' health. This is especially true as pharmacies continue to add health care clinics as part of their model.[5] Moreover, a national study found that cigarettes are priced cheaper in pharmacies than most other retailers,[6] which may further increase the appeal of tobacco products in pharmacies. Prohibiting the sale of tobacco products in pharmacies will ensure that these healthcare environments are supportive of tobacco cessation.[7]

Prohibiting the sale of tobacco products in pharmacies is a widely supported tobacco control strategy, with support from two-thirds of US adults.[8] This policy is endorsed by the American Pharmacists Association,[9] the National Community Pharmacists Association,[10] and the American Academy of Pediatrics,[11] based on the recognition that the sale of tobacco in pharmacies elicits a conflict of interest for health care providers.[12] In September 2014, CVS Health ceased tobacco sales, affecting more than 7,800 retailers in 47 states.[13] At least 151 municipalities in Massachusetts (covering over 67 percent of residents), [14] San Francisco, CA, and Rockland County, NY have already banned the sale of tobacco in pharmacies and other healthcare institutions. [15] This widespread support reflects the overwhelming recognition that selling a product that is the leading preventable cause of premature death is incompatible with a mission of health promotion.

Ending tobacco sales in pharmacies will send a clear message to consumers: a pharmacy is no place for tobacco. Such action would reduce the availability and marketing of tobacco products, accelerate progress in reducing tobacco use, and ultimately help end the tobacco epidemic for good.

Interventions to Increase the Price of Tobacco Products

The scientific research is very clear that raising cigarette prices is one of the most effective ways to reduce smoking, especially among kids. New York City has been at the forefront in its efforts to keep cigarettes out of the hands of kids, particularly by keeping cigarette prices high. The City took bold strides in this regard when it increased its cigarette tax in 2002 and then established minimum pack prices at $10.00 per pack for cigarettes and little cigars in 2014, while also prohibiting discounting and coupons of tobacco products. These actions have been instrumental in reducing smoking in the City among youth and adults.

At the same time, non-cigarette tobacco products are available as cheaper substitutes for cigarettes and the tobacco companies continue to use many strategies to keep prices low on those products. The City's proposal to extend existing policies to these other tobacco products is a necessary step to make it more difficult for kids seeking to avoid the high prices of cigarettes to access far cheaper tobacco products. These additional policies include:

- Applying a tax on non-cigarette tobacco products
- Setting a price floor on all major tobacco product categories and updating the price floor for cigarettes and little cigars
- Setting minimum package sizes for all tobacco products

These components are solidly grounded in science and experience. Decades of research on price increases and tobacco use show that when prices increase, use of tobacco products declines, especially among kids. As the 2012 Surgeon General's report states, "Because there is strong evidence that as the price of tobacco products increases, tobacco use decreases, especially among young people, then any actions that mitigate the impact of increased price and thus reduce the purchase price of tobacco can increase the initiation and level of use of tobacco products among young people."[16]

New York City's proposed measures will complement its existing policies to maintain higher prices on all tobacco products and drive down tobacco use rates in the City. These new efforts will go a long way to counter the industry's actions that keep products cheap and more accessible to price-sensitive populations, especially kids.

Tobacco Tax Increases Reduce Tobacco Use, Especially among Kids

The evidence that tobacco tax increases are effective at reducing tobacco use is well-established and extensive. Numerous scientific experts have concluded that one of the best ways to reduce tobacco use is to increase the price of tobacco products.[17] The 2014 Surgeon General's report stated, "The evidence is sufficient to conclude that increases in the prices of tobacco products, including those resulting from excise tax increases, prevent initiation of tobacco use, promote cessation, and reduce the prevalence and intensity of tobacco use among youth and adults."[18] And even the tobacco companies have long recognized the importance of price in promoting and sustaining tobacco use.[19]

Many economic studies have found that particular groups are more sensitive to price than others. For instance, youth are more price-sensitive than adults, and cigarette price and tax increases work even more effectively to reduce smoking among males, Blacks, Hispanics, and lower-income smokers.[20]

The 2012 Surgeon General's report specified, "disparities in tobacco taxation (i.e., higher taxes for cigarettes than for smokeless tobacco) could result in a switch to smokeless tobacco among young males."[21] Non-cigarette tobacco products that are priced and taxed lower than cigarettes can serve as cheaper replacements for cigarette smokers. There is less incentive to quit smoking due to higher cigarette prices if cheaper alternatives exist. Thus, New York City's proposed tax on other tobacco products can help keep these products out of the hands of youth.

Addressing Small and Cheap Packages of Tobacco Products That Appeal to Kids

Tobacco companies know that a variety of strategies work to reduce the effective price of tobacco products. In addition to regular discounting or coupons, which the City has already addressed, companies manipulate package sizes to make their products more affordable and seem like "good deals" for consumers. For instance, that is why nationally, packs of two to three cigars now make up the

largest share of the cigar market compared to just seven years ago when five packs of cigars dominated cigar sales.[22]

While the City's 2014 ordinance required price floors and minimum pack sizes for some cigars as well as cigarettes, it did not fully address other tobacco products that continue to appeal to youth, such as hookah and smokeless tobacco. By applying these same provisions to all other tobacco products, the City will help to make cheap tobacco products less accessible to New York City youth. For instance, though the specific policy elements were different, an evaluation of Boston's law requiring minimum prices and packaging sizes for certain cigars showed nearly complete compliance by retailers and successfully showed reductions in the availability of the single-packaged cigar product monitored in the study.[23]

In addition, combining the minimum package size and price floor provisions will address the loopholes that could arise from only enacting one of these provisions, such as cigars that are sold in the required minimum pack size, but at a low price, which would reduce the public health impact of these initiatives.

Reducing Tobacco Retail Density by Setting Caps on Retail Dealer Licenses

Tobacco retailers are extraordinarily common in the United States. A 2014 national study estimated that there are approximately 375,000 tobacco retailers in the United States,[24] the majority of which are convenience stores.[25] With nearly half of kids visiting convenience stores once a week, the chance of youth being repeatedly and regularly exposed to tobacco products is high.[26] According to a recent study of New York City's tobacco retailers, there is a tobacco retailer every five blocks in the City and 29 times more tobacco retailers than Starbucks, with a total of almost 9,000 tobacco retailers.[27] The ubiquity of tobacco retail outlets in New York City runs counter to the City's efforts to protect youth from tobacco products. New York has achieved historic declines in its youth smoking rate, but the City must remain vigilant in protecting its children from tobacco products. A key part of reducing tobacco use rates is signaling to youth that tobacco use is not the norm or acceptable. Allowing tobacco retailers every few blocks sends the opposite message, in addition to facilitating access to tobacco products themselves and exposing youth to tobacco marketing. High tobacco retailer density is a public health concern because it is associated with youth smoking initiation, increased consumption of tobacco products and decreased quitting.[28]

New York City proposes to reduce the number and density of tobacco retail outlets by capping licenses in each community at half the current level, achieved via a process of attrition over time. It also proposes to establish and then cap licenses for e-cigarettes to apply this strategy across all tobacco products. These strategies, working in combination with existing policies, will help reduce tobacco use by young people in the City by helping to change social norms, reduce easy access to tobacco products, and reduce exposure to tobacco industry marketing at the point of sale.

Tobacco retailer density correlates with population density, and 70 percent of tobacco retailers are located less than two blocks apart.[29] Higher retail density also correlates with lower income and with a greater proportion of African-American residents. [30] A high number of tobacco retailers impacts social norms by making it seem like tobacco use is more prevalent and socially acceptable than it really is.[31] The 2012 Surgeon General report found that "neighborhoods that are more densely populated with

stores selling tobacco may promote adolescent smoking not only by increasing access but also by increasing environmental cues to smoke."[32]

Research has long established that reducing retailer density is a strategy that must be considered as part of a comprehensive campaign to reduce tobacco use. The Surgeon General and the Institute of Medicine have recommended restricting the number and location of retail outlets for cigarettes in communities.[33] These recommendations are based on a growing body of research linking higher density of retailers with experimentation and initiation of youth smoking. For example, a study of mid-sized cities in California found an association between higher outlet density and lifetime smoking, especially for younger youth.[34] A study in *Preventive Medicine* found that current smoking was significantly higher at high schools in neighborhoods with the highest density of tobacco retailers than the smoking rate at high schools in neighborhoods without any tobacco retailers.[35] A study of Chicago youth found that youth who lived in neighborhoods with the highest density of tobacco retailers were 13 percent more likely to have smoked in the past month than those living in neighborhoods with the lowest density of tobacco retailers.[36] Similarly, several studies have found that tobacco retailer density is associated with experimental smoking among high school and middle school students."[37] In addition, higher tobacco retailer density is also associated with increased tobacco consumption and decreased quit attempts among smokers who want to quit.[38]

The number and density of tobacco retailers is of particular concern because tobacco industry efforts to recruit and keep smokers have increasingly been focused on the retail environment. The tobacco industry spends virtually its entire marketing budget – nearly $1 million dollars an hour – where tobacco products are sold directly to the consumer, so high numbers of tobacco retailers means that families have a hard time protecting their kids from exposure to tobacco company marketing.

Tobacco product marketing in the retail environment ensures that tobacco products are advertised heavily, displayed prominently and priced cheaply to appeal to both current and potential tobacco users, including impressionable, price-sensitive kids. Unfortunately, these efforts undermine all of our efforts to prevent youth from starting to smoke and to help smokers quit. Studies show that marketing in the retail environment provides cues to smoking, influences beliefs about the availability of tobacco and smoking initiation among youth, and stimulates purchasing among smokers trying to quit.[39]

In summary, the retailer license cap proposed by New York City is an effective strategy to reduce the availability of and access to tobacco products, reduce exposure to tobacco industry marketing, particularly among youth, and discourage tobacco use generally. This strategy is consistent with the City's public health goals of reducing tobacco use.

Creating a Retail License for E-cigarettes

Research demonstrates that licensing tobacco retailers plays an important role in helping to address tobacco use. Requiring a license for tobacco retailers enables states and localities to know who is selling tobacco products in their jurisdiction, which allows them to enact and enforce tobacco-related policies such as verifying the age of the purchaser and collection of tobacco taxes.[40] This is an important piece of New York City's overall strategy to reduce tobacco use.

It is important to extend licensing provisions to e-cigarette retailers, particularly given the rapid growth in the e-cigarette market and the burgeoning number of e-cigarette retailers. A significant number of youth are using electronic cigarettes (e-cigarettes),* which provide a relatively new way to deliver the addictive substance nicotine without burning tobacco. The number of youth using e-cigarettes is alarming and raises concerns that e-cigarettes could be an entryway to nicotine addiction and use of regular cigarettes for some kids. In New York City, the rate of e-cigarette use among high school students (15.9%) is more than twice as high as the high school smoking rate (5.8%).[41] In 2016, in recognition of the growing problem of e-cigarette use by youth, the Surgeon General issued a report stating that "e-cigarette use among U.S. youth and young adults is now a major public health concern." One of the interventions recommended by the Surgeon General is to license e-cigarette retailers in order to "help prevent sales to minors, prevent evasion of tobacco excise taxes, ensure that licensees comply with tobacco-related laws, and promote safe manufacturing practices."[42]

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[1] American Cancer Society Cancer Action Network, *Oversaturated: How An Oversaturation of Licensed Tobacco Retail Outlets in New York City Is Impacting Public Health*, 2017, https://www.acscan.org/oversaturated-nyc.

[2] See e.g., Payntner, J & Edwards, R, "The impact of tobacco promotion at the point of sale: A systematic review," *Nicotine & Tobacco Research* 11(1):25-35, 2009. Henriksen, L, et al., "A longitudinal study of exposure to retail cigarette advertising and smoking initiation," *Pediatrics* 126:232-238, 2010. Robertson, L, et al., "A Systematic Review on the Impact of Point-of-Sale Tobacco Promotion on Smoking," *Nicotine & Tobacco Research* 17(1):2-17, 2015.

[3] See e.g., Jin, Y, et al., "Tobacco-Free Pharmacy Laws and Trends in Tobacco Retailer Density in California and Massachusetts," *American Journal of Public Health* 106(4):679-685, 2016. Myers, AE, et al., "A comparison of three policy options for tobacco retailer reduction," *Preventive Medicine* 74:67-73, 2015.

[4] Carter, OB, et al., "The effect of retail cigarette pack displays on unplanned purchases: results from immediate postpurchase interviews," *Tobacco Control* 18(3):218-221, 2009. Wakefield, M, et al., "The effect of retail cigarette pack displays on impulse purchase," *Addiction* 103:322-328, 2008.

[5] Katz, MH, "Banning Tobacco Sales in Pharmacies: The Right Prescription," *Journal of the American Medical Association* 300(12):1451-1453, 2008.

[6] Henriksen, L, et al., "Prices for Tobacco and Nontobacco Products in Pharmacies Versus Other Stores: Results from Retail Marketing Surveillance in California and in the United States," *American Journal of Public Health*, 106(10): 1858-1864, 2016.

[7] Counter Tobacco, *Tobacco Free Pharmacies Action Guide,* Chapel Hill, NC, March 2014; Jin, Y, et al., "Tobacco-Free Pharmacy Laws and Trends in Tobacco Retailer Density in California and Massachusetts," *American Journal of Public Health* 106(4):679-685, 2016; Banning Tobacco Pharmacy Sales: Massachusetts, *State and Community Tobacco Control Research* (SCTC), February 2014.

[8] Wang, TW, et al., "Attitudes Toward Prohibiting Tobacco Sales in Pharmacies Among US Adults," *American Journal of Preventive Medicine* 51(6):1038-1043, 2016.

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AMERICAN LUNG ASSOCIATION. IN NEW YORK

Testimony of Michael Seilback
Re: Tobacco Control Package

April 27, 2017

Good morning, my name is Michael Seilback and I am the Vice President, Public Policy & Communications for the American Lung Association of the Northeast. Thank you Chairman Johnson and members of the committee. The Lung Association's mission is to save lives by preventing lung disease and improving lung health.

One of our key goals is to eliminate tobacco use and tobacco-related lung diseases. Smoking remains the number one preventable cause of death and disease in the United States. Additionally, lung cancer remains the number one cancer killer among both men and women in. No one deserves lung cancer, but we must continue to push policies that will reduce smoking rates and the amount of New Yorkers who get lung cancer.

New York City has seen smoking rates significantly decline through groundbreaking tobacco control policies- including strong smokefree air laws, a strong tobacco control & cessation program, a high tobacco tax, hard-hitting media campaigns and innovative tobacco control policies. However, despite our success there are pockets of our populations where smoking rates are double and triple that of the rest of the general population. There are various reasons for these disparities, but some include efforts by the tobacco industry to target these populations who are also harder to reach through our traditional tobacco control efforts.

If we are going to successfully reduce smoking rates in all communities in New York City, we need to continue moving forward with innovative policies which will prevent another generation of youth starting a lifetime of deadly addiction and promote initiatives that will encourage current smokers to successfully quit once and for all.

The American Lung Association thanks the City Council for considering these tobacco control policies today. The American Lung Association strongly supports the package of bills that the Mayor, Commissioner Bassett, Councilmembers Johnson, Lander and Cabrera introduced last week. We are excited by the City's efforts to reduce the amount of New York City smokers by 160,000 over the next 3 years, and commend the City for prioritizing the health of New Yorkers.

My verbal testimony will focus primarily on the smokefree pharmacies bill but will also touch on some of the other bills being considered today.

Intro 1131-A: Smokefree Pharmacies | STRONGLY SUPPORT
It is well-known that easy access to a product encourages its use. Pharmacies are in the business of helping make people better - they should not be pushing an addictive drug that worsens people's health. We applaud retailers like CVS and other independent pharmacies who have voluntarily stopped selling tobacco products. But there are over 550 pharmacies in New York City that are licensed to sell tobacco products.

Pharmacies are places where people go to purchase the medications they need to treat and cure disease: pharmacies shouldn't be in the business of selling the only consumer product that can kill you when used, as directed.

Pharmacists are one of the most trusted health care professionals and an important part of the health care team. Consumers frequently turn to pharmacists for medical information and advice.

In recent years, the cities of Boston and San Francisco adopted measures similar to this bill. Rockland County became the first municipality in New York to pass a smokefree pharmacy measure in January, joining 150 other municipalities nationwide.

Two-thirds of U.S. adults (66.1 percent), including nearly half of current cigarette smokers, support prohibiting tobacco sales in pharmacies, according to a recent study conducted by the US Centers for Disease Control and Prevention.

Intro 1544: Minimum Price Changes | STRONGLY SUPPORT
This bill will take several significant steps to increase the price of tobacco products in New York City. The bill would increase the minimum price of cigarettes and little cigars from the current $10.50 per pack to $13. The bill will also for the first time, set a price floor and tax for other tobacco products which includes cigars, smokeless tobacco, loose tobacco and tobacco-containing shisha. The bill also would establish a new 10 percent tax on other tobacco products with its revenue being dedicated to public housing.

The U.S. Surgeon General, in *The Health Consequences of Smoking – 50 Years of Progress,* released in January 2014 to commemorate the 50th anniversary of the first Surgeon General's report on smoking in 1964, concluded that "increases in the prices of tobacco products, including those resulting from excise tax increases, prevent initiation of tobacco use, promote cessation and reduce the prevalence and intensity of tobacco use among youth and adults."

Research has clearly demonstrated that as the price of cigarettes increases, consumption decreases. For each 10 percent price increase, it is estimated that consumption drops by about 7 percent for youth and 3 to 5 percent for adults. Increasing taxes on tobacco products other than cigarettes is also important as while rates of cigarette smoking are declining slowly, rates of cigar smoking and smokeless tobacco use are stagnant or increasing. In some states, rates of

cigar smoking among youth actually exceed rates of cigarette smoking. This proposal will encourage current smokers to quit and will prevent kids from starting to smoke.

Intro 1547: Retail License Reduction| STRONGLY SUPPORT
New York City has over 8,200 retailers who sell tobacco products in New York City. In fact, in some neighborhoods there is a retailer on every street corner. The proliferation of tobacco retailers has an adverse effect on the health of New York City residents. The easy availability of tobacco has two major effects: first it makes it incredibly easy to purchase tobacco products when the average New Yorker passes at least one retailer everyday: second, the proliferation of tobacco retailers normalizes tobacco use. It gives youth the perception that tobacco must be okay because they see more tobacco retailers than pizza places and Starbucks stores in their neighborhoods. By reducing the amount of tobacco retailers in New York City, we will make it less easy and therefore less likely kids will begin to smoke. Additionally, by reducing the amount of retailers, we also make it easier for current smokers to quit. Even just seeing tobacco retailers in your neighborhood, could be a trigger, which makes it harder to quit smoking.

This legislation would reduce the number of tobacco retailers by capping the tobacco retail dealer licenses in each community district at 50 percent of the current number of licenses in each district. No current tobacco retail dealers will lose their license as a result of this proposal.

Intro 1532: E-Cigarette Retailer Licenses| STRONGLY SUPPORT
E-cigarettes are a tobacco product which have drastically increased in use in recent years. In fact, the use of e-cigarettes by youth has increased by over 900 percent from 2011 – 2016.
The American Lung Association remains concerned about their impact on the public health, given the dramatic increase in use among youth. As FDA begins its oversight of these products, we will learn more about them and more safeguards will be put in place to protect the public health. In the meantime, it is crucially important for New York City to have a better handle on who exactly sells these products. Beyond knowing who is selling these products, these retailers should be treated the same way that tobacco retailers are treated.

This legislation would establish a new separate license for the retail sale of e-cigarettes and would establish the same cap on the number of these licenses as is being proposed in Intro 1547.

NOTE: The American Lung Association also **supports Intro 1471** which would increase the Cigarette Retailer License Fee from $110 to $340.

Intro 1585: Smoking Policy Disclosure | STRONGLY SUPPORT

Smoking Disclosure requirements give tenants, who have a physical aversion to smoke, an easy way to learn whether an apartment building allows smoking or not. Unfortunately, renters often are exposed to smoke after they have moved in or when a new tenant who is a smoker moves into a building.

Secondhand tobacco smoke kills. In fact, secondhand smoke is responsible for close to 50,000 deaths each year in the United States. The United States Surgeon General has declared there is "no risk-free level of exposure to secondhand smoke. Breathing even a little secondhand smoke can be harmful to your health.[1]"

Nationwide, secondhand smoke is responsible for over 50,000 deaths per year including 3,000 from lung cancer in nonsmokers. Secondhand smoke has also been scientifically linked to contributing and causing dozens of diseases and illnesses including asthma, heart disease, respiratory tract infections and ear infections. Secondhand smoke worsens asthma conditions and has been linked to being a significant cause of early childhood asthma.

A smoking policy disclosure law will provide a standardized method that will help a concerned renter learn of possible exposure to secondhand smoke before harmful exposure occurs.

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Intro 1140 Smoking in Cars with Kids – Would Support If Amended

Secondhand smoke is a carcinogen. The Surgeon General has stated that there is no safe level of exposure to secondhand smoke. Children have higher oxygen requirements and breathe at a faster rate than adults which leads to increased damage from secondhand smoke. Those exposed to secondhand smoke have higher risks of asthma, ear infections, bronchitis, pneumonia, depression and ADHD.

According to a Harvard School of Public Health study, "alarming" levels of secondhand smoke were generated in just five minutes in vehicles under various conditions. Being in a car where an adult smokes two cigarettes is similar to being in a smoke-filled bar, something New York City has seen fit to ban in order to protect fully grown adult lungs. Additionally, the levels of particulate matter found in the vehicles exceeded levels described by the U.S. Environmental Protection Agency (EPA) as "unhealthy for sensitive groups" like children and the elderly.

Children in cars are often not in a position to ask adults not to smoke. It is up to our elected officials to help protect these children who cannot advocate for themselves.

The goal of this legislation is a laudable one, but the Lung Association believes all youth should be protected from secondhand smoke and would urge the sponsor to amend his legislation so it applies to all youth.

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Here in New York City, strong tobacco control policies have helped reduce smoking rates to record levels. The package of bills announced last week will help solidify the City of New York's place as a global leader on tobacco control and public health.

For more information contact: Michael Seilback, Vice President, Public Policy & Communications for the American Lung Association of the Northeast, 631.415.0946 or Michael.Seilback@lung.org.

NYC SMOKE-FREE

Public Health Solutions

Testimony of **Patrick Kwan**

Director

NYC Smoke-Free at Public Health Solutions

before the

New York City Council Health Committee
City Hall Council Chambers

Regarding

Int. 1547

A Local Law to amend the administrative code of the city of New York, in relation to expanding the retail dealer license to include retailers of tobacco products and setting caps on retail dealer licenses

Int. 1131

A Local Law to amend the administrative code of the city of New York, in relation to the sale of tobacco products in pharmacies

April 27th, 2017

Patrick Kwan, Director
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Good morning and thank you Council Member Johnson and members of the Health Committee for the invitation and opportunity to speak today.

My name is Patrick Kwan, and I am the Director of NYC Smoke-Free - a program of Public Health Solutions, one of the country's largest public health institutes and one of New York's leading nonprofit organizations. NYC Smoke-Free (formerly the NYC Coalition for a Smoke-Free City) works to protect the health of New Yorkers through tobacco control policy, advocacy, and education. We partner with community members, legislators, and health advocates to support local efforts to end the devastating tobacco epidemic throughout New York City. We believe every New Yorker has the right to breathe clean, smoke-free air where they live, work and play.

Int. 1131 – Ending Pharmacies as Tobacco Outlets

While many New York City neighborhood pharmacies put the health of our communities first and do not sell cigarettes and other tobacco products, more than 600 pharmacies – half are Duane Reade and Rite Aid stores owned by Walgreens – still continue to peddle deadly and addictive tobacco products.

Pharmacies are crucial frontline providers of health care and medications as well as help New Yorkers treat, manage, and combat chronic diseases. There is an inherent conflict for pharmacies be an outlet of the tobacco industry, which is best known for targeting kids as a customer base for their deadly products.

Int. 1131 will stop irresponsible pharmacies from contributing to New York City's tobacco epidemic and get them out of the deadly tobacco business.

Int. 1547 – Stopping the Proliferation of Tobacco Outlets in NYC Neighborhoods

New Yorkers are seeing more and more tobacco in our neighborhoods. And in some of our most vulnerable communities, tobacco is both persistent and pervasive: chronic disparities of higher tobacco use and secondhand smoke exposure rates are coupled with widespread availability of dangerous tobacco products. Alarmingly, many neighborhoods are food deserts void of healthy foods, yet are also tobacco swamps abundant with deadly and addictive tobacco products.

In far too many New York City neighborhoods, it's easier for a child to find cigarettes than a book or a swing set as we have more than 8,500 tobacco outlets in our neighborhoods. More than 1 in every 3 NYC high school student who smoke obtain their cigarettes from a neighborhood tobacco outlet.

We all know candies and cigarettes don't belong together. Yet at neighborhood tobacco outlets, teens and kids are bombarded with bountiful arrays and colorful sales displays of tobacco products. These are one of the last avenues where the tobacco industry can still target and market to our youth as

replacements for the 12,000 New Yorkers who die from tobacco each year. The widespread availability of tobacco in our communities dangerously normalizes tobacco.

Deadly and addictive tobacco products simply do not belong on nearly every block and corner of our neighborhoods. The more tobacco outlets we have in New York City, the more outlets there are for kids to get hooked on tobacco. Neighborhoods swamped with tobacco make it easy to start and harder to quit.

We can help end the tobacco epidemic by ending tobacco proliferation in our neighborhoods. NYC doesn't need even more tobacco outlets to provide more easy access to deadly tobacco products. Int. 1547 will stop the unchecked proliferation of tobacco outlets in our communities.

Thank you.

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NYC Smoke-Free – a program of Public Health Solutions, one of the country's largest public health institutes and one of New York's leading nonprofit organizations – works to end the devastating tobacco epidemic and protect the health of all New Yorkers through tobacco control policy, advocacy, and education. For over 20 years, NYC Smoke-Free – formerly the NYC Coalition for a Smoke-Free City – has led community efforts to establish and expand smoke-free protections in New York City. We believe every New Yorker has the right to breathe clean, smoke-free air where they live, work, and play. For more information, please visit NYCSmokeFree.org

Public Health Solutions - the largest public health nonprofit organization in New York City, improves health among New York City's most vulnerable populations by tackling social, physical, and environmental factors that impact New Yorkers' ability to thrive. Today, PHS serves 200,000+ New Yorkers annually, and we support the work of more than 200 community-based nonprofit organizations. We implement innovative, cost-effective population-based health programs; conduct research providing insight on effective public health interventions; and provide services to government and other nonprofits to address public health issues. Together with our colleagues in the social services sector, government, philanthropy and policy organizations, we are thought leaders and cutting-edge public health professionals in New York City and New York State. To learn more, please visit us at healthsolutions.org.

NYC SMOKE-FREE

Public Health Solutions

Testimony of **Deidre Sully**

Deputy Director

NYC Smoke-Free at Public Health Solutions

before the

New York City Council Health Committee

City Hall Council Chambers
New York, NY 10007

regarding

Int. 139-B
A Local Law to amend the administrative code of the City of New York, in relation to the regulation of non-tobacco smoking products, and to amend the fire code of the city of New York, and the New York city mechanical code, in relation to the operation of non-tobacco smoking establishments

April 27th, 2017

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Good morning and thank you Council Member Johnson and members of the Health Committee for the invitation and opportunity to speak today.

My name is Deidre Sully, and I am the Deputy Director of NYC Smoke-Free - a program of Public Health Solutions, one of the country's largest public health institutes and one of New York's leading nonprofit organizations. NYC Smoke-Free (formerly the NYC Coalition for a Smoke-Free City) works to protect the health of New Yorkers through tobacco control policy, advocacy, and education. We partner with community members, legislators, and health advocates to support local efforts to end the devastating tobacco epidemic throughout New York City. We believe every New Yorker has the right to breathe clean, smoke-free air where they live, work and play.

Int.139-B would create an oversight and regulatory framework for hookah establishments to promote and ensure compliance of the Smoke-Free Air Act, which keeps tobacco products away from kids and protects New Yorkers – especially the workers who are employed at hookah establishments – from harmful secondhand smoke exposure.

A 2014 investigation[1] conducted by New York University students found that over a dozen of the City's most popular hookah-serving establishments were in violation of the Smoke-Free Air Act and laws that restrict youth under 21 years of age from tobacco products. All of the hookah establishments surveyed claimed to only use non-tobacco shisha; however, laboratory tests of the samples collected at all of locations showed that the shisha contained tobacco. This means that the establishments were illegally serving tobacco to youth under 21 years of age and exposing everyone in the establishment to second-hand tobacco smoke.

For more than a decade, NYC has achieved great successes in tobacco control, including a decline in teen use of cigarettes. The Smoke-Free Air Act was expanded to include bars and restaurants, hospital entryways, public parks, beaches, and pedestrian plazas and to prohibit the use of e-cigarettes wherever "conventional" smoking is banned. Unfortunately, now the use of non-tobacco smoking products, such as hookah, is a growing trend spreading among bars, restaurants and lounges across NYC – and is compromising all of the progress we have made. Currently, teens and young adults under the age of 21 can legally enter non-tobacco smoking establishments – such as hookah lounges and restaurants – that provide hookah products and services. Being exposed to use of hookah, re-normalizes smoking in general and may discourage those who are trying to quit using cigarettes.

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[1] New York City Department of Health and Mental Hygiene. (2015) Undercover Health Department Investigation Found 13 Hookah Bars in Violation of The Smoke-Free Air Act [Press Release] Retrieved from http://www1.nyc.gov/site/doh/about/press/pr2015/pr001-15.page

According to the Centers for Disease Control, some studies show that preparations for both tobacco and non-tobacco based shisha contain carcinogens that may lead to smoking related cancers as well as both heart and lung disease.[2] There is a common misconception that smoking hookah tobacco is safer and less addictive than cigarette smoking. In reality, hookah use can be as dangerous as smoking cigarettes. A number of studies suggest that hookah smoking may be just as addictive and perhaps even more harmful because of the way people smoke while using a waterpipe (i.e., hookah). Hookah smoke – whether tobacco-based or non-tobacco – contains many of the same harmful toxins as cigarette smoke and has been associated with lung cancer and respiratory illnesses.

While significant disparities exist in some of NYC's most vulnerable populations and communities – such as those with limited income and education who use and are exposed to tobacco at a much higher rate than other New Yorkers – the City of New York has been a leader in putting in place best practices in comprehensive tobacco control that have saved thousands of lives, increased life expectancy, prevented smoking addiction, and improved health for all New Yorkers. Thanks to this comprehensive approach that includes bold policies, limiting youth access to tobacco products through sales restrictions and cigarette price increases, hard-hitting media campaigns, and cessation services, the percentage of adults smoking in New York City is now 13.9%,[3] and the percentage of public high school students has fallen to 8.2%.[4] Evidence-based, best practices work, and we should continue to use them by regulating hookah in order to protect New Yorkers from adverse health effects of tobacco resulting from the increased use of a product which may seem new or trendy especially to youth and is misconstrued to harmless.

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NYC Smoke-Free – a program of Public Health Solutions, one of the country's largest public health institutes and one of New York's leading nonprofit organizations – works to end the devastating tobacco epidemic and protect the health of all New Yorkers through tobacco control policy, advocacy, and education. For over 20 years, NYC Smoke-Free – formerly the NYC Coalition for a Smoke-Free City – has led community efforts to establish and expand smoke-free protections in New York City. We believe every New Yorker has the right to breathe clean, smoke-free air where they live, work, and play. For more information, please visit **www.NYCSmokeFree.org**

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[2] Center for Disease Control and Prevention. Smoking & Tobacco Use. (Last Updated 2015, September 14)

[3] Community Health Survey, 2014. New York City Department of Health and Mental Hygiene.

[4] Youth Risk Behavior Survey, 2013. New York City Department of Health and Mental Hygiene.

NYC SMOKE-FREE

Public Health Solutions

Testimony of **Lisa Spitzner**

Community Engagement Coordinator

NYC Smoke-Free at Public Health Solutions

before the

New York City Council Health Committee
City Hall Council Chambers

Regarding

Int. 1585
A Local Law to amend the administrative code of the city of New York, in relation to disclosure of smoking policies for class A multiple dwellings

Int. 484
A Local Law to amend the administrative code of the city of New York, in relation to banning smoking in the common areas of all multiple dwellings

Int. 977
A Local Law to amend the administrative code of the city of New York, in relation to banning smoking in city-financed housing.

April 27th, 2017

Lisa Spitzner, Community Engagement Coordinator
NYC Smoke-Free, Public Health Solutions
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Good morning and thank you Council Member Johnson and members of the Health Committee for the invitation and opportunity to speak today.

My name is Lisa Spitzner, and I am the Manhattan Community Engagement Coordinator for NYC Smoke-Free - a program of Public Health Solutions, one of the country's largest public health institutes and one of New York's leading nonprofit organizations. NYC Smoke-Free (formerly the NYC Coalition for a Smoke-Free City) works to protect the health of New Yorkers through tobacco control policy, advocacy, and education. We partner with community members, legislators, and health advocates to support local efforts to end the devastating tobacco epidemic throughout New York City. We believe every New Yorker has the right to breathe clean, smoke-free air where they live, work and play.

Since 2009, NYC Smoke-Free has helped over 12,000 apartments – more than 6,500 in the last two years – to go smoke-free, impacting over 32,000 residents.

The three bills relating to smoke-free housing – Int. 1585, Int. 484, and Int. 977 – before the City Council Health Committee today will make it easier for New Yorkers to identify housing with smoke-free protections, breathe air free from harmful tobacco pollution, and find opportunities for smoke-free affordable housing.

Int. 1585 – Disclosure of Smoking Policy

It shouldn't be a mystery whether smoking is permitted or prohibited in an apartment building. New Yorkers should have the right to know their buildings' policy on smoking. At NYC Smoke-Free, we often hear from New Yorkers who are surprised to learn their apartment building lacks smoke-free protections. Families should not have to find out they will be subjected to dangerous secondhand smoke in their homes only after they sign a new lease and spend considerable expenses to move into a new home. Int. 1585 would provide New Yorkers with crucial information they can use to decide where to live.

Int. 484 – Extending Common Area Smoke-Free Protections for All Apartment Buildings

The New York City Smoke-Free Air Act of 2002 prohibits smoking in lobbies, stairwells, hallways, elevators, laundry rooms, and other common areas in residential buildings with ten or more units. For nearly 15 years, this important law has helped protect New Yorkers from harmful secondhand smoke in the common areas of residential buildings with ten or more units and reduce indoor tobacco pollution in these buildings. Now after 15 years, Int. 484 will extend this important and common sense

protection for all New Yorkers who live in apartment buildings instead of just New Yorkers who live in buildings with ten or more units.

Int. 977 – Expanding Smoke-Free Affordable Housing

Luxury condos, co-ops, and rentals are increasingly going smoke-free, but this positive trend has been slow to reach – and out of reach for – most New Yorkers, especially families who depend on affordable housing opportunities.

Int. 977 will expand much-needed opportunities for smoke-free affordable housing.

While New Yorkers with options are choosing housing with smoke-free protections, the great majority of New Yorkers who are rent-burdened or struggle in the city's competitive housing market have few options but to stay where they are when their families are subjected to dangerous secondhand smoke pollution in their homes.

A recent NYC rental market survey conducted for NYC Smoke-Free by real estate listing giant *StreetEasy* of over 60,000 rental listings over 5 years found apartments in smoke-free buildings rent from $1,000 to $1,300 more – per month – than apartments that lack smoke-free protections. And less than 4% of rental listings are in smoke-free buildings.

Smoke-free air should not be a luxury. For families with children suffering from asthma, secondhand smoke can be a nightmare - just a breath can trigger an asthma attack and a trip to the emergency room.

Int. 977 will help more families from having to endure dangerous tobacco pollution in their homes.

Thank you.

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NYC Smoke-Free – a program of Public Health Solutions, one of the country's largest public health institutes and one of New York's leading nonprofit organizations – works to end the devastating tobacco epidemic and protect the health of all New Yorkers through tobacco control policy, advocacy, and education. For over 20 years, NYC Smoke-Free – formerly the NYC Coalition for a Smoke-Free City – has led community efforts to establish and expand smoke-free protections in New York City. We believe every New Yorker has the right to breathe clean, smoke-free air where they live, work, and play. For more information, please visit NYCSmokeFree.org

Public Health Solutions - the largest public health nonprofit organization in New York City, improves health among New York City's most vulnerable populations by tackling social, physical, and environmental factors that impact New Yorkers' ability to thrive. Today, PHS serves 200,000+ New Yorkers annually, and we support the work of more than 200 community-based nonprofit organizations. We implement innovative, cost-effective population-based health programs; conduct research providing insight on effective public health interventions; and provide services to government and other nonprofits to address public health issues. Together with our colleagues in the social services sector, government, philanthropy and policy organizations, we are thought leaders and cutting-edge public health professionals in New York City and New York State. To learn more, please visit us at healthsolutions.org.

Advocates of the Food Industry Since 1900

FOOD INDUSTRY ALLIANCE OF NEW YORK STATE, INC.

130 Washington Avenue • Albany, NY 12210 • Tel (518) 434-1900 • Fax (518) 434-9962
Government Relations (518) 434-8144

Testimony
By the Food Industry Alliance of New York State, Inc.
in Opposition to
Int. No. 1547-2017

Thank you for the opportunity to testify on behalf of the Food Industry Alliance of New York State (FIA) regarding Int. No. 1547-2017. FIA is a nonprofit trade association that promotes the interests statewide of New York's grocery, drug and convenience stores. Our members include chain and independent grocery stores that account for a significant share of New York City's retail food market and the grocery wholesalers that supply them, as well as drug and convenience stores.

FIA opposes this legislation which, among other things, would establish a fourth condition to obtaining a retail dealer license: That the number of licenses in the community district in which the applicant's establishment is located is lower than the community district retail dealer cap. The initial cap must be fifty percent of the total number of licenses issued to retail dealers in the community district on the effective date of the local law, as determined by the Department of Consumer Affairs. Additional reductions in the retail dealer cap are contemplated under the legislation.

The Declaration of legislative findings and intent section of the bill provides that the city has approximately 9,000 licensed cigarette retailers. Accordingly, the goal of the legislation is to reduce the number of retail dealer licenses by 4,500.

If a prospective store buyer believes that it won't be able to sell cigarettes and tobacco products at a location, such as a convenience store or a bodega, that is heavily dependent on sales of these products, as well as the non-tobacco items that are part of the same transaction, then either the business will be sold at a significantly reduced price or there will be no buyer at all. Either way, small business owners who have endured long hours and severe competition could have their equity in the business, and therefore their savings (including their retirement savings), wiped out and default on personally guaranteed debt, which would result in the forfeiture of personal assets to lenders and suppliers. If convenience stores or bodegas shut due to a lack of buyers, job losses will result.

These outcomes will occur even though users of cigarettes and tobacco products are fully informed purchasers of legal products. These products are heavily regulated and taxed (NYC has some of the highest excise tax rates in the country), including a prohibition on sales to minors, a price floor for cigarettes and a ban on promotions and coupons. Enactment of the other bills being considered at this committee meeting will increase regulation and restrict access even further.

In addition, New York already has a significant and growing illegal trade in tobacco products. According to a January 2017 study by the Tax Foundation, 55.4% of cigarettes consumed in New York

state are from smuggled sources. Moreover, in 2015 the Obama Administration released a report titled "The Global Illicit Trade in Tobacco: A Threat to National Security." The report stated that cigarette smuggling provides funding for everything from terrorism and human trafficking to weapons.

Accordingly, eliminating thousands of responsible, heavily regulated, taxpaying locations that ID minors will cause a further expansion of illicit sales as well as an increase in legal sales outside NYC, including cross-border brick and mortar stores, the internet and Indian reservations.

In addition, both the adult and youth smoking rates have been declining significantly in New York. According to the Declaration of legislative findings and intent section of this legislation, the adult smoking rate in the city declined from 21.5% in 2002 to 14.3% in 2015. Moreover, on March 13, 2017, Governor Cuomo announced that New York state's high school student smoking rate in 2016 was the lowest on record at 4.3%, down from 27.1% in 2000. These trends clearly demonstrate that current policy has been very effective. We therefore respectfully request that this legislation be withdrawn.

Should you choose to proceed, it is our understanding that the legislation is not intended to affect the ability to renew an existing license. Accordingly, we respectfully request that proposed section 20-202(d)(1)(D) be amended to expressly exempt renewals of existing licenses: "other than with respect to an application to renew a retail dealer license obtained prior to the effective date of the local law that added this section, the number of licenses in the community district in which the place of business of such applicant is located is lower than the community district retail dealer cap." The proposed added language is underlined.

For the foregoing reasons, FIA, on behalf of its members, opposes adoption of this legislation. We look forward to working with government stakeholders to address our concerns.

Respectfully submitted,

Food Industry Alliance of New York State, Inc.
Jay M. Peltz
General Counsel and Vice President of Government Relations
Metro Office: 914-833-1002
jay@fiany.com

April 27, 2017

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Testimony
By the Food Industry Alliance of New York State, Inc.
in Opposition to
Int. No. 1532-2017

Thank you for the opportunity to testify on behalf of the Food Industry Alliance of New York State (FIA) regarding Int. No. 1532-2017. FIA is a nonprofit trade association that promotes the interests statewide of New York's grocery, drug and convenience stores. Our members include chain and independent grocery stores that account for a significant share of New York City's retail food market and the grocery wholesalers that supply them, as well as drug and convenience stores.

FIA opposes this legislation, which would make it unlawful for any establishment to engage in business as an electronic cigarette retail dealer without first having obtained a separate license for each place of business where electronic cigarettes are sold at retail in the city. The bill would also prohibit pharmacies from obtaining a license to sell electronic cigarettes. In addition, license applications could only be filed by businesses engaged in the retail sale of electronic cigarettes as of the enactment date of this bill and license applications can only be filed within 90 days of the effective date of this legislation.

A local law was adopted in Suffolk County last year (local law No. 29-2016) that required sellers of electronic cigarettes to register with the county. However, businesses registered to sell tobacco products under a state license are exempt from the separate registration requirement. The separate registration requirement was deemed unnecessary since sellers of electronic cigarettes who are also licensed sellers of tobacco products can easily be identified through that data base. This will allow the county to enforce laws regarding the sale of electronic cigarettes at those establishments.

This rationale is even stronger in the city, which has its own license requirement to sell cigarettes and tobacco products. There is no need to impose another license requirement and fee on businesses that are already licensed and paying a fee to sell cigarettes and tobacco products. These establishments are already regulated and inspected by the city. Accordingly, the existing retail dealer license provisions can simply be amended to authorize retail dealers to sell electronic cigarettes as well as cigarettes and tobacco products. Alternatively, establishments that want to sell electronic cigarettes, but not cigarettes or other tobacco products, could apply for the separate license contemplated under the bill.

In addition, the provisions of the legislation barring pharmacies from obtaining a license to sell electronic cigarettes and severely restricting the number of electronic cigarette licenses to be issued are counterproductive. According to a January 2017 study by the Tax Foundation, 55.4% of cigarettes consumed in New York state are from smuggled sources. Moreover, in 2015 the Obama Administration released a report titled "The Global Illicit Trade in Tobacco: A Threat to National

Security." The report stated that cigarette smuggling provides funding for everything from terrorism and human trafficking to weapons.

Prohibiting pharmacies from selling electronic cigarettes and severely restricting the number of electronic cigarette licenses to be issued could fuel a black market in electronic cigarettes comparable to the illicit trade in traditional cigarettes. Any shift in sales from legal, taxed and heavily regulated and inspected sellers to a market where taxes are not paid and minors are not IDed would have adverse health and economic consequences.

Finally, combined with the severe reduction in retail dealer licenses required under Int. 1547, if a prospective store buyer believes that it won't be able to sell cigarettes, tobacco products and electronic cigarettes at a location, such as a convenience store or a bodega, that is heavily dependent on sales of these products, as well as the non-tobacco items that are part of the same transaction, then either the business will be sold at a significantly reduced price or there will be no buyer at all. Either way, small business owners who have endured long hours and severe competition could have their equity in the business, and therefore their savings (including their retirement savings), wiped out and default on personally guaranteed debt, which would result in the forfeiture of personal assets to lenders and suppliers. If convenience stores or bodegas shut due to a lack of buyers, job losses will result.

Accordingly, we respectfully request that the legislation be amended to exempt establishments licensed as retail dealers in the city from the requirement to obtain a separate license to sell electronic cigarettes. The administrative code should thus be revised so that the definition of "retail dealer" includes electronic cigarettes. This change, combined with proposed revisions to the definition of retail dealer in Int. 1547, would license retail dealers to sell cigarettes, tobacco products and electronic cigarettes.

Should you choose to enact this legislation without making the foregoing revisions, we respectfully request that provisions in the bill banning pharmacies from selling electronic cigarettes and severely restricting the number of electronic cigarette licenses to be issued be deleted in their entirety.

For the above reasons, FIA, on behalf of its members, opposes adoption of this legislation. We look forward to working with government stakeholders to address our concerns.

Respectfully submitted,

Food Industry Alliance of New York State, Inc.
Jay M. Peltz
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April 27, 2017

NATO

April 27, 2017

Chairperson Corey Johnson
Members of the New York City Committee on Health
New York City Hall
250 Broadway
New York, NY 10007

Subject: Comments on Proposed Tobacco-Related Ordinances

Dear Chairperson Johnson and Members of the Committee on Health:

As the Executive Director and legal counsel for the National Association of Tobacco Outlets, Inc. (NATO), a national retail tobacco trade association, I am submitting this letter on behalf of the association and it member retail stores located in New York City.

The Problem of Social Sources Must Be Addressed to Protect the Public Health

If the goal of the proposed tobacco ordinances is to truly protect the public health, then one solution must be to focus on the real root cause of access to tobacco by those not of age. That is, an educational campaign is needed to change societal attitudes that it is not permissible for adults to legally obtain tobacco products and then improperly provide those same tobacco products to underage persons.

In 2016, the U.S. Food and Drug Administration released the initial findings of a major study titled the Population Assessment of Tobacco and Health, or PATH for short. This PATH study found what other studies had already concluded, namely, that the vast majority of underage youth obtain tobacco products from non-retail sources known as social sources. These social sources include older friends, adult age siblings, parents, and even strangers. In fact, the FDA study found that 86% of underage youth obtain cigarettes from other adults, give an adult money to buy cigarettes for them, or ask someone for cigarettes. Similarly, the FDA study found that 79% of underage youth obtain cigars and cigarillos from social sources.

Additionally, a 2014 study titled "Usual Source of Cigarettes and Alcohol Among U.S. High School Students" published in the Journal of School Health found that social sources including borrowing or bumming cigarettes from someone else or giving someone else money to buy cigarettes were the two most common methods that underage youth rely on to obtain cigarettes.

In other words, retailers are not the problem when it comes to access tobacco products by underage youth. They take the business of selling tobacco products very seriously and

implement measures to train store personnel so that underage persons are not sold tobacco products.

While these studies confirm that social sources are the primary means by which a vast majority of individuals under the legal age gain access to tobacco products, government agencies, elected officials and those advocates that support the proposed introductions being considered by the Committee on Health have yet to develop a strategy and undertake efforts to combat the social sources problem.

Enacting ever higher minimum prices on cigarettes and tobacco products, assessing a new excise tax on other tobacco products, capping and reducing the number of retail tobacco licenses, and banning the sale of tobacco products in pharmacies does not address the problem of social sources. This means that these proposed policy actions will not augment the protection of the public health. Until policymakers, including the New York City Committee on Health, acknowledge the problem of social sources and take affirmative action to address the problem, then public health goals for underage individuals will not be achieved.

Higher Prices and a New Tax on Tobacco Products Would Not Protect the Public Health

Introduction No. 1544-A would increase the minimum price for a pack of cigarettes and little cigars from $10.50 to $13.00, plus mandate new minimum prices of $8.00 for a package of smokeless tobacco, $17 for a package of loose tobacco, and $8.00 for a package of up to four cigars, plus $2.00 for each additional cigar in a package. In addition, this proposed ordinance would also assess a new 10% tax on other tobacco products.

New York residents who purchase and use tobacco products will perceive an action by their elected city council members to further increase prices on tobacco products as being an unfair exercise of local government authority. A perception of unfairness already exists because so many New York residents turn to cross border or black market sources for cigarettes and tobacco products. According to a study titled "Cigarette Taxes and Smuggling" published by the Mackinac Center for Public Policy in 2016, the State of New York ranks Number 1 in cigarette smuggling in the country with an in-bound cigarette smuggling rate of 55.4%. According to the study, "New Yorkers consume more smuggled cigarettes that they do legally taxed ones" and the high state excise tax rate compounded by the New York City cigarette tax of $1.50 per pack "contribute to [New York's] high smuggling rate."

This high rate of purchasing untaxed or smuggled tobacco products by New York City residents demonstrates that tobacco consumers will seek out lower priced alternative sources for tobacco, including black market sources. The unintended consequence of incentivizing New York City residents to seek out non-regulated, non-law abiding sources of cigarettes and tobacco products further threatens the public health and the health of the overall community. The health of a city is not measured by just the physical well being of its residents, but also by the degree of adherence to and respect for laws and the level of safety perceived by those in the community. Raising the minimum prices for tobacco products even further will simply exacerbate the level of forced disobedience of the law by New York City residents and increase the level of criminal black market sales of tobacco products.

Higher Minimum Prices Will Force More Family-Owned Retail Stores to Close

In 2013, prior to the enactment of an ordinance by the New York City Council setting the current minimum cigarette and tobacco product prices, there were 9,804 retailers licensed to sell tobacco products in the city. In the past three years, the number of retailers licensed to sell tobacco products has declined to 8,992. This means that 812 retail stores are no longer in the business of selling tobacco products and that thousands of jobs were lost. Many of these stores were simply closed due to an inability to compete with the rampant black market in New York City for cigarettes and tobacco products and because many adult consumers sought out other lower priced sources for the tobacco products they desire to purchase.

The proposed increase in minimum cigarette and tobacco product prices will accelerate the closing of family-owned retail stores. According to the National Association of Convenience Stores, cigarette and tobacco sales comprise 36% of in-store sales for an average convenience store. These higher prices will cause sales of cigarettes and tobacco products by legitimate and law-abiding retailers to decline well below the 36% threshold needed to remain in business.

License Cap Will Cause Loss of Equity in Retail Businesses

If the future closing of numerous retail stores because of the proposed higher cigarette and tobacco minimum prices was not enough, Introduction No. 1547 would eliminate one half of the retail stores that sell tobacco in New York City through attrition. The ordinance provides that a retail dealer license cap will be set at 50% of the existing number of retailers licensed to sell tobacco products in each community district. This means that for almost 4,500 retail businesses in New York City, storeowners will find it nearly impossible to realize the full value of their investment upon the sale of their store if the new buyer is unable to obtain a license to continue selling tobacco products. The only exception allowed is if a store was continually licensed to sell tobacco products for the five consecutive years immediately preceding the sale of the store.

The license density cap also means that a retailer will not be able to open a new store in any community district where the number of existing retail stores selling tobacco meets or exceeds the cap limit. This limitation essentially guarantees that no new retail store development will occur in a substantial portion of New York City.

Banning Sales in Pharmacies Eliminates Protection Afforded by Responsible Retailers

Introduction No. 1131 would prohibit the sale of cigarettes and tobacco products in pharmacies. Pharmacy retailers are responsible, law-abiding members of the community who are not in the business of selling tobacco products to underage persons. By banning the sale of legal tobacco products in pharmacies, some 600 retail stores that ensure compliance with the law through requesting photo identification of customers and verifying legal age will no longer be able allowed to protect against the possibility of underage individuals buying tobacco products. With 600 fewer licensed locations from which to purchase tobacco products, some New York City residents will likely turn to black market sellers that make themselves readily available to sell cigarettes and tobacco products without any concerns whether they comply with age verification laws and minimum pricing requirements.

Additional Tobacco Regulations Will Make Black Market Worse

The high cigarette tax environment and mandated minimum prices in New York City has led to a rampant black market in illicit cigarettes, with low taxed cigarettes brought in from other states by black market profiteers and then being sold illegally within the city limits. This black market in cigarettes has expanded exponentially since 2006 and adopting even more regulations will only make the illicit marketplace for cigarettes and tobacco products worse. There are more than enough current local, state and FDA retail tobacco regulations to prevent the sale of tobacco to underage youth and retailers are responsible people who are not in the business of selling tobacco products to minors.

However, with black market cigarette sellers indifferent about checking identification and willing to sell cigarettes to anyone of any age who has cash, the gains that law-abiding retailers have made in reducing youth access to tobacco are being undermined. Adopting more regulatory burdens and prohibitions on law-abiding retailers will not solve the problem with the black market. The focus needs to be on law enforcement so that the black market will not continue to flourish to the detriment of local retailers and the City of New York.

Proposed Regulations Will Severely Impact the Mental Health of Retailers and Employees

There will be a very real impact on the emotional well being of those retailers that must close their store because of higher mandated prices or lose the value in their business because of an inability of a buyer to obtain a retail tobacco license. In addition, the psychological health of employees who lose their jobs due to the proposed ordinances will also be harmed.

That is, the proposed ordinances will have the unintended consequence of impairing the mental health of hardworking retailers that suddenly find themselves losing what they worked so long to build and of employees who will be unable to financially provide for their families. The charge of the Committee on Health to adopt laws and regulations that protect the public health must take into account every aspect of a person's health, including their mental health. In short, the proposed ordinances fail to adequately protect the mental health of retailers and their employees.

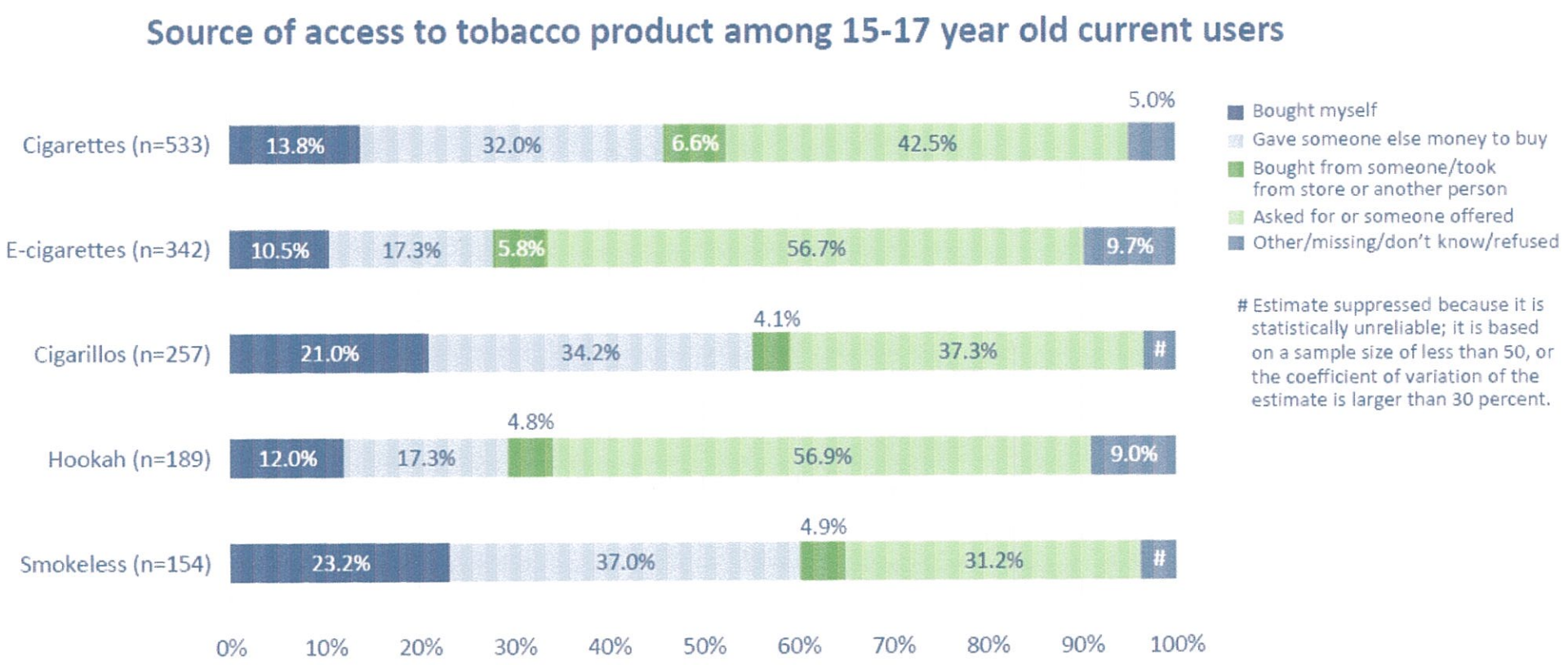
For all of these reasons, I respectfully request that you not support Introductions 1131, 1544-A and 1547.

Sincerely,

Thomas A. Briant

NATO Executive Director and Legal Counsel

YOUTH ACCESS TO TOBACCO PRODUCTS AMONG PAST 30-DAY USERS: WHERE DO YOUTH GET TOBACCO?



MANHATTAN CHAMBER OF COMMERCE

FOR THE RECORD

WRITTEN COMMENTS TO THE NEW YORK CITY COUNCIL COMMITTEE ON HEALTH

HEARING ON A LEGISLATIVE PACKAGE AIMED AT REDUCING TOBACCO USE IN NYC

JESSICA WALKER
PRESIDENT AND CEO

THURSDAY, APRIL 27, 2017

The Manhattan Chamber of Commerce is an organization that drives broad economic prosperity by helping businesses succeed in New York. We do this by facilitating connections, providing resources and advocating for them in pertinent public policy and economic development discussions.

We agree that the goal of continuing to reduce tobacco use among underage consumers, and adults, is a laudable one. But we harbor concerns about the unintended consequences of some of the bills under consideration today.

The city's small grocers, bodegas and retailers who sell tobacco have been central to the successes over the years in bringing rates of smoking down. Retailer compliance rates to prevent underage tobacco sales in New York have risen to the point that the city now has one of the lowest retailer violation rates in the nation – eight percent in FY2012. And youth smoking rates have decreased, as one of the findings in Int. 1547 explains: "Smoking prevalence among NYC public high students also declined substantially from 17.6% in 2001 to 5.8% in 2015."

Our fear is that some measures being heard today are overly punitive for the very retailers who have served as constructive partners in reducing tobacco use. Specific concerns are outlined below.

- **Int. 1547 – License Cap**
  This ordinance aims to eliminate half of the tobacco retailers in NYC. A store owner selling his or her business will potentially lose thousands of dollars in value and a substantial portion of their life savings if the new owners are not able to retain a lawful tobacco license.

- **Int. 1544A – New Excise Taxes, Price Floors & Package Sizes**
  This ordinance raises the minimum price for cigarettes from $10.50/pack to $13.00/pack and implements new minimum price requirements for moist snuff tobacco ($8/package) and cigars ($2/cigar – min. of $8/pack). Tobacco products in NYC are already taxed and priced among the highest in the nation. This environment has created a booming black market that more than doubled between 2006 and 2011. This new measure will further push cigarette sales to the black market, depriving lawful stores of sales and the city and state of tax revenue.

- **Int. 1462 – Display Ban**
  The bill would prohibit the display of tobacco products and "non-tobacco smoking products" such as non-tobacco shisha, or their packaging, until the moment of sale. This poses a logistical burden for many small retailers and newsstand operators, many of which have very little room to store tobacco products out of sight. The fines for noncompliance are also particularly steep.

- **Int. 1131 – Pharmacy Ban**
  This bill seeks to eliminate the sale of tobacco in stores also containing pharmacies. If a store desires to do this on its own, as CVS did, that is within their right. But it is intrusive government overreach and a disturbing precedent to dictate what legal products are consistent with their "mission."

Retailers want to remain strategic partners with the city as it works to further reduce smoking rates. However it cannot be at the expense of their ability to survive as a business. We strongly urge you to reject these measures and protect small businesses.

Date: April 27, 2017

To: The Honorable Chair Corey D. Johnson and Health Committee Members

FOR THE RECORD

From: Mittin Chadha, 7-Eleven Franchisee Store Owner

RE: Int. 1547-2017 Tobacco License Cap Bill

Chair Johnson and Members of the Committee:

Thank you for allowing me to testify before you today. My name is Mittin Chadha and I own a 7-Eleven convenience store located at 3508 East Tremont Avenue in the Bronx.

I have 10 employees and have been a small business owner for 11 years.

I am here to ask for your help because of the proposed bill to limit new tobacco licenses.

If this passes, it would significantly financially harm the value of my store. I am responsible convenience store owner. My store's employees are trained and provide friendly service and convenience to our customers. In addition, 7-Eleven goes above and beyond training with very strict compliance checks. On a regular basis my store is mystery shopped to ensure that my staff is properly checking ID on adult purchases.

Under this proposed bill, when I go to sell my business, I will likely not be able to sell it at its rightful valuation. That's because my store will be in a district with license caps and a new tobacco permit likely will not be granted to the new potential owner.

Tobacco sales are approximately 20 percent of my business so if I cannot sell it with that license being available to the next owner, it devalues my business by many thousands of dollars. I estimate the loss to me to be $100,000 if this bill passes.

I've worked tirelessly to build up business at my store to support my family and I contribute to my community. It is unfair to take that value away from me. This is my livelihood and we are selling legal products.

If this becomes law, I also believe jobs will be lost when small business retailers like me close and the city will also lose tax revenues on lost tobacco and related sales. Our tobacco customers buy beverages and snacks, too.

If our customers are forced to go elsewhere for their tobacco purchases, we will lose more sales than just legal tobacco products.

Also, if this becomes law, it could subject me to possibly losing my license permanently if I accidently miss the renewal date by a day for any reason. That's because I would have to apply for a new license and those would not be available. This is very concerning.

I am proud of the work I do and my staff. As a small business, I contribute directly to my store's neighborhood and my community. Please consider the harm this legislation would cause.

Also, another license bill is on your agenda and it's somewhat concerning. That's the proposed high license fee bill. It would increase the current tobacco license fee from $110 to $340. I ask you to consider reducing that as the new fee is more than triple the current fee. It's another costly increase for my local small businesses.

With that said, the license cap bill is my great concern as I would lose my financial investment in my store and also funding for my children's college education unjustly. I respectfully ask you to vote against this tobacco license cap bill.

Thank you for hearing my concerns and I will try to answer any questions you may have.

FOR THE RECORD

April 27, 2017
TESTIMONY OF LAWRENCE A. MANDELKER for
THE NEW YORK METROPOLITAN RETAIL ASSOCIATION (NYMRA)
COMMITTEE ON CONSUMER AFFAIRS
Chair: Hon. Corey Johnson

NYC COUNCIL INTRO 1131-A

Chair Johnson and members of the Committee: I represent NYMRA, the New York Metropolitan Retail Association. NYMRA is an organization of national chain retailers operating in the City of New York. A few of our members have retail stores that contain a pharmacy within the meaning of Intro 1131-A, at which tobacco products are available for sale.

Because of the acknowledged detrimental effects that smoking has on health, government has tried to discourage the use of tobacco products. The Federal Government requires explicit warnings on cigarette packs. The State and others have recovered millions in damages from tobacco companies and used the proceeds to fund a series of graphic commercials about the health risks and consequences of smoking. The State and City have imposed substantial excise taxes on tobacco products to discourage their purchase; and the City prohibits the sale of tobacco products to those under 21. New York City has gone even further by banning smoking in places of public accommodation and gathering – including places that are outdoors. But government has yet to place tobacco on a list of controlled substances and banned its possession and/or sale.

A recent article in the Daily News argues that there is a glut of tobacco selling outlets in the City, 8,992, to be exact. 2,725 are in Brooklyn, 2,196 are in Manhattan, 2,117 are in Queens, 1,542 are in the Bronx and 412 are in Staten Island. There are calls to reduce the number of outlets by half.

Intro 1131-A will eventually prohibit retail stores containing a pharmacy ("Retail Stores/Pharmacies") from selling tobacco products. I am advised that NYMRA's members operate approximately 300 Retail Stores/Pharmacies in the City. Prohibiting them from selling tobacco products would reduce the number of outlets by only 0.03 (3%), and that's by outlet, not by volume.

We understand the rhetorical contrast being made between a seller of medicine and a seller of tobacco. But this is about much more than a nice turn of

phrase. For years, NYMRA has been warning that brick and mortar retail – a source of entry level and upwardly mobile employment – is under siege by its online competitors. A day doesn't go by without another digital or analogue article discussing the stresses on brick and mortar retail. So what does any of this have to do with Intro 1131-A?

"Department stores" are based on a singular concept. A customer enters to purchase a particular item and notices a second item the customer wants to buy at a nearby counter or display. The customer winds up buying both items. I am advised that measured by sales proceeds, by themselves, tobacco products, are far from a Retail Stores/Pharmacy 's most important source of revenue. But as a product that brings customers into the store where they are exposed to, and often purchase other products for sale, the availability of tobacco products for sale has a significant impact on profitability.

Under Intro 1131-A, tobacco products will continue to be for sale at other retail stores. Those seeking to purchase tobacco products will shop at retail stores that do not contain a pharmacy. They will be exposed to, and purchase the other products offered for sale. Such stores will have a competitive advantage over Retail Stores/Pharmacies. In effect, the City will be picking winners and losers. Lower sales will adversely impact employment, including employment of "opportunity youth," those 16-28years without jobs.

Intro 1131-A only affects Retail Stores/Pharmacies. No matter how high the volume of its sale of tobacco products, no matter how close to a school or another seller of tobacco products, non-pharmacy retailers will still be free to sell tobacco products. Their ability to attract foot traffic to their stores – stores that directly compete with Retail Stores/Pharmacies – will remain undiminished. As salutary as Intro 1131-A's goals are, its effect is to disadvantage only one class of merchant, without significantly reducing the sale of tobacco products in the City.

There must be other ways that retailer-pharmacies can assist the City in its efforts to reduce tobacco use. NYMRA and its relevant members would welcome an opportunity to meet with you and discuss this issue in greater depth.

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FOR THE RECORD

April 27, 2017

To: The Honorable Chair Corey Johnson and Health Committee Members

RE: Tobacco License Cap Bill # Int. 1547-2017 and related bills

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Chair Johnson and Committee Members,

On behalf of the nearly 200 members of the United Franchise Owners of Long Island and New York 7-Eleven members in the city and as a 7-Eleven Franchisee, thank you for allowing me to submit this written testimony today. My name is Jack Rugen and I am the President of UFOLINY and have been a 7-Eleven Franchisee for over 26 years.

To provide you with an overview, there are over one hundred and eighty-seven 7-Eleven locations in New York City and **90% of them are independently owned small businesses**. Your local store owners are committed to providing the best service and convenient products to our customers.

Additionally, our 7-Eleven stores have state of the art software that prompts sales associates to ask for identification when tobacco products are scanned for purchase. All employees are trained to age verify when adult products like tobacco are purchased. In fact, we have a 97% compliance rate for sale of age-restricted products.

Today, our 7-Eleven small business owners respectfully ask you to vote against the tobacco licensing cap bill # 1547-2017 for many important reasons.

NEW YORK

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Specifically, we ask that you support our maintaining our small businesses value and investment.

If passed, this new law creates tobacco permit caps that would harm current 7-Eleven store owners who have tobacco permits and future business owners. Based upon the bills inclusion of a 50% reduction of new licenses in first two years and the additional assessments and reductions that it would allow – the city will likely have no new licenses available in our districts because the city will already be over indexed. What does this mean to our current store owners?

It means that the hard-working men and women of 7-Eleven and our Franchisees' panel who will testify before you today and who have worked for years and invested in their small business, will lose significant dollars and part of their investment. The value of their small businesses in the community district license cap areas would be significantly diminished because on average 35-40% of their sales are tobacco products.

Additionally, when we decide to retire and sell our small business or grow our business locations, a tobacco permit would likely not be available for a potential store buyer under this proposed bill. **That loss of a store's good will value is estimated to be over $500,000 on average per location because not only are you penalizing the existing and future Franchisee but our Franchisor, 7-Eleven, Inc., because our franchise agreement mandates certain licenses be acquired and maintained effectively altering the franchise agreement.**

We are also concerned that if a new buyer cannot acquire a tobacco license, there are strong indicators that without that income, a store may not be able to continue at that location. What does that mean?

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It means a loss of our locations. It means the loss of branded responsible stores, a loss of grocery and other products for customers including SNAP/EBT recipients, as well as a loss of services including bill payment and more that we provide. That, in turn, means a loss of jobs and revenue for the city.

It is already challenging for a small business in NYC to compete against larger competitors and in a highly-regulated environment. If passed, this bill would be a major impediment that will likely lead to store closures and job loss for our members' convenience stores here.

It is also concerning that, if passed, this law would create a hurdle to further growth in the city. To just maintain the value of our existing small businesses, we ask that the proposed density cap be removed. One possible suggestion would be for stores that sell less than 50% tobacco products to be exempt from the cap initiative.

We truly appreciate the work that you do at City Council to protect and assist your constituents' small businesses like ours. We urge you to act today to protect your local store and vote against this bill. Also, you will also be hearing from 7-Eleven owners who took time away from their stores today to share the impact and economic harm that they will face if this cap bill becomes a law.

Thank you for your consideration of our concerns.

Jack W. Rugen
President

FOR THE RECORD

City of New York
Community Board #1, Queens

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April 25, 2017

Honorable Vincent J. Gentile
Council Member
8018 5th Avenue
Brooklyn, New York 11209

Dear Council Member Gentile:

On April 24, 2017, Community Board 1, Queens Health and Senior Services Committee met to discuss Intro. 139B. After reviewing the bill, Community Board 1, Queens Health and Senior Services Committee voted in favor of this bill with the following stipulations:

Regarding Sanitizing Hookah Equipment and Paraphernalia:

- Second violation should be suspension of the permit with a re-evaluation in 30 days. If the facility is still in violation then the permit will be revoked.

Regarding General Fire Code Provisions:

- Please add fabric and decorations should be flame resistant

In addition:

- Rules over hookah bars may not exceed over the rules of cigar bars.

The results of the Health and Senior Services Committee recommendations will be presented and voted on at the next Community Board 1, Queens Full Board meeting in May.

Thank you.

Very truly yours,

Joseph Risi
Chairman

Attachment

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THE COUNCIL
OF
THE CITY OF NEW YORK

VINCENT J. GENTILE
COUNCIL MEMBER, 43RD DISTRICT
BROOKLYN

CHAIR
OVERSIGHT & INVESTIGATIONS

COMMITTEES
CONSUMER AFFAIRS
ECONOMIC DEVELOPMENT
EDUCATION
PUBLIC SAFETY
LAND USE
ZONING & FRANCHISES

Intro. 139B

- Adds non- tobacco hookah smoking to the Smoke Free Air Act (SFAA)
- Department of Health and Mental Hygiene (DOHMH) issues a permit to non-tobacco hookah smoking establishments at a cost of $25 as long as they:
    - Generate 50% profit from the on-site sale of non-tobacco smoking products
    - Do not owe any civil penalties in relation to tobacco products
    - Do not expand in size or change location
        - Have 180 days to apply and clear up violations
- DOHMH has the right to revoke a permit if the non-tobacco hookah smoking establishment is found to have served tobacco or nicotine in violation of the SFAA
    - The recovery of the costs and expert testimony must be paid by the hookah bar that was found guilty
- Once granted a permit, non-tobacco smoking establishments must follow certain regulations such as:
    - Prohibit minors under the age of 21 entry
        - First violation is $200

        - Second violation is $500 and revocation of non-tobacco smoking establishment permit
    - Cleaning and sanitizing hookah equipment and paraphernalia
        - First violation is $100
        - Additional violation on the same day is $200
        - **No revocation of permit for failure to sanitize**
- DOHMH must educate businesses (and promulgate rules with their input)
- Ventilation and Air Quality/ Air Flow standards that non-tobacco smoking establishments have to follow
    - Hookah establishments would be mandated to meet the same requirements as smoking lounges (cigar bars)
    - **Three year grace period allowed for compliance to mitigate the costs**
- General Fire Code Provisions (as per **FDNY** request):
    - Permit required
    - Required employee to hold a Certificate of Fitness to handle charcoal and other combustible materials
    - Charcoal must be prepared in a vented furnace or oven
    - Smoking paraphernalia must be must be in compliance with FDNY rules to minimize the risk of fire
    - Portable fire extinguishers
    - Decorations must be flame resistant
- The education portion goes into effect immediately while the rest of the bill goes into effect when Intro. 1076 gets passed
    - Only hookah bars that were operating since at least the date of enactment can apply

Testimony of Pace University Environmental Policy Clinic

Before the New York City Council Committee on Health

Hearing on Legislation to Curb Smoking and Tobacco Usage

April 27, 2017

Hello Chairman Johnson and members of the City Council. Thank you for allowing us the opportunity to appear before you today.

I am a member of the Pace University Environmental Policy Clinic. On behalf of my fellow clinicians, who are present here today, I offer our enthusiastic support for the package of City Council bills aimed at further curbing tobacco usage and smoking. In addition, we encourage you to adopt a measure that will outlaw the purchase and possession of tobacco by underage youth.

Our Environmental Policy Clinic has spent the semester studying various state programs aimed at prohibiting possession and purchase of tobacco products by those underage. New York is currently one of only five states in the nation that actually allows the possession and use of tobacco products by those below the allowable age for sale. Indeed, even the leading tobacco producing states, including North Carolina, Kentucky, Virginia, and Tennessee, have instituted a ban for underage possession.

In other words, while it is illegal for a store owner to sell tobacco products to a child, any fifteen year-old can stand on a street corner and smoke a cigarette with impunity. It would be illegal for that same child to possess liquor or drive a car. Yet, smoking at a young age is the start of most lifelong tobacco addictions, leading to a range of fatal and debilitating diseases, including cancer, heart disease and lung disease.

Just this week, we submitted a proposal to New York State Assemblymember Linda Rosenthal and Senator Diane Savino urging them to add a purchase and possession prohibition to their Tobacco-21 bill, which raises the state smoking age to 21. We now urge the City Council to adopt that same measure citywide.

The current memo for the Tobacco-21 bill states, "The key to reducing the number of smokers in New York is to stop them before they start." We agree wholeheartedly. As youth who are part of the targeted age for tobacco laws, it is our position that New York City and New York State should institute every measure possible to prevent underage youth from ever being introduced to tobacco products. The traditional approach of preventing sales alone is not enough. The law should not allow the purchase, attempted purchase, possession and attempted possession of tobacco products by children, adolescents, teens and young adults.

Some statistical research purports to cast doubt on the efficacy of tobacco possession laws in reducing the number of smokers. However, this research misses the point. Outdated and decades old, it was conducted before states and cities instituted aggressive public educational campaigns. It is a confusing message to underage youth that the law bans sale to those underage while enabling any child to possess and use tobacco products. Nearly 90% of adult smokers indicate that they first started smoking before the legal age of sale. In fact, most smokers began in their teen years, and approximately 80% of adult smokers became addicted by the time they were 18. Meanwhile, most who do not take up smoking usually never will. It is incongruous that there is a continuing national debate about outlawing tobacco products generally, when immediately

before us is the opportunity to outlaw tobacco products for the most vulnerable segment of our population, our youth.

5.6 million of those under 18 today will die from tobacco-related diseases. Roughly one-third of those who will eventually die from smoking. In addition, research indicates that the majority of underage youth are introduced to tobacco products by friends and acquaintances, rather than through illegal sale. In addition, evidence also shows that smoking can be a first step toward other substance abuse. New York City law should take every precaution to halt that first step and thereby reduce the risk that kids will progress to other substances.

We examined the law in other states with a primary focus on South Carolina and Washington State. The legislative findings of the Washington law capture well the spirit in which this provision should be incorporated into New York City's municipal law:

> The legislature finds that the protection of adolescents' health requires a strong set of comprehensive health and law enforcement interventions. We know that youth are deterred from using alcohol in public because of existing laws making possession illegal. However, while the purchase of tobacco by youth is clearly prohibited, the possession of tobacco is not. It is the legislature's intent that youth hear consistent messages from public entities, including law enforcement, about public opposition to their illegal use of tobacco products.

The approaches of these two states were of special interest because they did not "criminalize" possession. While the fines are modest, the penalty provisions put in the hands of court the authority to require tobacco education and/or community service. Here is a summary of the provisions:

South Carolina[1]:

- A minor under the age of eighteen years must not **purchase, attempt to purchase, possess, or attempt to possess a tobacco product or an alternative nicotine product, or present or offer proof of age that is false or fraudulent for the purpose of purchasing or possessing these products.**
- **A minor who knowingly violates a provision** of item (1) in person, by agent, or in any other way commits a noncriminal offense and **is subject to a civil fine of twenty-five dollars.** The civil fine is subject to all applicable court costs, assessments, and surcharges
- **In lieu of the civil fine, the court may require a minor to successfully complete a tobacco prevention program, or to perform not more than five hours of community service** for a charitable institution.
- If a **minor fails to pay the civil fine, successfully complete a smoking cessation or tobacco prevention program, or perform the required hours of community service as ordered by the court, the court may restrict the minor's driving privileges** to driving only to and from school, work, and church, or as the court considers appropriate for a period of ninety days

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1 http://www.scstatehouse.gov/sess120_2013-2014/bills/3538.htm

- If the **minor does not have a driver's license or permit, the court may delay the issuance of the minor's driver's license** or permit for a **period of ninety days beginning from the date the minor applies** for a driver's license or permit.

Washington State[2]:

Purchasing, possessing by persons under eighteen—Civil infraction—Jurisdiction.

- (1) **A person under the age of eighteen who purchases or attempts to purchase, possesses, or obtains or attempts to obtain cigarettes or tobacco products commits a class 3 civil infraction** under chapter **7.80** RCW and is subject to a fine as set out in chapter **7.80** RCW or participation in **up to four hours of community restitution, or both.** The **court may also require participation in a smoking cessation program**. This provision does not apply if a person under the age of eighteen, with parental authorization, is participating in a controlled purchase as part of a *liquor control board, law enforcement, or local health department activity.
- (2) Municipal and district courts within the state have jurisdiction for enforcement of this section.

Such an amendment prohibiting tobacco possession and purchase will communicate New York City's intent to close any gap that allows youth legal access to tobacco, and communicate as well that society at-large should embrace the same values. It will establish a consistent set of policies for this and future generations. It will ensure a better and healthier life for teens in particular.

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2 http://app.leg.wa.gov/RCW/default.aspx?cite=70.155.080

And it will significantly decrease the risks associated with the inhalation of secondhand smoke by non-smoking youth.

We respectfully request that you add to your list of anti-tobacco legislation an additional measure to prohibit possession, attempted possession, purchase and attempted purchase of tobacco products by those under the minimum legal age. In this way New York City will close a significant loophole in its campaign to keep tobacco products out of the hands of the city's youth.

Thank you for your attention to our proposal. My colleagues and I are happy to address any questions that you may have.

Abdul Mubarez

President of Yemeni American Merchants Association

3342 9th Street

Long Island City, NY 11106

Testimony of Abdul Mubarez

In opposition of **Int. 1547; Int. 1544A;**

Before The New York City Council-Committee on Health

April 27, 2017

Council Members of the New York City Health Committee,

I am, Abdul Mubarez, president of the Yemeni American Merchants Association, owner of several businesses and a proud member of the Yemeni- American community in New York City.

I strongly oppose these 2 bills that are in consideration today. As a business owner and merchant myself and close friend of many others in my position I can tell you, from firsthand experience, how negatively these bills would affect our community and all New York communities as a whole.

In today's environment where the profit margin in our business is already being reduced daily by online retailers we are fighting to survive. One of our main generators of profit that has not been affected by online retailers and can be bought locally is our tobacco products. By increasing prices and taxes you are essentially killing the business as a whole. These businesses, mostly located in low-income neighborhoods, are also selling hundreds of other products needed by our local communities such as groceries, household appliances, cash and medicine.

If we are unable to maintain our businesses because of the increase in tax and price on tax as proposed by these bills our communities would lose access to all of these essential products.

If you limit the amount of licenses distributed you would eliminate the incentive to open business in these low income neighborhoods. The market for sale or transfer of these businesses will be completely destroyed.

The Yemeni American Merchants are a major staple in NYC as clearly noted by recent events and demonstrations. We are a big community that provide major contributions to our communities. This bill

would create serious harm to our businesses, communities and families. This would not only move the advantage completely to big-name retailers but will also open the door even wider for black market sales of cigarettes.

The assumption of these bill is that by raising the price of the cigarettes you are directly impacting a cigarette smoker's pocket which will in turn encourage them to quit smoking. The only pockets that will be affected by these bills would be local business owners whose pockets are already affected enough.

This bill actually provides further incentive for tobacco user to find alternative, even illegal, means to get their tobacco fix. It will just close the door on where they get all their other products for living and hurts their pocket in that matter.

Council Members, thank you for accepting my testimony and please consider opposing bills 1547 and 1544.

Regards,

Abdul Mubarez

YAMA-President

New York State
VAPOR ASSOCIATION

TRUTH > LIFE > New York JOBS
Representing the TRUTH about VAPING

Commissioner Zucker,

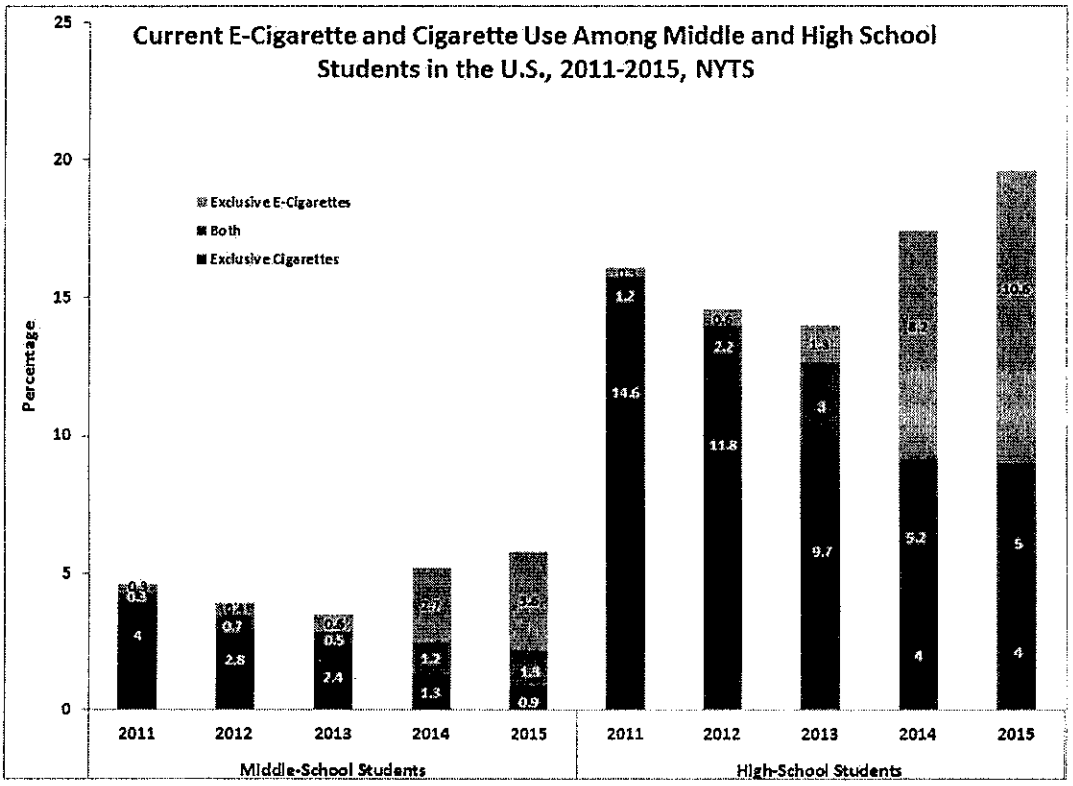
March 17,2017

In a letter sent to S. Babaian, M.A., Technical Analysis Director for the New York State Vapor Association (NYSVA), and in another letter sent to medical professionals in the state of New York, the New York State Health Commissioner made the following statements (in bold below). NYSVA's responses are posted below each statement with references and/or links to corresponding studies and analyses.

YOUTH DATA

Commissioner states... "The good news is that the smoking rate among New York's high school students declined to a historic low of 4.3 percent in 2016. The bad news is that during the last two years, the use of e-cigarettes among youth nearly doubled from 10.5 percent in 2014 to 20.6 percent in 2016.

This statement is correct. NYTS (National Youth Tobacco Survey) Data 2011-2015 shows the youth smoking rate declined to a record low simultaneous with the rise in the current use of vapor products.



https://1.bp.blogspot.com/-WtCROyRJIOo/WHeiZv7Qa3I/AAAAAAAACC4/Im7TQLELJIoFFUthIDtli-GeOh0fjyCWACLcB/s1600/2011-2015%2BNYTS.png

Commissioner states... " Research also shows that the use of e-cigarettes by young people is associated with the use of other tobacco products, including cigarettes." E-cigarette use is associated with tobacco use due to the risk taking nature of the user. Experimentation is typical with adolescents.[4] A causal relationship from tobacco use to e-cigarette use, as is implied in the Commissioner's statement, would show an increase in youth tobacco use based on the NYS Youth Tobacco Survey[5] data showing e-cigarette use doubled, yet the rate of youth tobacco use continues to fall.

A growing mass of evidence shows there is no validity to the statement that e-cigarettes are a gateway to tobacco use. NYTS (National Youth Tobacco Survey) shows daily or frequent use of vapor products is under 4 percent for all subgroups of youth except when including current daily/frequent tobacco users (10 percent).[6] NIDA website shows data from Monitoring the Future study that past 30 day e-cigarette use among youth has decreased from 2014 - 2016 for 8th, 10th and 12th Graders.[7][8] This is likely due to a slowing of experimentation as many youth had already tried the product upon first introduction into the US Market.[9] Studies show that only a small percentage of the small number of youth using e-cigarettes are likely using them with nicotine.[10]

> "Current e-cigarette users at baseline were no more likely to progress to current smoking than young adults who were not using e-cigarettes."[11]
> Michael Siegel, Boston University School of Public Health

The UK has had availability of e-cigarettes and vapor products for about 2 years longer than we have here in the US so they have significantly more users per capita and more long term data than we do. The statement below is from the Royal College of Physicians report entitled "Nicotine without Smoke". This is the same organization that that linked tobacco smoking to lung cancer in the 1960's and instigated the first Surgeon General's Report, Smoking and Health.

> "There are concerns that e-cigarettes will increase tobacco smoking by renormalising the act of smoking, acting as a gateway to smoking in young people, and being used for temporary, not permanent, abstinence from smoking. To date, there is no evidence that any of these processes is occurring to any significant degree in the UK. Rather, the available evidence to date indicates that e-cigarettes are being used almost exclusively as safer alternatives to smoked tobacco, by confirmed smokers who are trying to reduce harm to themselves or others from smoking, or to quit smoking completely." [12]
> Royal College of Physicians report - "Nicotine without Smoke"

Commissioner states... "Many young people are lured by the intentionally sweet flavors and the mistaken belief that e-cigarettes are safe to use."
Fruit and candy flavors appeal to adults and the majority of adult vapor product consumers, are using primarily non-tobacco flavors. The number using primarily non-tobacco flavors is even higher when including only former smokers. Scientists suggest that, as shown above, regular e-cigarette use by nonsmoking youth is currently minimal (0.2 percent) and implementing regulatory restrictions on flavors could cause harm to current adult vapers with no public health benefit to youth. Any potential future risk for youth can be sufficiently minimized by strictly prohibiting sales of vapor products to youth and properly enforcing these restrictions.

Commissioner states... "Both cigarettes and e-cigarettes contain nicotine, which is highly addictive and can cause permanent changes in young, developing brains."
Youth and adolescents should not be using nicotine products. Members of NYSVA have always supported preventing sales to youth under 18 and believes enforcement of these laws should be a priority for the state of New York.

CESSATION DATA

Commissioner states... "...are not approved by the U.S. Food and Drug Administration (FDA) as a cessation method from combustible tobacco."

> "Use of e-cigarettes is associated with smoking cessation and reduction. More randomised controlled trials are needed to assess effectiveness against other cessation methods."

Whether or not they are approved for this purpose, an abundance of data shows this is how they are being used and much research suggests they are effective for this purpose.

> "Data from 2014 National Health Interview Survey indicate that e-cigarettes have not been attracting adult non-smokers or promoting relapse in longer term former smokers. Moreover, the data are suggestive that some recent quitters may have done so with the assistance of e-cigarettes."

"For patients who are already using traditional cigarettes or e-cigarettes, there are currently seven FDA-approved medications for smoking cessation, including five nicotine replacement therapies."
Unfortunately long term efficacy of NRTs for smoking cessation in the real world is typically around 7 percent. This is not acceptable. No other FDA approved medication for any condition, lethal or otherwise, has such a low success rate and can remain on the market.

HEALTH DATA

Commissioner states... "are increasingly used by youth and young adults with potential for deleterious short- and long-term effects;"

A multitude of studies show reduced exposure to tobacco specific toxins from vapor products compared to tobacco smoke and suggest this substantially reduces risk for smokers.[4][18][19][20][33][34][35] There is a lack of correlative or causative evidence showing any short or long term effects from daily use of e-cigarettes for youth or adults (with the exception of smoking cessation)[26]

> "...the hazard to health arising from long-term vapour inhalation from the e-cigarettes available today is unlikely to exceed 5% of the harm from smoking tobacco" [15]
> Nicotine without Smoke pg.189
> Royal College of Physicians

Commissioner states... "In addition, although combustible tobacco products contain more toxins than e-cigarettes, the aerosol produced by e-cigarettes is not harmless water vapor. Rather, it often contains ultrafine particles that have been linked to lung disease;"

This suggests that e-cigarettes have been linked to lung disease and is a highly misleading statement considering there are no studies that show any link between e-cigarettes and lung disease and there is growing evidence to the contrary. E-cigarettes have been shown to benefit the health of users with Asthma and COPD and have even been shown to reverse lung damage from years of tobacco smoking. [9][27][28][29] Ultrafine particles are present at significantly lower concentrations in vapor from e-cigarettes than in tobacco smoke and there is no evidence that ultrafine particles in e-cigarettes contribute to any negative short or long term effects.[20][27][28][39][40]

> "In conclusion, smokers who quit by switching to regular ECs use can reduce risk and reverse harm from tobacco smoking. Innovation in the e-vapour category is likely not only to further minimise residual health risks, but also to maximise health benefits." [15]

Commissioner states... "emit aerosol containing heavy metals, toxic particles and chemicals known to damage the lungs, liver, kidneys and central nervous system;"
"heavy metals such as tin, lead and nickel;"

A research study from Roswell Park Cancer Center, Buffalo, NY, tested 12 brands of e-cigarettes and found that the same metals found in trace amounts in vapor from an e-cigarette were detected in Nicorette® inhalator and also in blank samples. This study concluded there may be another source for the metals measured. [18]

Another paper analyzed the data on heavy metals and concluded that based on currently available data, overall exposure to metals was not expected to be of significant health concern for smokers switching to vapor products." [41] Three additional studies, using older model e-cigarettes to collect their data, showed some levels of heavy metals.[42][43][44] One study

concluded these could be reduced or eliminated by using the proper metals to construct the heating elements of the device and concluded that more research was needed.[44] Advancements in technology and newer products make most of this data obsolete as new technology vapor products use stainless steel and do not use solder in the heating element the way older models did.

Commissioner states... "and volatile organic compounds such as benzene and toluene."
The most recent study produced findings that breathing air had higher concentrations of benzene than inhaling e-cigarette vapor.[45][46] Previous studies showed levels of Benzene to be at nontoxic levels, below detection limits and magnitudes of order lower than in tobacco smoke.[19][34][35][47, 48]

Commissioner states..."But e-cigarettes are not safe."
To state unquestionably that e-cigarettes are not safe is irresponsible. This is especially true when all evidence suggests they are most frequently used as a substitute to combustible tobacco, one of the foremost causes of preventable death in the world.

LEGISLATION DATA

Commissioner states... "As a result of this mounting evidence, New York State is considering legislation to add vapor products to the Clean Indoor Air Act "

> "In this study, the data suggest that any additional chemicals present in indoor air from the exhaled e-cigarette aerosol, are unlikely to present an air quality issue to bystanders at the levels measured when compared to the regulatory standards that are used for workplaces or general indoor air quality."[42][47]

No studies to date show toxic levels of any substance in secondhand vapor. Studies show that vapor products produce significantly lower levels of toxins than those found in tobacco smoke.[12][28][29][33][34][35][37][39][45][47, 48][49][50][52] To treat the products the same as combustible tobacco does not make sense for public health. Including electronic cigarettes in the Clean Indoor Air Act forces former smokers outside into an environment filled with secondhand smoke and exposes them to a product they are trying to avoid which has the potential to cause relapse to smoking. An indoor ban will only serve to convince people that e-cigarettes are the same as cigarettes and discourage use of a product that, if positioned properly, could have a tremendous positive impact on public health.

> "For all byproducts measured, electronic cigarettes produce very small exposures relative to tobacco cigarettes. The study indicates no apparent risk to human health from e-cigarette emissions..."[47]

Commissioner states... "...and impose a state tax on e-liquids and gels."
Encouraging a sin tax on these products, often used in the state of New York because they are less expensive than cigarettes, discourages smokers from switching to what is, by your own admission, a less toxic product.

> "The rationale of tobacco harm reduction is to make nicotine products that are satisfying as a smoking substitute available to smokers at least as easily as cigarettes, and at competitive prices, hence providing all smokers with an easily obtainable lower-risk alternative to smoking."

Putting a significant tax on tobacco products only discourages legal purchase of that product and encourages online skirting of sales tax, dangerous DIY (Do-It-Yourself) mixing of e-liquid, and black market purchases. New Yorkers would be using unregulated, untested liquids made without following industry standards and GMPs (Good Manufacturing Processes). In the case of black market manufacturing and DIY e-liquids, this presents a huge risk to public health.

> "In the face of a rapidly evolving nicotine-product marketplace, policymakers could consider differentially taxing these products to maximize incentives for tobacco users to switch from the most harmful products to the least harmful ones."

Commissioner states..."To date, the evidence on vapor products, electronic cigarettes and similar devices finds the products have no credible public health value in real world use;"

> The NYSVA believes that when the lives of New Yorkers are at risk, and the consequence is prolonging use of a lethal substance like combustible tobacco, making statements that are not supported by scientific data can have deadly consequences.

We hope the evidence we have provided will be used to enact public policy that is in the best interest of the health of the people of the State of New York. If after reviewing the studies cited above, the Commissioner or Dr. Juster would like to meet and discuss the evidence I am happy to come discuss the data in person. We have contacted Dr. Juster at the Bureau of Tobacco and await his reply with the data that supports the Commissioner's statements and the mounting evidence referenced in the letter we received.

Discouraging smokers and former smokers from using a product that has great potential to reduce the risk of harm from combustible tobacco is "tantamount to public health malpractice".

S. Babaian
Technical Analysis Director
New York State Vapor Association

Additional signatories include...
Jeff Stier Senior Fellow, National Center for Public Policy Research
Murray Laugesen Founder, Health New Zealand
David T. Sweanor J.D. Centre for Health Law, Policy & Ethics, University of Ottawa
Bill Godshall Executive Director, Smokefree Pennsylvania
Greg Conley President, American Vaping Association
Timothy McAuley MS, PhD Founder, Consulting for Health, Air, Nature, & a Greener Environment, LLC

Included addendums:
Response to letter from the Commissioner Michael Siegel, Boston University School of Public Health
The Heartland Institute Public Policy on E-cigarettes

Sent to...
Harlan.Juster@health.ny.gov
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Tina.Mazula@health.ny.gov
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gov.cuomo@chamber.state.ny.us

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Bill de Blasio's Ideas for E-Cig Regulations Are Anti-Science

Research shows a correlation between the rise of vaping and a decrease in smoking.

1:59 PM, Apr 26, 2017 | By Alice B. Lloyd - http://www.weeklystandard.com/print/bill-de-blasios-ideas-for-e-cig-regulations-are-anti-science/article/2007786

When former New York City mayor Michael Bloomberg banned smoking in public parks, it made logical sense from a certain autocratic urban-beautification standpoint. Who wants tobacco smoke stinking up their stroll along the Lilac Walk? I grumbled at the time, but the prohibition, which was followed two years later by more anti-smoking measures, at least bore some semblance to reason. The same cannot be said for his successor's bouquet of punitive policy proposals, which combine a tax on tobacco with a cap on e-cigarette retailers in the five boroughs.

Progressive mayor Bill de Blasio, with these new regulations, would secure for the city of cities a distinction that many assumed it held: the most expensive pack of cigarettes in the nation at $13. But the most important——and least logical——of these measures is a a licensing mandate and cap on the number of e-cigarette retailers.

Retailers who sell e-cigs will have a finite time frame in which to apply for a license from the city to keep selling vape products and attendant paraphernalia. These range from cigarette-like "vape pens" with replaceable cartridges that click into place where a filter would be to the more esoteric contraptions that need to be refilled with a nicotine-infused potion. The wide world of vaping spawned its own subculture and grew a new industry. According to public health experts, at least, this trend has been a boon to the developed world's well-being.

Nicotine addicts who make the switch from combustible cigarettes to vaping are less likely to relapse than smokers who slap on a nicotine patch or go for the gum. And while there's much more to the e-cigarette—much more to its marketing, certainly—than a saintly plea for smoking cessation, even a smoker who moves to e-cigs spares herself 95 percent of its ill-effects. Or so says the Royal College of Physicians, the British professional body that's set an international standard in the medical field since the Tudors reigned. (The same Royal College tied tobacco to lung cancer in 1962, two years before our surgeon general.)

Nearly a year ago, a report from the RCP determined e-cigarettes to be a "harm reduction" tool and a "gateway from smoking" rather than the opposite as many have alleged and still do. Their recommendation: "In the interests of public health it is important to promote the use of e-cigarettes, [nicotine replacement therapy] and other non-tobacco nicotine products as widely as possible as a substitute for smoking in the UK." The same report concluded, "Although it is not possible to precisely quantify the long-term health risks associated with e-cigarettes, the available data suggest that [e-cigarettes] are unlikely to exceed 5% of those associated with smoked tobacco products, and may well be substantially lower than this figure." In other words, combustible cigarettes are at least 95 percent worse for you than e-cigs.

And yet—in the very same week progressives set aside to celebrate the achievements of objective science—the city's answer is to cap the number of retailers licensed to sell a medically preferable alternative to combustible tobacco.

New York City's handling of conventional cigarettes will only encourage the black market to find a way. (Australia's prohibitively steep tobacco tax hikes, for instance, carved out a new criminal underworld.) E-cig restrictions pretty much guarantee it: "If you begin to chisel away at the number of stores that can legally sell e-cigarettes," public health advocate Jeff Stier told me, "then you further increase the likelihood that people are going to go to the black market—because you're making harder for them to quit."

A recent survey from the Centers for Disease Control found that e-cigarettes are the most popular path away from smoking: Nicotine addicts who switch to e-cigs have a higher cessation rate than than those who choose one of the other nicotine-delivery alternatives. As popular, and demonstrably less deadly, cessation tool e-cigs should be widely available—and according the Royal College of Physicians, they can be prescribed.

With the city government already in the business of telling New Yorkers what to do, "We should really be encouraging more e-cigarette outlets, not fewer," said Michael Siegel, a professor of public health and medicine at Boston University and tobacco control expert. "Because the more that cigarette smokers have access to these alternatives, the easier it will be for them to quit smoking," he added, commonsensically.

Common sense hasn't shaped the city's tobacco policies, though. When the city scolds, "In 2015, 15.9 percent of New York City high school students were e-cigarette users," one has to wonder—would anyone rather these kids were smoking Camel straights?

CDC data on high-schoolers shows that vaping has increased at the same time cigarette smoking has plummeted. Dr. Brad Rodu, a professor of oncology at the University of Louisville School of Medicine, who's made an intensive study of the otherwise overlooked implications of the federal findings, won't go so far as to say the availability and popularity of e-cigarettes have caused the dramatic decrease in cigarette smoking.

"But when somebody tells me that e-cigarettes are going to raise smoking rates among children, this is evidence that that isn't happening," he said. (The Royal College of Physicians reached the same conclusion last year.) Although any real or perceived risk to their overall well-being inspires an instinctual panic, younger generations' health shouldn't broadly take precedent over their parents' and grandparents'—certainly not when it comes to public health policy that ought to help as many people as possible.

Dr. Riccardo Polosa, director of the Institute of Internal Medicine and Clinical Immunology at the University of Catania, takes the causal leap Rodu wouldn't. "The increasing prevalence of e-cigarette use between 2010 and 2015 has coincided with the sharpest declines in the smoking rate among U.S. youth and young adults on record, while e-cigarette use is already starting to decline," Dr. Polosa told me via email, adding that, "The surgeon general may in future reports wish to give greater consideration to the possibility that the next generation of young Americans will be decreasingly likely to start smoking tobacco because of, not in spite of, the availability of e-cigarettes."

And in the meantime, the poorest of the poor—the people likeliest to remain inveterate smokers, and to buy and sell loose, black-market cigarettes (Eric Garner's crime, incidentally)—bear the brunt. As Dr. Polosa stirringly puts it, "Regulators are targeting the poorest smokers, condemning them, not only to an increased economic burden, but also to lives rampaged by further serious disease, lower quality of life, and premature death."

A policy package likely to disadvantage the underclasses is pretty sharply inconsistent with the Sandinista mayor's ideological underpinnings (less so their historical outcomes). The combined effect of taxing conventional cigarettes and restricting the sale of their less harmful modern alternative may help Mayor de Blasio shine on his activistic gleam leading into election season. Otherwise, it's poised to do more harm than good.

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7109 Route 22, West Chazy NY 12992

New York City Council Health Committee Members,

My name is Spike Babaian. I am the Technical Analysis Director for the New York State Vapor Association. We are a registered lobbying organization for the vapor product industry and consumers representing more than 600 New York vapor product businesses with more than 2200 employees and hundreds of thousands of customers.
A few days ago, we sent an email to all of you with some of the documentation I am presenting today because it contains electronic links to scientific studies I refer to.

Re: 1532 -
-NYC already requires an "E-cig Retail Registration License" in the city of New York under NYC Administrative Code 17-513.3. Additional licensing is unnecessary.
-By passing a law that no new vapor product locations may open, tobacco shops will outnumber vapor product retailers by 1000 to 1 and it will remain that way if this law is passed. This will further encourage the use of combustible tobacco by making it easier to obtain tobacco than vapor products.
-New York City Vapor Shop Retailers employ nearly 400 people in our city. If these shops are unable to get a license in time or unaware that they need one, they will be closed and their employees will have no jobs. These shop owners are not big tobacco. They are small mom and pop stores.
-Tobacco sales are increasingly being restricted in pharmacies because of decades of evidence showing harm from use of combustible tobacco. No studies suggest harm from proper use of e-cigarettes. Nearly all evidence suggests they increase smoking cessation which benefits individual and public health by reducing smoking and production of secondhand smoke.

Re: 1140-
When City Council added vapor product use to the Indoor Air Ban, it was said that there was not enough science to show safety, even though we did provide a handful of studies back in 2013. The Council members admitted they were banning indoor use because they were afraid it was confusing to business owners and would make it hard to enforce the smoking laws, but not because there was any evidence it was harmful to bystanders. Just over 3 years later we have nearly a hundred studies that show evidence that secondhand vapor is not harmful to bystanders. Many of these studies were cited in the letter I sent to the NYS Health Commissioner included in your packet.

Without science showing that there is risk of harm to bystanders, this legislation causes people to think the product is harmful when there is no evidence showing this. I would encourage you to ask the people supporting this bill to show you evidence that there IS harm to bystanders. NOT a statement from a person saying that it is harmful, but ACTUAL science showing evidence it is

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harmful. And if they do, I would encourage you to READ the actual study. Does it say they could "potentially" be harmful? Or that they have evidence it IS harmful?

The Mayor has said on the news that e-cigarettes are NOT a safe option. This has caused dozens of people who have been NON smokers for a long time to come to my shop and ask if they should just go back to smoking instead of using an e-cigarette. Is that what we want?

As proposed, the bills will slow the decline of smoking in NYC by limiting adult access to vapor products which have been shown over and over to increase smoking cessation with more efficacy than any FDA approved smoking cessation method. Even recent CDC data showed that more adult smokers choose to use e-cigarettes as a method of quitting smoking than any other product.

The Mayor suggests that 12,000 NYC residents die each year from tobacco smoking related illness. How many have died GLOBALLY from actually using vapor products or from an illness caused by using the products in the last 14 years?

Spike Babalan
Technical Analysis Director
New York State Vapor Association
516 902 0824

About Us: The New York State Vapor Association (NYSVA.org) is the first non-profit organization in New York made up of and dedicated to vapor product small business owners. NYS has more than 600 New York vapor product businesses with more than 2200 employees and hundreds of thousands of customers. The NYSVA board of directors has educated researchers, legislators, government agencies and stakeholders for 8 years, locally, statewide, federally and internationally.

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Smoking rate of teens is increasing in areas where their access to vapor products is restricted.

- "[E-cigarette] age purchasing restrictions are associated with an increase in adolescent cigarette use." Published in *Preventative Medicine*, Weill Cornell Medicine
  http://www.sciencedirect.com/science/article/pii/S0091743516000396
- "...as a result of these bans, more teenagers are using conventional cigarettes than otherwise would have done so." says author, Dr. Abigail Friedman.
  http://scholar.harvard.edu/files/afriedman/files/how_do_electronic_cigarettes_affect_adolescent_smoking_circulate_0.pdf
- "It appears that some portion of the decrease in e-cigarette use...may come at the cost of higher conventional cigarette use, at least in the short-term until the youth has aged out of the restrictions...." National Bureau of Economic Research (NBER) :
  http://www.nber.org/papers/w23313.pdf
- "We show that ENDS MLSA laws had the unintended effects of increasing pregnant teen's [tobacco] cigarette use." Princeton University, Woodrow Wilson School of Public and International Affairs
  http://www.nber.org/papers/w22792.pdf

Growing evidence shows vapor products are not a gateway to cigarette use.

- NYTS (National Youth Tobacco Survey) Data 2011-2015 shows the youth smoking rate declined to a record low simultaneous with the rise in the current use of vapor products.
  https://goo.gl/qbcWO7
- "The national trends in vaping and cigarette smoking do not support the argument that vaping is leading to smoking," Lynn Kozlowski, University at Buffalo and the University of Michigan *Journal Drug and Alcohol Dependence.*
  https://medicalxpress.com/news/2017-03-e-cigarettes-gateway-published.html#jCp
  http://www.drugandalcoholdependence.com/article/S0376-8716(17)30023-6/abstract
- "To the extent that electronic cigarette use remains distinguishable from smoking combustible cigarettes there is a possibility that vaping may be associated with further denormalization of smoking."
  https://clinmedjournals.org/articles/iaarm/international-archives-of-addiction-research-and-medicine-iaarm-2-023.pdf
- "There are concerns that e-cigarettes will increase tobacco smoking by renormalising the act of smoking, acting as a gateway to smoking in young people, and being used for temporary, not permanent, abstinence from smoking. To date, there is no evidence that any of these processes is occurring to any significant degree in the UK. Rather, the available evidence to date indicates that e-cigarettes are being used almost exclusively as safer alternatives to smoked tobacco, by confirmed smokers who are trying to reduce harm to themselves or others from smoking, or to quit smoking completely." The Royal College of Physicians report, *Nicotine without Smoke:*
  https://www.rcplondon.ac.uk/news/promote-e-cigarettes-widely-substitute-smoking-says-new-rcp-report

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Opposition to Including E-cigarette Use in Public Smoking Bans

➢**E-cigarettes do not contain tobacco or produce smoke during proper use. No evidence suggests harm or risk to bystanders from secondhand exposure.** https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-14-18

➢**E-cigarette aerosol was found to contain lower levels of volatile organic compounds than exhaled human breath.** https://www.ncbi.nlm.nih.gov/pubmed/26243705

➢**Public vaping bans inhibit "Accidental Quitting" phenomenon (smokers who vape where smoking is not allowed, but go on to quit smoking cigarettes completely) and eliminate one of the biggest incentives to try e-cigarettes.**

➢**Indoor bans force former smokers to stand in smoking sections and be involuntarily exposed to toxic secondhand smoke. Many slip back to smoking combustible cigarettes. We don't ask recovering alcoholics to drink water in a bar.**

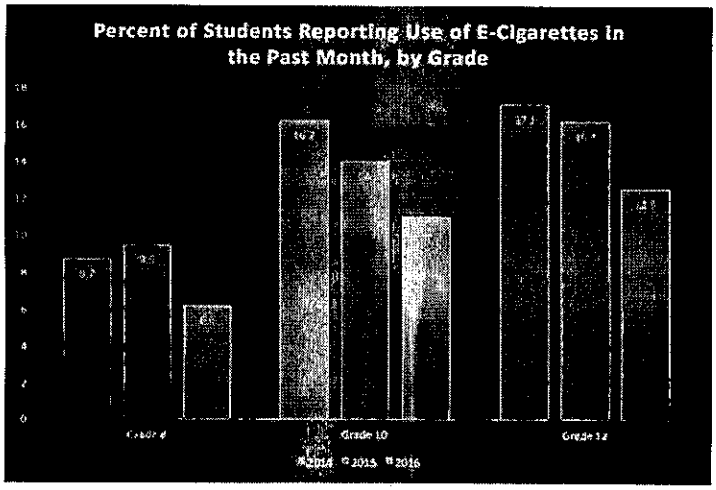
➢**"Vaping bans are "a cosmetic regulation aimed at people who 'look like' they are smoking." "Such bans stigmatize vapor products as just as dangerous as smoking and deter smokers from switching to the less harmful products."** https://www.heartland.org/publications-resources/publications/vaping-e-cigarettes-and-public-policy-toward-alternatives-to-smoking

➢**E-cigarette use in public view improves public health by inspiring smokers to switch to vapor products, and reduce their health risks by an estimated 95%.** "In the interests of public health it is important to promote the use of e-cigarette...as widely as possible as a substitute for smoking." https://www.rcplondon.ac.uk/projects/outputs/nicotine-without-smoke-tobacco-harm-reduction-0

➢**Many business owners in New York have set their own vaping policies, and should retain the right to allow or disallow vapor product use with required signage.** NY employers who have encouraged employees to switch to vapor products have seen benefits to their employees' health and productivity.

➢**Research data does not support the "gateway" theory for youth.**
http://www.sciencedirect.com/science/article/pii/S0376871617300236
Teen smoking rates are at historic lows, and teen e-cigarette usage has dropped from 2013-2016 nationally.

➢**480,000 Americans die every year from smoking related diseases--the health risks to smokers who don't quit because e-cigarette use is prohibited far outweigh any good done by eliminating their sight in public spaces.**



National Institute on Drug Abuse, Monitoring the Future Survey

McKeganey et al. Int Arch Addict Res Med 2016, 2:023
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Addiction Research and Medicine

Research Article: Open Access

Visible Vaping: E-Cigarettes and the Further De-Normalization of Smoking

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Abstract

Background: With the growth in the use of electronic cigarettes in many areas concerns have increased that these devices, enabling users to inhale nicotine and flavored liquids in aerosolized form, might result in the renormalization of smoking and ultimately to an increase in smoking prevalence. The current study describes the views and behavior of a sample of non-smokers who have witnessed electronic cigarette use (vaping) on frequent occasions. The aim of the research was to identify whether such visible vaping was having a notable impact on how this sample of non-smokers viewed smoking, their likelihood of starting to smoke and their attitudes towards smoking and vaping.

Methods: Semi structured interviews were undertaken with 100 non-smokers recruited from Scotland and the north of England. Interviews were undertaken by trained peer interviewers, audio recorded and subjected to detailed thematic analysis.

Results: Visible vaping was commonly reported by interviewees who typically interpreted such vaping as indicating that the individual was seeking to reduce or cease his or her smoking. Whilst the sight of someone using an e-cigarette could stimulate curiosity on the part of non-smokers as to what the experience of vaping was like there was little indication that our sample of non-smokers were intending taking up vaping on a regular basis. There were indications from our interviews that visible vaping had resulted in either no change in what individuals assessed as their likelihood of to smoke and for a minority of interviewees visible vaping had resulted in a reduced likelihood of smoking as assessed by interviewees.

Conclusions: To the extent that electronic cigarette use remains distinguishable from smoking combustible cigarettes there is a possibility that vaping may be associated with further de-normalization of smoking.

Keywords

E-cigarettes, Renormalization, Smoking, Young people, Semi-structured interviews

Introduction

For at least the last twenty years a key part of global tobacco control policies has been to de-normalize smoking, that is to turn smoking from being a common place and commonly accepted behavior, to making it an unusual, socially stigmatized and unaccepted behavior. Policies aimed at facilitating the de-normalization of smoking include the requirement to place graphic health warnings on tobacco packaging, the ban on smoking in enclosed public spaces, the ban on smoking in cars where children are present, the ban on advertising of tobacco products, the ban on the sale of tobacco products to young people, and the requirement to market tobacco products in plain or standardized form. Collectively these tobacco control policies have succeeded in making smoking both less visible and less socially acceptable and, when combined with serial increases in taxation applied to tobacco products, have been shown to be associated with a sustained reduction in smoking prevalence [1-6].

In contrast to the reduction in smoking prevalence that has been witnessed in many countries there has been a marked recent increase in many of the very same countries (including both the U.S. and the U.K.) in the use of electronic cigarettes. According to the U.K. based "Action on Smoking and Health" anti-smoking lobby group, there are approximately 2.8 million e-cigarette users in the UK, of whom the majority (51%) are current smokers, 47% are former smokers and 2% are never smokers [7]. Within the United States, the Centers for Diseases Control and Prevention have estimated that there may be 8.34 million current e-cigarette users (Centers for Disease Control and Prevention, 2016). According to Schoeborn and Gindi [8] around one in ten adults within the U.S. has used an e-cigarette at least once. In the light of those figures it is perhaps not surprising that the e-cigarette industry has been projected to be worth $50B by 2025 [9].

E-cigarettes have been characterized by Public Health England as beingup to 95% less harmful than combustible tobacco products [10]. Recent research from the U.K. has also shown that e-cigarettes may have an important role to play in facilitating smokers quit attempts. Researchers working on the UK based "Smoking Toolkit Study", which involves regular assessments of a large cohort of smokers, have reported that individuals trying to quit smoking using e-cigarettes were more likely to remain abstinent than those seeking to quit using either "over the counter" nicotine replacement or a cold turkey approach [11]. Farsalinos, et al. have recently reported evidence of e-cigarettes having helped a very large number of former smokers to quit smoking drawing upon European wide survey data from over 27,000 vapers [12] According to the Royal College of Physicians, "e-cigarette use is likely to lead to quit attempts that would not have happened", and in a proportion of these to successful cessation [13].

Alongside such positive assessments, concerns have been expressed regarding the potential adverse impact of e-cigarettes. Attention has been drawn to the unknown harms that may be

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associated with long term e-cigarette use [14], to the accuracy in the labeling of e-cigarettes particularly with regard to misleading information on the nicotine content of e-liquids [15]; to the potential of e-cigarettes to increase levels of nicotine dependence [16,17] to the combined use of e-cigarettes and combustible tobacco products [18-20], to the risks of former smokers being reintroduced to nicotine dependence as a result of taking up e-cigarette use after having quit smoking [21], to the risks associated with second had (passive) vaping [22-24] and to the manufacturing quality of some e-cigarettes with reports of devices exploding and causing burns [25].

Alongside these various concerns, attention has also been repeatedly drawn to the possibility that e-cigarettes might act as both a gateway to smoking and a mechanism through which smoking might be renormalized. Arrazola and colleagues [26] analyzed data from the National Youth Tobacco Survey and identified that e-cigarette use in the last 30 days increased from 1.5% of high school students in 2011 to 13.4% in 2014). Leventhal and colleagues have shown that ninth grade students within the U.S. who had used an e-cigarette were 2.7 times more likely than non e-cigarette users to have initiated smoking over a twelve-month period [27]. Unger and colleagues have reported the results of a survey of 1332 Hispanic young adults (mean age 22.7 years) showing that non-smokers who reported e-cigarette use were more likely to have smoked in the last month compared to non e-cigarette users [28]. Similarly, Wills and colleagues, reported the results of a longitudinal survey of 2338 high school pupils in Hawaii which found that the probability of pupils' smoking was significantly greater in the case of those pupils who had previously used an e-cigarette than amongst those who had not previously used e-cigarettes. The authors of this study have speculated that one possible explanation though which such a gateway effect might be occurring is as a result of the fact that:

...some e-cigarettes mimic the look and feel of cigarettes, and the inhaling and exhaling of e-cigarettes aerosol produces some of the same sensory experiences as smoking a cigarette. This similar experience may contribute towards an inclination towards trying cigarette smoking [29].

Elsewhere Kandel and Kandel have suggested another possible mechanism through which a gateway effect involving e-cigarettes might occur:

Nicotine acts as a gateway drug on the brain, and this effect is likely to occur whether the exposure is from smoking tobacco, passive tobacco smoke, or e-cigarettes [30].

The evidence of e-cigarettes having a possible gateway effect has however been contested by some researchers. Miech and colleagues for example, have recently shown that the proportion of young people using e-cigarettes on a regular basis may be substantially smaller than the number who report any past use. Based on a survey 14,983 school pupils in the US, Miech, et al. report that whilst 26.9% of the pupils had used an e-cigarette in the past, only 4.1% (616) had vaped on more than six occasions in the last 30 days [31]. Similarly, Miech and colleagues have shown that nicotine containing e-liquids were consumed much less frequently by young people than fruit flavored liquids [31]. Similarly, Measham and colleagues, reporting qualitative data from the U.K., found that the attraction of vaping to young people had more to do with the visual appeal of producing large vapor plumes and the variety of available flavors than the issue of nicotine dependence [32].

Alongside the concern that e-cigarette use might act as a gateway to smoking conventional cigarettes attention has also been drawn towards their possible role in renormalizing smoking. According to the World Health Organization:

The renormalization effect refers to the possibility that everything that makes ENDS (electronic nicotine delivery systems) attractive to smokers may enhance the attractiveness of smoking itself and perpetuate the smoking epidemic [33].

of a possible renormalization effect associated with the use of e-cigarettes others researchers have questioned whether a smoking renormalization effect linked to e-cigarettes is occurring. Barrington-Trimis and colleagues [34] undertook research looking at the possible relationship between adolescent e-cigarette use and smoking focusing on the extent to which aspects of the home and school environment of 11th and 12 grade pupils in schools in Southern California increased the likelihood of e-cigarette use and smoking (N = 1694). According to the researchers on this study adolescent e-cigarette use, and a positive e-cigarette social environment, were associated with a doubling in the susceptibility to future cigarette use. Barrington Trimis and colleagues note by way of explanation of these findings that:

The societal "denormalization" of cigarette smoking has been a major achievement of tobacco control efforts and is generally recognized as an important reason for the continuing decrease in the prevalence of smoking; however, the increasing social acceptability of e-cigarette use could potentially lead to the social "renormalization" of smoking behaviors more generally, contributing to increased use of e-cigarettes and cigarettes in adolescence [34].

In contrast, Vasiljevic and colleagues identified very little evidence of a renormalization effect from their study of young peoples' reactions to e-cigarette promotional material:

In an experimental study, we found no evidence that exposing English children aged 11-16 years to adverts for candy-like flavored and non-flavored e-cigarettes increased the low appeal of smoking tobacco, the low appeal of using e-cigarettes, or low susceptibility to tobacco smoking. Nor did it reduce the high perceived harm of tobacco smoking.... Our data provide no support for the renormalization hypothesis, since exposure to e-cigarette adverts did not increase the appeal of tobacco smoking in this sample of children [35].

In assessing whether e-cigarette use might be acting as a gateway to smoking or a means of renormalizing smoking there is a need to complement the various quantitative studies surveying relatively large population samples, with more focused qualitative research that can explore whether, and in what ways, e-cigarette use might be having an impact on the social acceptability of smoking and the likelihood of non-smokers initiating smoking. Previous studies have reported in detail on the e-cigarette users views and experiences of vaping [36]. In this paper by contrast, our focus is on the views and experiences of non-smokers/non e-cigarette users who were witnessing visible e-cigarette use within naturally occurring social situations.

In this study we were particularly interested in the extent to which non-smokers/non e-cigarette users felt able to visually differentiate between vaping and smoking, their views of the people they saw vaping, whether they felt their own and other people's attitudes towards smoking had changed as a result of e-cigarette use becoming an increasingly common sight, and whether they felt their own likelihood of starting to smoke had changed as a result of witnessing people vaping.

Research Methods

In this paper we report the results of having undertaken semi structured interviews with "nonsmoking/non e-cigarette users" who had witnessed people vaping in a wide range of social situations. We felt that semi structured, face-to-face, interviews using trained peer interviewers would be one way of eliciting research subjects' views and experiences of visible vaping whilst minimizing the likelihood of producing a response set of more stylized views that might have been produced had we undertaken focus group interviews. Our team of six peer interviewers (three males three females aged from 17 to 30), all of whom received training within the Centre for Substance Use Research on the methods of qualitative interviewing, were requested to recruit individuals who were non-smokers/non e-cigarette users, aged between 16 to 30, and who had witnessed individuals using e-cigarettes. Non-use of e-cigarettes on the part of our interviewees

e-cigarette on only an occasional, experimental basis.

In total, we interviewed 100 respondents (47 males, 53 females whose average age was 21.2). Interviewees were recruited from Scotland and the North of England from a range of educational/work/social settings. All interviewees were provided with a detailed information sheet on the nature of the research we were undertaking and a signed consent form signaling their willingness to take part in the research. One of the authors (MB), who has extensive experience of qualitative research methods, provided training to all interviewers and provided feedback to each individual interviewer on their first interviews undertaken with research subjects.

The two lead authors on this paper (NM and MB) developed the topic guide for these interviews based on a review of the literature around the possible renormalization effect of e-cigarettes and an exploratory focus group with four young people (aged 17) who were invited to discuss their view of e-cigarettes. The topic guide invited interviewees to describe the circumstances in which they had seen people vaping and whether they had been able to distinguish between visible vaping and smoking, their perception of the various people they had seen vaping, their reactions to visible vaping-including whether the sight of someone vaping had stimulated their own interest in trying vaping, their attitudes towards vaping and smoking-including whether their attitudes towards smoking had changed as a result of witnessing people vaping, whether they felt that the current visibility of vaping had led to a change in the social acceptability of smoking more broadly, and whether in their view their likelihood of smoking had increased, decreased, or remained the same as a result of having seen people using electronic cigarettes. Interviewees were recruited from a wide range of work, leisure and educational settings across Scotland and the North of England and were paid £15 for taking part in the interview process.

All interviews were audio recorded and transcribed by staff within the Centre for Substance Use Research. Individual identifying details were removed from the transcripts which were then read, coded and analyzed by two of the leading authors of the present paper (NM and MB)- both of whom are experienced qualitative researchers. Analysis of the interview transcripts involved reviewing all data extracts around key themes (e.g., recognizing vaping), identifying the most commonly expressed views (how did most interviewees recognize vaping as distinct from smoking) and paying equal attention to both the predominant views and those that were expressed by a minority of respondents. There is a danger in qualitative studies that in writing up the results of either qualitative interviews or observational fieldwork researchers pay disproportionate attention to the most memorable events/views described rather than the most commonly expressed events/views recorded. To further counter this possibility, we have also sought to provide a numerical assessment of the frequency with which various views/attitudes were articulated by interviewers.

Results

Visibility and recognizability of vaping

All of our interviewees had seen people vaping on many occasions and in a wide range of situations:

I've seen people using them walking down the street and they're also getting much more popular. I've seen shops like the Vaper Heaven Shop down in Smithson Street. I've seen people there using them. The engineer I work with uses them, vapes e-cigarettes, so yeah they are obviously popular and getting more popular every day. I've also seen them at music festivals and at gigs, I suppose that's a place where you see them getting used (Female Aged 18).

I see them daily definitely because I think you can smoke them inside some places. I think you now see them more than cigarettes because people can smoke them inside and obviously you can't smoke I said, inside you can't smoke normal cigarettes so anyone smoking inside are smoking e-cigarettes (Male Aged 19).

When asked whether they felt able to easily distinguish between vaping and smoking the overwhelming majority of our interviewees (96%) said that they had no difficulty in visually differentiating between smoking and vaping. Interviewees cited various features of e-cigarettes use and appearance which they said made it very easy now to differentiate between the two activities referring to such features as the larger, often "tank like" appearance of e-cigarettes, the way in which they were typically held in the palm of the hand with all four fingers and thumb wrapped around the device, the large plumes of expressed vapor, the lack of a noticeable tobacco smell and the types of settings (indoors) where the devices would often be seen being used:

You know it's an e-cigarette 'cause there's not many of the ones that are shaped like normal cigarettes now, they just come in like a pen or like the big chunk package machine ones which are odd and there is certainly more smoke that comes off them, and they do have like a more like pungent smell cause of all the different flavours with the whiter smoke (Male Aged 17).

It's quite noticeably different with the huge vape clouds or whatever (Female Aged 19).

Although the vast majority of individuals commented that they were able to distinguish between vaping and smoking,a significant minority [22] commented that this had not always been the case, and that in the past they had sometimes struggled to determine whether the person was smoking or vaping:

I think the first time I saw them it was one of those ones like a cigarette and I did think it was a real cigarette yes (Male Aged 21).

I remember seeing someone in the supermarket doing it and just thinking theywere smoking a cigarette and I remember thinking that was pure weird but that was the first time I'd ever seen it really (Male Aged 23).

It shocked me the first time I saw it. I was on the bus and I was like why is this guy smoking on the bus. Then I realised he was vaping and I was like "oh maybe that's allowed" (Female Aged 18).

By contrast, a very small number of interviewees indicated that they still occasionally felt unsure as to whether the person they were seeing was vaping or smoking:

With ones that are kind of small and disposable, those ones you can't really tell the difference because it's covered in the hand so it just looks like they are smoking something. But like with other ones they are more noticeable because they are bigger and the steam and stuff (Male Aged 17).

The reaction to seeing people vaping

Interviewees were asked about their reaction to the sight of people vaping, whether they were curious about the experience of vaping, what they thought about the people they saw vaping, and whether they felt inclined to initiate vaping themselves. 61% of those interviewed commented that the experience of seeing people vapehad made them curious about what the experience of vaping was actually like. Such comments as the following were typical in this regard:

I suppose I am curious as to how it works but I'm not like ever going to take it up (Female Aged 22).

I am curious in a way but I'm not a smoker so it's never really appealed to me (Male Aged 23).

One third of those who commented that the sight of someone vaping had made them curious said that they had subsequently tried vaping. However, none of those who commented that they had tried vaping,having been curious about the experience, described themselves as having initiated a pattern of frequent vaping. Typically, individuals described having tried vaping on a small number of

My friend was using an e-cig and she was quitting smoking but she had the one without nicotine she liked the feeling of it just in her hand to try to help her quit. So I tried that but it didn't do anything for me. It was a bit pointless (Female Aged 21).

I tried it once but I wouldn't buy my own 'cos I don't smoke. I don't really feel the need to have one and smoke all these different flavours that they have. It doesn't really appeal to me (Male Aged 19).

38% of our interviewees commented that the sight of people vaping had not in any way led them to feel curious about the experience of vaping. Almost all of those who indicated that they had not felt any curiosity as a result of seeing people vape explained this in terms of their perception that e-cigarettes were predominantly being used by smokers as a way of quitting smoking:

I've got no wish to try vaping not at all. I don't smoke so I don't see why I would do it (Female Aged 21).

I've never really been that bothered by it, there's people who have offered me it, like "I've got watermelon flavour do you want to try it?" But it's never really appealed that much to me to be honest. It just kind of seems a bit pointless, like there isn't any really aim to it for me (Male Aged 29).

I probably wouldn't just try it because I don't smoke and just because I don't really like that sort of thing but I do understand it's better than smoking so in a way I do have more respect for the people that are using it to try and quit (Female Aged 19).

Views of smoking and perceived likelihood of smoking

Interviewees were asked whether in their view smoking had become more or less stigmatized as a result of vaping becoming much more visible in recent years. 34% of our interviewees indicated that in their view smoking was now more stigmatized as a result of the popularity of vaping with a number of interviewees expressing their surprise that anybody would now smoke given the availability of what they saw as a less harmful means of consuming nicotine:

I think I hate it even more because I just don't understand why people would still smoke like when there are things like e-cigs around (Male Aged 23).

Yea it has changed in the sense that now that there is a healthier alternative to smoking actual cigarettes yeah I think people should maybe take that into consideration and maybe consider smoking e-cigarettes over actual cigarettes (Female Aged 17).

I think that attitudes towards smoking and smokers have gotten worse. I think there is a much more negative towards smoking than there was back in the day when smoking was a lot more accepted going way back (Female Aged 25).

22% of our interviewees commented that in their view smoking had become less stigmatized as a result of the visibility of people vaping:

I'd say it has become a bit more relaxed because the amount of people you see smoking e-cigs is almost more than smoking cigarettes so I don't know, I'm not quite sure on that question (Female Aged 26).

I would say it (smoking) has become more accepted. For a lot of people it's become a lot more acceptable to see people walking around smoking because of the image of seeing someone walking around with something in their mouth has become a more common because of the vape and the e-cigarette (Male Aged 21).

There are now more options to smoke so it kind of makes it more tailored towards others so more people can do it I guess. So it kind of increases the popularity of smoking (Male Aged 19).

However, the largest proportion of our interviewees (43%) said that in their view the increasing visibility of vaping had not had any notable impact in changing social attitudes towards smoking:

No not really, I feel that they were pretty stigmatised beforehand lot of people have moved on to vaping. But I guess it just doesn't work for some people (Male Aged 19).

No my attitudes towards smoking hasn't changed at all (Female Aged 26).

I think a lot of people just hate smoking altogether and they won't change their view on it (Female Aged 18).

In contrast to the possible impact of vaping on attitudes towards smoking nineteen of our interviewees drew attention to what they saw as the increasing social acceptability (normalization) of vaping itself as something that had occurred in recent years:

Vaping has become more accepted, like it's more incorporated into society. If you see someone smoking a cigarette that smell's there, that horrible unpleasantness when you're walking round someone who's smoked or the breath of someone who smokes whereas with e-cigarettes that's not there, it's sort of socially accepted more (Male Aged 18).

I think it's more that vaping has become more accepted because of the aspect of it being cleaner, nicer, you can smoke it in more places. I think smoking cigarettes becomes less accepted actually. I think people who have been smoking their entire lives won't move on to e-cigs, they'll probably carry on until they die but I think the newer generation will definitely move on to e-cigs (Male Aged 22).

Because vaping has become more and more noticeable you are able to distinguish the difference so easily now. I'd say smoking is probably more frowned upon now but vaping is just like a normal thing to see now (Male Aged 16).

To further explore whether the sight of individuals' vaping had increased the likelihood of smoking, interviewees were asked whether in their view they were more or less likely to smoke now as a result of vaping becoming more visible. The distribution of responses to that question was very stark with 84% of respondents indicating that their likelihood of smoking had remained unchanged even despite vaping becoming much more prominent:

Probably the same. I mean I was quite curious of them at first but just as I was with smoking to start with I think it's just sort of a phase that will die out. For me anyway it just doesn't really interest me (Female Aged 21).

Chances of me smoking are zero- it's just not something that I've had any interest in (Male Aged 24).

I'd say it's stayed the same I've been quite opposed to smoking in any form for a long time so I don't think it's changed particularly (Male Aged 21).

14% of our interviewees indicated that their likelihood of smoking had actually decreased as a result of the increasing availability and access to e-cigarettes:

If I was to smoke now I would go for an e-cigarette because I am scared of getting hooked. So I don't want to get hooked so I would go for the e-cigarette (Female Aged 21).

Clearly it is not possible on the basis of the kind of qualitative data that we have collected to comment on the existence of a causal relationship between an increased or decreased likelihood of smoking and the sight of people vaping. Nevertheless, the predominant view of our interviewees was that their likelihood of smoking had not changed as a result of seeing people vape and in a small number of cases they felt that their likelihood of smoking had actually decreased.

Discussion and Conclusions

The data collected in this study were obtained from a sample of non-smokers whose ages ranged from sixteen to twenty-nine. These individuals were interviewed using a semi-structured instrument (topic guide) by peer interviewers trained in the methods of semi-structured interviewing. Interviewees were recruited from a wide range of work, educational, and social settings by our team of peer

Clearly, one cannot claim that this sample of 100 interviewees is in any way representative of the large population of non-smokers or of the population of non-smokers that have witnessed people vaping. Ours was an opportunistic sample of non-smokers who had seen people vaping, and from whom we could elicit qualitative information on what they saw as the impact of visible vaping occurring in their social world. Our interest was specifically in examining whether interviewees felt confident in their ability to visually distinguish between smoking and vaping, whether the sight of people vaping had stimulated their own interest in starting to vape, how they saw or regarded people who were vaping, whether they felt attitudes -including their own attitudes towards smokers and smoking -had changed as a result of vaping becoming an increasingly common sight and whether they felt their own likelihood of smoking had increased within the context of more widespread vaping in their social world.

Whilst visible vaping was reported to be a common sight the overwhelming majority of our interviewees appeared to have no difficulty in distinguishing between vaping and smoking with attention being drawn to such elements as the design of the vaping equipment, the lack of a tobacco smell, the way in which devices were held in the hand, and the large plumes of exhaled vapor. Typically, vaping was interpreted as a sign that the individual was trying to reduce his or her tobacco consumption and in this sense it was seen to be something that was socially very distant from the non-smokers we were interviewing. Whilst the sight of someone vaping could certainly induce a level of curiosity as to what the experience of vaping was actually like, we found very little evidence of our non-smokers taking up vaping as a regular behavior or expressing an interest in doing so. Amongst those who indicated that they had tried vaping, after having seen people they knew using e-cigarettes, this largely amounted to exploratory use on a small number of occasions. Similarly, whilst just under a quarter of our interviewees indicated that in their view social attitudes towards smoking had softened as a result of more widespread e-cigarette use there was no indications that this had resulted in individual's judging that their own likelihood of smoking had increased. Rather, it appeared that for the largest proportion of our interviewees the visibility of e-cigarette use had no impact in changing their view of smoking. For some of our interviewees the visibility of people vaping had made smoking seem even less appealing.

The claim that e-cigarettes may be serving to renormalize smoking has been made most forcibly in relation to its possible effect on young people-with a number of researchers pointing to the increased likelihood that young people who have tried an e-cigarette go on to initiate smoking [37-39]. Clearly, there is a need to explore the possible gateway effect between initial use of e-cigarettes and subsequent use of combustible tobacco using surveys that collect data from young people over an extended period of time. Through such surveys it should be possible to quantify the relative risk of smoking initiation on the part of e-cigarette using and non e-cigarette using young people.

However, whilst the issue of smoking renormalization is linked in part to the issue of smoking prevalence (and possible gateway) the concept itself cannot be reduced to a measure of smoking prevalence. The notion of renormalization relates to the social acceptability of the activity- in effect whether smoking is becoming more socially acceptable in the aftermath of visible vaping than was previously the case. On the basis of our data whilst it could be said that e-cigarette use is becoming increasingly normalized in social situations, there did not appear to be strong evidence that vaping was leading to smoking itself becoming normalized. Over half (61%) of our interviewees did not feel that their view of smoking had changed as a result of vaping becoming more visible and one third indicated that in their view social attitudes towards smoking were actually more negative within a context in which e-cigarette use was becoming increasingly common place.

research with a younger age cohort than we have studied here to establish whether early teen and pre-teens attitudes towards smoking are changing as a result of the visible use of e-cigarettes. However, the claimed renormalization effect of e-cigarette use has also been suggested to apply to older individuals [39,40]. On the basis of our qualitative interviews with a sample of U.K. non-smokers ranging from those in their mid-teens to their late twenties we have found very little evidence of a renormalization effect occurring.

As has been noted by Voight [41] one of the ways to reduce the likelihood that e-cigarettes might serve to renormalize smoking would be to maintain the visual differences between these activities. To the extent that vaping and smoking are seen as being very different visually and experientially there is a reduced likelihood that increased vaping would lead to smoking becoming more accepted. Indeed, a more likely effect of the growth in the use of e-cigarettes might be the normalization of vaping itself- with some indication in our own data that this may now be occurring. If this is the case, then there may well be merit in seeking to ensure that the existing visual differences between vaping and smoking are maintained.

Within the U.S. the application of recent legislation (Deeming Regulations) have placed restrictions on e-cigarette design and manufacturing which may well see a marked reduction in the availability of the large tank like e-cigarette devices and a return to the smaller, cig-a-like, devices. These regulations are likely to reduce the scope for user modifications of vaping equipment and will likely mean that e-cigarettes appear visually to be much closer to normal cigarettes than is the case at present. In addition, restrictions on the contents of e-liquids will likely see a reduction in the capacity of vapers to produce the distinctive large vapor plumes that were often cited in our research as being key in visually distinguishing between vaping and smoking. Within the European Union (from which the U.K. is currently in the process of withdrawing) similar legislation has been produced (Tobacco Products Directive) which set out regulations governing the design, manufacture, labeling and promotion of e-cigarettes and the constituents of e-liquids. These regulations, as in the U.S., place e-cigarette manufactures under a legal responsibility to provide information on the use and sale of these devices and their impact on public health including their impact on vulnerable i.e., young people. As with the U.S. regulations the E.U. regulations govern maximum refillable tank size (10 milliliters). As a result, these regulations will see the disappearance of the larger refillable tanks that make e-cigarettes very distinctive at present.

In tandem these regulations (both U.S. and E.U.) may well mean that in the future e-cigarettes more closely resemble combustible cigarettes than is the case at present. The danger here, as noted by Voight [41], is that regulation designed to protect public health, and reduce the adverse impact of electronic nicotine delivery systems, give rise to the renormalization phenomenon that others have previously warned about. This would be enormously regrettable given the evidence which we have presented that in their current form e-cigarettes might actually serve an important function in further de-normalizing smoking.

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E-cigarettes a gateway to smoking? Not likely

Date: March 13, 2017

Source: University at Buffalo

Summary: Major national studies provide little evidence that e-cigarette users move to smoking cigarettes as a result, researchers write.

FULL STORY

Are e-cigarettes a gateway product that lead more people, especially teens, to smoke regular cigarettes?

No, according to public health researchers from the University at Buffalo and the University of Michigan writing in the journal *Drug and Alcohol Dependence*.

"The national trends in vaping and cigarette smoking do not support the argument that vaping is leading to smoking," said Lynn Kozlowski, the paper's lead author and a professor of community health and health behavior in UB's School of Public Health and Health Professions.

Kozlowski, PhD, added that research in the U.S. shows that as use of e-cigarettes -- the act of which is known as vaping -- has increased, overall smoking rates have decreased.

Kozlowski's co-author is Kenneth Warner, the Avedis Donabedian Distinguished University Professor of Public Health in Michigan's School of Public Health. Both Kozlowski and Warner are also former deans of their respective public health schools.

"Our analysis focused on the risks for moving from e-cigarettes to cigarettes. There is little evidence that those who have never smoked cigarettes or never used other tobacco products and first try e-cigarettes will later move on to cigarette usage with great frequency or daily, regular smoking," said Kozlowski.

Their paper highlights several shortcomings in studies that appear to show a link between e-cigarette use and subsequent smoking.

For example, many studies use misleading measures for what is actually considered smoking. "Measures of 'at least one puff in the past six months' can mean little more than the experimenting vaper was curious how cigarettes compared," Kozlowski said.

Warner added that in one study, only four e-cigarette users who previously hadn't smoked reported smoking cigarettes when measured again at a later time. "All of them said they'd smoked only one or two cigarettes in the past 12 months," Warner said. "None of the studies was designed to be able to follow up smoking intensity at a later date."

E-cigarette flavorings are another important consideration, because many young people report vaping with only flavorings -- no nicotine. Kozlowski and Warner pointed to a 2015 national survey of eighth- through 12th-grade students conducted by the University of Michigan's Monitoring the Future, an ongoing study of the behaviors,

attitudes and values of American students and young adults and funded by the National Institute on Drug Abuse. The results showed that only 20 percent of the students surveyed who had used an e-cigarette reported that it contained nicotine.

Major national studies also have failed to control for most other tobacco use, including smokeless tobacco, and few have paid sufficient attention to confounding issues such as other alcohol and drug use and mental health issues, the researchers say. Youth who are experimenting with other substances are more likely to also try e-cigarettes or combustible cigarettes, according to the researchers.

"The evidence from the prospective studies is weak at best," Warner said. "All that it demonstrates is that there is a connection between kids who vape and future experimentation with smoking. But we know that these kids are different from those who do not vape. Even if there is a small gateway effect, it is totally swamped by the overall trend toward less and less smoking," Warner adds.

For next steps, Kozlowski and Warner say that regulations are needed to minimize product risks. "The public deserves accurate information on the health risks of e-cigarettes versus cigarettes," Kozlowski said. "From the best evidence to date, e-cigarettes are much less dangerous than cigarettes. The public has become confused about this."

Adds Warner: "The persistent focus on the potential risks to kids has caused adults' understanding of the risks of e-cigarettes to worsen over time. This is likely discouraging adult smokers from using e-cigarettes as a smoking cessation tool."

Story Source:

Materials provided by **University at Buffalo**. *Note: Content may be edited for style and length.*

Journal Reference:

1. Lynn T. Kozlowski, Kenneth E. Warner. **Adolescents and e-cigarettes: Objects of concern may appear larger than they are.** *Drug and Alcohol Dependence*, 2017; DOI: 10.1016/j.drugalcdep.2017.01.001

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New York State
VAPOR ASSOCIATION

TRUTH > LIFE > New York JOBS
Representing the TRUTH about VAPING

"A View that treats all tobacco/nicotine use as equally bad is no longer consistent with the evidence base and represents a runaway rhetoric."
Dr. David B. Abrams,Tobacco Policy Research, Truth Initiative and Professor, Johns Hopkins and Georgetown University

VAPOR PRODUCT TAXATION

"The rationale of tobacco harm reduction is to make nicotine products that are satisfying as a smoking substitute available to smokers at least as easily as cigarettes, and at competitive prices, hence providing all smokers with an easily obtainable lower-risk alternative to smoking."
Saitta et al. 2014 (http://journals.sagepub.com/doi/abs/10.1177/2040622314521271)

- It is dangerous to put a tobacco tax on a product many people use because it is more affordable than the deadly alternative. A tax has the potential to make using vapor products more expensive than smoking cigarettes in the State of NY which could send former smokers back to tobacco.
- Vapor product taxes imposed in other localities have caused hundreds of stores to close/move out of state, caused consumers to purchase online, cost thousands of jobs, caused loss of sales tax, real estate tax and payroll tax revenue.
- Some will make their own liquid or turn to a black market and begin using unregulated liquids which puts the health of many New Yorkers at risk.

VAPOR IN THE CLEAN INDOOR AIR ACT

"...data suggest that any additional chemicals present in indoor air from the exhaled e-cigarette aerosol, are unlikely to present an air quality issue to bystanders at the levels measured when compared to the regulatory standards that are used for workplaces or general indoor air quality."
O'Connell et al. 2015 https://www.scienceopen.com/document?vid=c03acc50-a561-4b7b-950f-877ed93ab566

- NYSVA supports sensible restrictions on use at schools, non-residential municipal buildings, playgrounds, and school buses.
- Without risk of harm to employees, business owners should have the right to choose their own policies at their establishments. Most have done so already. Signage permitting or disallowing use should be required.
- Confining former smokers to the "smoking" section outside is like forcing an alcoholic to go to a bar to drink water.

RAISING THE AGE TO 21

- In New York City, the law encourages kids 18-21 to smoke cigarettes because they are easier to get than vapor products.
- 18 year olds will attempt to buy online with a credit card or get older kids to buy for them
- 18 year olds can die for their country, get married and VOTE. They should be able to choose a much less harmful alternative to smoking.

FLAVORS IN VAPOR PRODUCTS

- Flavors are imperative in vapor products.
- Fruit and candy flavors appeal to adults. The majority of adult vapor product consumers, are using primarily non-tobacco flavors and do not want to be reminded of tobacco cigarettes.
- Scientists suggest that implementing regulatory restrictions on flavors could cause harm to current adult vapers with no public health benefit to youth. Any potential risk for youth can be sufficiently minimized by strictly prohibiting sales of vapor products to youth and properly enforcing these restrictions.

About Us: The New York State Vapor Association (NYSVA.org) is the first non-profit organization in New York made up of and dedicated to vapor product small business owners. NYS has more than 600 New York vapor product businesses with more than 2200 employees and hundreds of thousands of customers. The NYSVA board of directors has educated researchers, legislators, government agencies and stakeholders for 8 years, locally, statewide, federally and internationally.

Public Health Solutions
MERGING RESEARCH AND ACTION

Testimony of Public Health Solutions

In relation to Int. No. 1471-2017, Int. No. 1532 and Proposed Int. No. 1544-A
Before the NYC Council Committee on Health

April 27, 2017

Good morning Chairman Johnson and Council Members. I am Marla Tepper, Vice President of Legal Affairs and General Counsel of Public Health Solutions. We appreciate the opportunity to testify in support of the package of bills before the Council today. Enhancing the City's regulation of tobacco will reduce access to and use of deadly and addictive tobacco products, particularly among youth and young people and contribute to improved public health.

Public Health Solutions is one of the country's largest public health institutes and one of New York's leading nonprofit organizations. We integrate research, policy, capacity building, and direct service in a broad range of areas, including Nutrition, Reproductive Health, Maternal & Infant Healthcare, HIV/AIDS/STD Prevention & Care, and more, directly benefitting over 200,000 adults and children every year. NYC Smoke-Free, a program of Public Health Solutions, works to protect the health of New Yorkers through tobacco control policy, advocacy, and education. The program partners with community members, legislators, and health advocates to support local efforts to end the tobacco epidemic in New York City with the belief that every New Yorker has the right to breathe clean, smoke-free air where they live, work and play.

Int. No. 1471-2017 (Johnson, Salamanca, Gentile and Rodriguez)

Int 1471-2017 would raise the current license fee for tobacco retail dealers from 100 dollars to 340 dollars. Public Health Solutions supports this legislation as it may have a positive effect on community health. At least one research study suggests that an increase in license fees could potentially reduce the number of tobacco retail dealers.[1] Second, a higher license fee could incentivize retailers to comply with all relevant laws, including important laws regarding sales to minors, to avoid incurring additional fees such as costly violations or loss of a license. Finally, the Department of Consumer Affairs might use the increased license fees to engage in increased inspections, enforcement and education of consumers and retailers.

[1] Bowden JA, Dono J, John DL, *et al What happens when the price of a tobacco retailer license increases?* Tobacco Control 2014;23:178-180. http://tobaccocontrol.bmj.com/content/23/2/178.info. Accessed on March 26, 2017.

Int. No. 1532 (Cabrera)

Public Health Solutions strongly supports Int. No. 1532 (Cabrera), which requires the licensing of e-cigarette sellers, caps the number of e-cigarette sellers and prohibits pharmacies from selling e-cigarettes.

Use of e-cigarettes among youth and young adults is a significant public health concern.[2] E-cigarettes are now the most commonly used tobacco product among youth, surpassing conventional cigarettes.[3] The U.S. Surgeon General found that e-cigarette use among high school students increased "an astounding 900 percent" from 2011 to 2015.[4] More than 3 million middle and high school students regularly used e-cigarettes in 2015.[5] And, more than a quarter of youth in middle and high school have tried e-cigarettes.[6]

The e-cigarette industry entices youth with flavors that are especially appealing to young people. In a 2016 Report, the Surgeon General concluded that flavors are the leading reason for youth use. The Surgeon General reported that more than 85% of e-cigarette users ages 12-17 use flavored e-cigarettes; more than 9 of 10 young adult e-cigarette users said they use e-cigarettes flavored to taste like menthol, alcohol, fruit, chocolate, or other sweets.[7]

The taste may be sweet, but the health impacts of e-cigarettes are distinctly bitter. E-cigarettes pose dangers to population health generally, and in particular, to youth. According to the Centers for Disease Control (CDC) and the 2016 Surgeon General's report on e-cigarettes and youth: E-cigarettes are unsafe for youth, pregnant women and fetuses. Exposure to nicotine-containing e-cigarettes during periods of significant brain development, such as adolescence, can disrupt the growth of brain circuits that control attention and learning.[8]

- Most e-cigarettes contain nicotine, which causes addiction and could lead to continued tobacco product use among youth.[9]

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[2] U.S. Department of Health and Human Services. *E-Cigarette Use among Youth and Young Adults: A Report of the Surgeon General—Executive Summary.* Atlanta, GA: 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, 2016. E-cigarettes.Surgeongeneral.gov. Accessed on April 25, 3017

[3] U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. Singh T, Arrazola RA, Corey CG, et al. *Tobacco Use Among Middle and High School Students — United States, 2011–2015.* MMWR Morb Mortal Wkly Rep 2016;65:361–367. DOI: http://dx.doi.org/10.15585/mmwr.mm6514a1, Accessed April 25, 2017.

[4] *E-Cigarette Use Among Youth and Young Adults: A Report of the Surgeon General*

[5] *E-Cigarette Use among Youth and Young Adults: A Report of the Surgeon General.*

[6] *E-Cigarette Use among Youth and Young Adults: A Report of the Surgeon General.*

[7] *E-Cigarette Use Among Youth and Young Adults: A Report of the Surgeon General.*

[8] *E-Cigarette Use among Youth and Young Adults: A Report of the Surgeon General.*

[9] U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. *Vital Signs-E-Cigarettes and Youth. https://www.cdc.gov/vitalsigns/ecigarette-ads/index.html. Accessed on April 25, 2017.*

Additional dangers and risks include:

- Involuntary secondhand exposure to aerosolized nicotine. E-cigarette aerosol is not "water vapor." It contains nicotine and can contain additional toxins. E-cigarette emissions are a health concern for those exposed to the secondhand aerosol.[10]
- Accidental poisonings resulting from ingestion or absorption through the skin of liquids containing high concentrations of nicotine.[11]

As of 2014, the e-cigarette industry spent $125 million a year to advertise their addictive products, aggressively marketing to youth, promoting flavors popular among youth, using celebrities, sexual content, and claims of independence to glamorize these addictive products. [12]

- More than 18 million (7 in 10) U.S. middle and high school youth were exposed to e-cigarette ads in 2014.
- More than 1 in 2 middle and high school youth were exposed to e-cigarette ads in retail stores. Nearly 2 in 5 middle and high school youth saw e-cigarette ads online.

Against the backdrop, licensing is critical to restricting youth access to e-cigarettes and reducing use. The CDC and the Office of the Surgeon General support licensing as one of the most effective strategies for preventing youth tobacco use, including e-cigarettes.[13] If licensed, e-cigarette sellers would be subject to enforcement and to violations for sales to minors as well as other misconduct. Repeat violators could face license suspension or revocation, incentivizing compliance. Limiting the number of sellers of e-cigarettes, as this bill does, will further limit access to e-cigarettes and ultimately benefit public health. As a recent study demonstrates, increased retailer density is associated with a higher likelihood of initiating non-combustible use among 18-24 year olds.[14] Finally, this bill, like Int. No. 1131-A, appropriately bans pharmacies from engaging in sales of products antithetical to their health mission. Given the density of pharmacies in New York City, this measure should have a significant impact on reducing access to e-cigarettes and falsely conveying a positive health message.

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[10] *E-Cigarette Use among Youth and Young Adults: A Report of the Surgeon General.*

[11] *E-Cigarette Use Among Youth and Young Adults: A Report of the Surgeon General.*

[12] *Vital Signs-E-Cigarettes and Youth; E-Cigarette Use among Youth and Young Adults: A Report of the Surgeon General.*

[13] U.S. Department of Health and Human Services. Centers for Disease Control and Prevention . *The Call to Action on E-Cigarette Use among Youth and Young Adults* at 245. https://www.cdc.gov/tobacco/data_statistics/sgr/e-cigarettes/pdfs/2016_SGR_The_Call-508.pdf.
Accessed on April 25, 2017.

[14] Cantrell J, Pearson JL, Anesetti-Rothermel A *et al.* Tobacco retail outlet density and young adult tobacco initiation. Nicotine Tob Res 2016;18:130–7. doi:10.1093/ntr/ntv036 [PMC free article] [PubMed] Accessed on April 26, 2017.

Proposed Int. No. 1544-A (Johnson)

Public Health Solutions supports Proposed Int. No. 1544-A (Johnson), which would establish price floors and minimum package sizes for tobacco products and shisha and establish a tax on tobacco products other than cigarettes.

Like the World Health Organization (WHO), the CDC has concluded that increasing the price of tobacco products is the single most effective way to reduce consumption. For example, the CDC found that a 10% increase in price has been estimated to reduce overall cigarette consumption by 3–5%. The impact of price increases on youth and young adults is even more profound. Research on cigarette consumption suggests that both youth and young adults are two to three times more likely to respond to increases in price than adults.[15]

Employing economic strategies that deter and prevent consumers, especially young consumers, from purchasing tobacco and other tobacco products is a powerful approach to combatting tobacco use.

Thank you for allowing Public Health Solutions to testify today. Please feel free to contact us if you have any questions. We would welcome the opportunity to work with you to advance the goals of this important legislation.

Respectfully submitted,

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[15] U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. Fact Sheet: Economic Trends in Tobacco.
https://www.cdc.gov/tobacco/data_statistics/fact_sheets/economics/econ_facts/index.htm Accessed on April 25, 2017.

FOR THE RECORD

Advocates of the Food Industry Since 1900

FOOD INDUSTRY ALLIANCE OF NEW YORK STATE, INC.

130 Washington Avenue • Albany, NY 12210 • Tel (518) 434-1900 • Fax (518) 434-9962
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Testimony
By the Food Industry Alliance of New York State, Inc.
in Opposition to
Proposed Int. No. 1131-A-2016

Thank you for the opportunity to testify on behalf of the Food Industry Alliance of New York State (FIA) regarding Proposed Int. No. 1131-A-2016. FIA is a nonprofit trade association that promotes the interests statewide of New York's grocery, drug and convenience stores. Our members include chain and independent grocery stores that account for a significant share of New York City's retail food market and the grocery wholesalers that supply them, as well as drug and convenience stores.

FIA opposes this legislation, which would make it unlawful for a pharmacy to obtain a license to engage in business as a retail dealer. In effect, the bill would prohibit pharmacies from selling cigarettes and tobacco products after December 31, 2018.

Prohibiting pharmacies from selling tobacco products and cigarettes will not reduce consumption of those products, since those items are widely available outside of pharmacies, including nearby brick and mortar stores (sometimes located next door or across the street), the internet and Indian reservations. As sales by legal, taxed and heavily regulated and inspected sellers decrease, purchases in the illicit market, where minors are not IDed and taxes are not paid, will increase. This unintended development would have adverse health, economic and even national security consequences.

According to a January 2017 study by the Tax Foundation, 55.4% of cigarettes consumed in New York state are from smuggled sources. Moreover, in 2015 the Obama Administration released a report titled "The Global Illicit Trade in Tobacco: A Threat to National Security." The report stated that cigarette smuggling provides funding for everything from terrorism and human trafficking to weapons. We believe the restrictions contained in this bill and the other measures in the legislative package being considered at this committee meeting will further expand the illicit trade in cigarettes.

While there will be no benefit from the ban, the costs will be substantial. Pharmacies will lose sales, as shoppers seeking the convenience of one stop shopping take their entire ticket (tobacco and non-tobacco items) elsewhere. The lost sales, combined with the pay scale effects of a minimum wage that will reach $15.00 an hour by December 31, 2018, may result in job losses.

In addition, according to the Declaration of legislative findings and intent section of Int. 1547 (being considered simultaneously with this bill), while there are more than 2,700 pharmacies in the city, approximately 600 of them have a retail dealer license to sell cigarettes. That means that a supermajority – almost 78% - of NYC's pharmacies do **not** sell cigarettes. Thus, the impact of this bill

will be largely symbolic, while forcing the pharmacies that currently sell these products, and their workers, to absorb the harmful effects.

In addition, this legislation will have health impacts. Smokers will spend less time in pharmacies. As a result, they will interact less with pharmacists who can counsel them about the smoking cessation products offered in those stores.

Users of cigarettes and tobacco products are fully informed purchasers of a legal product. These products are heavily regulated and taxed (NYC has some of the highest excise tax rates in the nation), including a prohibition on sales to minors, a price floor for cigarettes and a ban on promotions and coupons. Enactment of the legislative package being considered at this committee meeting will increase regulation and restrict access even further. These circumstances make it clear that there is no reason to single out pharmacies for an outright ban.

Proponents of a ban argue that pharmacies are places of health and therefore should not sell these types of products. But this is like asserting that physicians who smoke, are overweight, or drink aggressively should be barred from practicing medicine. Government should give private stakeholders the latitude to determine how their corporate mission will be implemented, particularly when the activity involves the sale of a legal, taxed and heavily regulated product.

For the foregoing reasons, FIA, on behalf of its members, opposes adoption of this legislation. We look forward to working with government stakeholders to address our concerns.

Respectfully submitted,

Food Industry Alliance of New York State, Inc.
Jay M. Peltz
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April 27, 2017

CVSHealth

One CVS Drive
Woonsocket, RI 02895

April 27, 2017

Council Member Corey Johnson
Chair, Committee on Health
Council Legislative Office
250 Broadway, Suite 1856
New York, New York 10007

Dear Chairman Johnson:

CVS Health is pleased to provide the attached report and white paper from the CVS Health Research Institute, which evaluate the impact of CVS/pharmacy's decision to remove nationwide cigarette and nicotine patch purchases.

Smoking is the leading cause of preventable morbidity and mortality in the United States, accounting for >480,000 deaths each year, $133 billion in medical costs, and $156 billion in lost productivity. Although smoking rates have declined, nearly 1 in 4 American adults still use tobacco, and 16.8% Americans smoke cigarettes. Reducing tobacco use continues to be a public health priority.

Accumulating evidence suggests that restricting access to and limiting opportunities to smoke tobacco reduces tobacco use. On September 3, 2014, CVS removed tobacco products from its >7,800 retail stores in 47 states nationwide. We hypothesized that restricting access to tobacco would reduce cigarette purchasing and used two complementary data sources to evaluate this hypothesis. With household-level data, we compared the effect of CVS Health's decision to stop selling tobacco on cigarette purchasing in consumers who previously purchased cigarettes at CVS versus those who purchased at other retail outlets. We used state-level data to assess whether the CVS decision led to population-level reductions in cigarette purchasing, comparing states with substantial CVS retail market share to states with no CVS retail presence. The results of our evaluation were recently published in the American Journal of Public Health, included with this letter, and in a white paper released by CVS Health, also included.

We found that CVS' removal of tobacco products in its retail stores did result in fewer tobacco purchases. Households that had purchased cigarettes exclusively at CVS Pharmacy prior to tobacco removal were 38% more likely to stop buying cigarettes at any outlet after CVS stopped tobacco sales, and those CVS Pharmacy consumers that bought more cigarettes, "≥3 pack purchasers," were more than twice as likely to stop buying cigarettes, likely reflecting the greater disruption in their tobacco use and purchasing behaviors when CVS removed tobacco. Similarly, at the population level, in

CVSHealth

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the 13 states with ≥15% CVS Pharmacy retail market share, consumers purchased 95 million fewer packs of cigarettes over the 8 months subsequent to tobacco removal (equivalent to 5 fewer packs per smoker), representing a 1% reduction in cigarette sales in these states.

Taken together, CVS' decision to remove tobacco from its stores meaningfully reduced household-level and population-level cigarette purchasing, and thus, presumably, consumption. The findings from this study highlight another strategy that can reduce tobacco use and improve the nation's health.

Finally, CVS Health is an advocate for living tobacco free, and partners with the nation's leading tobacco control and youth organizations to support comprehensive education, tobacco cessation and healthy behavior programming. This commitment reflects our company's purpose as the nation' largest pharmacy innovation company to helping people on their path to better health.

Sincerely,

Jennifer M. Polinski, ScD, MPH
Senior Director, Enterprise Evaluation and Population Health Analytics

Impact of CVS Pharmacy's Discontinuance of Tobacco Sales on Cigarette Purchasing (2012–2014)

Jennifer M. Polinski, ScD, MPH, Benjamin Howell, PhD, MPP, Michael A. Gagnon, MA, Steven M. Kymes, PhD, Troyen A. Brennan, MD, JD, MPH, and William H. Shrank, MD, MSHS

Objectives. To assess the impact of CVS Health's discontinuation of tobacco sales on cigarette purchasing.

Methods. We used households' purchasing data to assess rates at which households stopped cigarette purchasing for at least 6 months during September 2014 to August 2015 among 3 baseline groups: CVS-exclusive cigarette purchasers, CVS+ (CVS and other retailers), and other-exclusive (only non-CVS retailers). In state-level analyses using retailers' point-of-sale purchase data, an interrupted time series compared cigarette purchasing before (January 2012 to August 2014) and after (September 2014 to April 2015) tobacco removal in 13 intervention states with CVS market share of at least 15% versus 3 control states with no CVS stores.

Results. Compared with other-exclusive purchasers, CVS-exclusive purchasers were 38% likelier (95% confidence interval = 1.06, 1.81) to stop cigarette purchasing after tobacco removal. Compared with control states, intervention states had a significant mean decrease of 0.14 (95% confidence interval = 0.06, 0.22) in packs per smoker per month.

Conclusions. After CVS's tobacco removal, household- and population-level cigarette purchasing declined significantly. Private retailers can play a meaningful role in restricting access to tobacco. This highlights one approach to reducing tobacco use and improving public health. (*Am J Public Health.* 2017;107:556–562. doi:10.2105/AJPH.2016.303612)

See also Galea and Vaughan, p. 500.

Smoking is the leading cause of preventable morbidity and mortality in the United States, accounting for more than 480 000 deaths each year, $133 billion in medical costs, and $156 billion in lost productivity.[1,2] Although smoking rates have declined, nearly 1 in 4 US adults still use tobacco, and 16.8% of persons in the United States smoke cigarettes.[3,4] Reducing tobacco use continues to be a public health priority.

Accumulating evidence suggests that restricting access to and limiting opportunities to smoke tobacco reduces tobacco use.[5–7] Prohibiting smoking in public and private locations, increasing financial costs through taxation, and raising the tobacco purchasing age are all linked to decreases in smoking prevalence.[5,7] Limiting the number of locations where tobacco can be purchased is also effective. When San Francisco, California, and Boston, Massachusetts, prohibited tobacco sales in pharmacies, cigarette purchasing declined.[6]

On September 3, 2014, after changing its name to CVS Health, CVS removed tobacco products from its more than 7800 retail stores in 47 states nationwide and began a high-profile media and advertising campaign both in and outside of its stores to encourage smoking cessation.[8] Little is known about whether such a decision by a large retail pharmacy chain led to reductions in tobacco use, or if consumers simply switched their purchasing to alternative retailers. We sought to examine the effect of CVS's decision on cigarette purchasing by evaluating 2 complementary data sources. With household-level data, we compared the effect of CVS Health's decision to stop selling tobacco on cigarette purchasing by consumers who previously purchased cigarettes at CVS versus those who purchased at other retail outlets. We used state-level data to assess whether the CVS decision led to population-level reductions in cigarette purchasing, comparing states with substantial CVS retail market share to states with no CVS retail presence. We hypothesized that restricting access to tobacco would reduce cigarette purchasing at the household and population levels.

METHODS

Data were provided by IRi Worldwide, a firm that collects retail purchasing data by using various methods to understand and track consumers' purchasing behaviors for specific retail goods.[9] To assess changes in cigarette purchasing associated with tobacco removal, we used monthly data for unique households participating in IRi's Household Panel Survey, a nationally representative, opt-in panel in which household members regularly scan

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and report all retail purchases and corresponding purchasing locations. All purchases are recorded, regardless of retailer. Data included unique households' demographic data (female or male head of household's age, race, education, marital status, occupation, and Hispanic ethnicity; family size; presence of children; income; rented or owned residence) and monthly cigarette pack purchasing volume, frequency, and location. IRi tracks households' participation monthly and flags those households who do not report any purchases of any retail good within a given month. We used this participation flag to determine households' study eligibility and, when appropriate, to censor those households that were no longer contributing information to the panel. All households were deidentified.

Because many readers may be unfamiliar with such companies and data collection, it may be useful to think of an analogous situation: the Nielsen Company's monitoring of television viewership, in which households are asked to report on their television program viewing on a monthly basis to understand shows' popularity, what the characteristics are of people who are watching, and other data.[10]

To compare state-level purchasing of tobacco products before and after CVS tobacco removal in states where CVS Pharmacies are located versus states with no CVS Pharmacies, IRi provided monthly point-of-sale cigarette purchasing data from all drug, food, big box, dollar, convenience, and gas station retailers in 26 states: Alabama, Arizona, Arkansas, Colorado, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maryland, Michigan, Missouri, Nevada, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Vermont, Virginia, Washington, and Wisconsin. Only 26 states' data were available because of competitive restrictions. To protect retailers' competitive information, IRi only releases data if there are more than 2 retailers reflected in the relevant household purchase behaviors (in this case, cigarettes) at all levels of geography (e.g., local market, county, state).

Study Designs

Household-level study. The main household-level study used an open cohort study design, which recognized that the incidence of the outcome, stopping cigarette purchasing, was likely to vary during the follow-up period. Cohort study–eligible households reported 1 or more purchase of any retail good in each of June, July, and August 2014 (i.e., they were actively participating in IRi's panel survey, collectively defined as the 3-month baseline period). Households were followed for 52 weeks immediately following tobacco removal at CVS, September 2014 to August 2015. Households could leave the panel during follow-up.

Recognizing that the cohort design itself could not account for the seasonality of tobacco use, we conducted a sensitivity analysis by using a cross-sectional, difference-in-differences approach. We compared changes in cigarette purchasing in the months immediately before and after tobacco removal at CVS in September 2014 (tobacco-removal period): the baseline months were July and August 2014, and the follow-up months were September 2014 to February 2015. To understand the cigarette purchasing behaviors of households in the absence of tobacco removal by CVS, we repeated this comparison 1 year earlier, which we refer to as the comparison period: July and August 2013 (baseline) and September 2013 to February 2014 (follow-up). Eligible households purchased 1 or more cigarette packs during baseline and 1 or more retail goods every month to ensure they remained in the IRi panel, consistent with the cross-sectional design. Figure A, available as a supplement to the online version of this article at http://www.ajph.org, depicts each of the household-level study design approaches.

State-level studies. We used an interrupted time series design with 40 monthly measurements for each state, 32 before (January 2012–August 2014) and 8 after tobacco removal (September 2014–April 2015).

Exposure

Household-level studies. In the cohort study, we created 3 groups, defined in the baseline period, to examine whether greater CVS loyalty as a source for cigarettes was associated with a greater likelihood of stopping cigarette purchasing after tobacco removal. CVS-exclusive purchasers only bought cigarettes at CVS, CVS+ purchasers bought at both CVS and non-CVS stores, and other-exclusive purchasers bought exclusively at non-CVS locations and acted as the reference group. In the difference-in-differences sensitivity analysis, we compared CVS-exclusive purchasers with mixed purchasers—households that bought cigarettes at both CVS and non-CVS stores or that bought exclusively at non-CVS stores. These groups are mutually exclusive. In both studies, we explored effect modification by greater baseline cigarette consumption: 3-or-more-pack purchasers bought 3 or more packs during the baseline period, the equivalent of 1 pack per month in the cohort study's baseline period, admittedly a low cutpoint. We wanted to test the hypothesis that even at low consumption levels, CVS-exclusive purchasers who consumed even slightly more cigarettes were more likely to show disruption in their cigarette purchasing behaviors as a result of CVS's action, and therefore might be more likely to stop purchasing cigarettes altogether.

State-level studies. In our primary population-level analysis, we compared 13 intervention-group states (AL, FL, GA, IL, IN, MD, NV, NY, NC, OH, PN, SC, VA) where CVS had market share of 15% or higher (based on all retail sales) to a control group of the only 3 states with no CVS Pharmacy retail stores (CO, OR, WA). To assess whether there was a dose–response association between CVS market share and cigarette purchasing after tobacco removal, we next analyzed data from all 26 states with any value of CVS market share, using the log of CVS Pharmacy's market share (to account for the observed nonlinear pattern that as market share increased, changes in cigarette purchasing diminished, the phenomenon known as the "law of diminishing returns") as a continuous exposure.

Outcomes and Censoring

Household-level studies. A household stopped cigarette purchasing when no cigarette purchases were made during any 6-month span in the follow-up period. In the open cohort study with a 12-month follow-up period, the outcome was specified as the first month after the 6-month criterion was

met, because, by definition, the outcome was not possible to ascertain until the full 6 months had passed. We censored households at the first month when no consumer good purchases were reported (indicating that the household had left the panel), occurrence of the outcome, or the end follow-up. In the difference-in-differences sensitivity analysis, the follow-up period was 6 months, so we assessed the outcome only once, at the very end of the follow-up period.

State-level studies. The state-level outcome was cigarette packs per smoker, calculated for each state as purchased cigarette packs divided by the state's number of adult smokers. Each state's smoking population was estimated as the number of adults (from the American Community Survey)[11] times the prevalence of adult smokers (from the Behavioral Risk Factor Surveillance System),[12] each updated yearly for 2012 to 2014; 2015 data were not yet available, so we used 2014 data again.

Statistical Analysis

Household-level studies. In the cohort study, descriptive statistics depict household characteristics and cigarette purchasing frequency (number of cigarette purchase transactions during the baseline period) and volume (number of cigarette packs during the baseline period for all and ≥3 pack purchasers). We calculated unadjusted risks (number of households that stopped cigarette purchasing divided by total households) and rates (number of households that stopped cigarette purchasing divided by household-months). We calculated household-months as the sum of the months contributed by each household before having the outcome or being censored. We evaluated the unadjusted and adjusted hazards of stopping cigarette purchases by using Cox proportional hazards models and generalized estimating equations to account for repeated measurements across households.[13,14] Adjusted models included all household demographic characteristics. We also adjusted for baseline cigarette purchasing frequency and purchasing volume, as we anticipated that these might differ substantially between CVS-exclusive and other purchasers.

In the cross-sectional study, we calculated the same descriptive statistics and unadjusted risks as described previously. In a multivariable logistic regression, we compared changes in stopping cigarette purchasing between the tobacco removal period and the comparison period occurring 1 year before for CVS-exclusive versus mixed purchasers, adjusting for all covariates described previously, including purchasing frequency and volume. Because of the rarity of the outcome, the resulting odds ratio approximated a risk ratio.

State-level studies. For each interrupted time series, linear regression models allowed for an immediate-level change in September 2014 at tobacco removal and a postremoval slope change to assess longer-term trend effects. All models used generalized estimating equations to account for repeated measurements.[13,14] We adjusted for known seasonality in cigarette purchasing (e.g., New Year's resolutions to quit smoking) with quarterly indicators and for state-specific, time-varying tobacco control and health care program changes that might influence cigarette purchasing: cigarette taxes,[15] Medicaid expansion (or not) that expanded access to smoking cessation resources,[16] and the yearly ratio of a state's tobacco control spending to the Centers for Disease Control and Prevention's recommended spending for that state.[17,18] Using only the statistically significant parameter result (slope change), we quantified how many fewer packs were purchased per smoker over the 8-month follow-up by summing the results across the 8 months:

$$\begin{aligned}&(\text{slope change} * \text{month } 1)\\&+ (\text{slope change} * \text{month } 2) + \ldots\\&+ (\text{slope change} * \text{month } 8).\end{aligned} \quad (1)$$

We then extrapolated this result to calculate how many fewer packs were purchased in states with CVS market share of greater than or equal to 15% over the 8 months after removal by multiplying the pack purchasing changes per adult smoker in the 8 months by the total estimated adult smokers in each of the states with CVS market share greater than or equal to 15%, and then summed all these states' results. We then calculated the percentage change in pack purchases in these states over the 8 months after removal by comparing how many fewer packs were purchased to the estimated total pack purchases in these states had tobacco removal from CVS not occurred.

RESULTS

Results from the household-level studies are described first, followed by those from the state-level studies.

Household-Level Studies

In the cohort study, 8952 households purchased cigarettes during baseline, with 5366 purchasing 3 or more packs (Table A, available as a supplement to the online version of this article at http://www.ajph.org). Among all purchasers, CVS-exclusive purchasers (29%) were more likely to be employed in professional, managerial, or administrator jobs compared with CVS+ (22%) or other-exclusive (22%) purchasers. Fully 42% of CVS-exclusive purchasers reported household incomes greater than or equal to $60 000, compared with CVS+ (30%) and other-exclusive purchasers (28%).

Compared with only 16% of CVS-exclusive purchasers who bought cigarettes in all 3 baseline months (June–August 2014), 65% of CVS+ purchasers bought cigarettes in all 3 baseline months (Table 1). During the 3-month baseline period, CVS-exclusive purchasers bought fewer cigarette packs (mean = 13, [SD = 25]; compared with mean = 41, [SD = 42] for CVS+ and mean = 30, [SD = 44] for other-exclusive purchasers).

Among all purchasers in adjusted models, CVS-exclusive purchasers' rates of stopping cigarette purchases (0.04 per household-month) were at least twice as high as rates among CVS+ (0.01 per household-month) and other-exclusive (0.02 per household-month) purchasers (Table 2). Compared with other-exclusive purchasers, CVS-exclusive purchasers were 38% more likely (95% confidence interval [CI] = 1.06, 1.81) to stop cigarette purchases, with adjustment for all other factors. The likelihood was even greater for 3-or-more-pack purchasers buying exclusively at CVS (hazard ratio [HR] = 2.31; 95% CI = 1.55, 3.44). CVS+ purchasers' likelihood of stopping cigarette purchases was comparable with that of other-exclusive purchasers: among all smokers

TABLE 1—Cigarette Pack Purchasing Frequency and Volume in the Baseline Period: Household-Level Cohort Study, United States, June–August 2014

Variable	CVS Exclusive	CVS+	Other-Exclusive	*P*
All purchasers[a]				
No.	185	453	8314	
Pack frequency, no. (%)				
≥1 pack in only 1 mo	128 (69)	44 (10)	3560 (43)	<.001
≥1 pack in each of 2 mo	27 (15)	114 (25)	1894 (23)	
≥1 pack in each of 3 mo	30 (16)	295 (65)	2860 (34)	
Pack volume[b]				
At CVS, mean ±SD	13 ±25	15 ±25	0	<.001
At CVS, median (IQR)	4 (2–12)	5 (2–16)	0	
At all other non-CVS retailers, mean ±SD	0	26 ±34	30 ±44	
At all other non-CVS retailers, median (IQR)	0	13 (4–33)	10 (3–38)	
At any retailer, mean ±SD	13 ±25	41 ±42	30 ±44	
At any retailer, median (IQR)	4 (2–12)	26 (11–60)	10 (3–38)	
≥3 pack purchasers[c]				
No.	88	326	4952	
Pack frequency, no. (%)				
≥1 pack in only 1 mo	59 (67)	38 (12)	1673 (34)	<.001
≥1 pack in each of 2 mo	8 (9)	55 (17)	1011 (20)	
≥1 pack in each of 3 mo	21 (24)	233 (71)	2268 (46)	
Pack volume				
At CVS, mean ±SD	25 ±33	19 ±28	0	<.001
At CVS, median (IQR)	12 (6–24)	8 (2–24)	0	
At all other non-CVS retailers, mean ±SD	0	34 ±36	46 ±50	
At all other non-CVS retailers, median (IQR)	0	20 (10–49)	29 (10–66)	
At any retailer, mean ±SD	25 ±33	53 ±44	46 ±50	
At any retailer, median (IQR)	12 (6–24)	40 (20–77)	29 (10–66)	

Note. IQR = interquartile range. CVS-exclusive purchasers only bought cigarettes at CVS, CVS+ purchasers bought at both CVS and non-CVS stores, and other-exclusive purchasers bought exclusively at non-CVS locations.

[a]All purchasers were households that purchased at least 1 cigarette pack in the baseline period.

[b]Pack volume was the sum of all cigarette pack purchases in the baseline period, June–August 2014. Only 1 pack purchase is required during the 3-mo period.

[c]≥3 pack purchasers were households that purchased at least 3 cigarette packs in the baseline period.

(HR = 0.82; 95% CI = 0.61, 1.09); among 3-or-more-pack purchasers (HR = 0.81; 95% CI = 0.55, 1.22).

The difference-in-differences sensitivity study's household demographic characteristics and cigarette purchasing frequency and volume were similar to those in the cohort study (data not shown). Among all households there were 121 CVS-exclusive and 4914 mixed purchasers in the pre–tobacco-removal period (baseline = July–Aug 2013; follow-up = September 2013–April 2014) and 94 CVS-exclusive and 4884 mixed purchasers in the comparator post–tobacco-removal period (baseline = July–Aug 2014; follow-up = September 2014–April 2015). Among 3-or-more-pack purchasers, there were 60 CVS-exclusive and 3503 mixed purchasers in the pre– and 51 CVS exclusive and 3416 mixed purchasers in the post–tobacco-removal periods. CVS-exclusive purchasers' likelihood of stopping cigarette purchases increased 10% (all purchasers) and 20% (≥3 pack purchasers) in the post–tobacco-removal period, whereas mixed purchasers' risk did not change (Table 3). When we adjusted for all covariates including baseline purchasing frequency and volume, CVS exclusive purchasers had a higher likelihood of stopping purchases versus mixed purchasers: mixed purchasers' risk ratio was 2.14 (95% CI = 1.02, 4.46); 3-or-more-pack purchasers' risk ratio was 6.04 (95% CI = 1.45, 25.16).

State-Level Studies

In 2012, the smoking prevalence ranged from 12.6% in California to 28.3% in Kentucky (Table B, available as a supplement to the online version of this article at http://www.ajph.org) and generally decreased with time. Cigarette taxes were largely stable. Thirteen states expanded Medicaid in 2014; 2 in 2015.

After tobacco removal, there was no short-term change in cigarette pack purchases between intervention and control states (Table 4). However, over the 8-month follow-up, compared with control-state smokers, intervention-state smokers did decrease cigarette purchases after tobacco removal by a mean of 0.14 (95% confidence interval [CI] = 0.06, 0.22) packs per smoker per month. On average, in the 8 months after removal, intervention state smokers reduced purchasing by an additional mean of 5.31 (95% CI = 2.25, 8.36) packs. Similarly, increasing CVS market share was not associated with a short-term change in pack purchases, but each 5% increase in CVS market share was associated with a mean decrease of 0.15 (95% CI = 0.01, 0.29) packs per smoker per month.

DISCUSSION

To our knowledge, this is the first study to evaluate the impact of a large retail company's decision to end cigarette sales on unique household and population-level cigarette purchasing. Our findings suggest that the decision to eliminate cigarette sales at 1 retail pharmacy chain had a meaningful effect on cigarette purchasing behavior. Although some consumers of tobacco products at CVS certainly altered their cigarette purchasing locations when cigarettes became unavailable at CVS, our findings demonstrate that other CVS tobacco consumers purchased less tobacco.

In survival analyses, households that had purchased cigarettes exclusively at CVS Pharmacy were 38% more likely to stop buying cigarettes after CVS stopped tobacco sales, and those CVS Pharmacy consumers who bought more cigarettes, "3-or-more-pack purchasers," were more than twice as likely to stop buying cigarettes, likely reflecting the greater disruption in their

TABLE 2—Risk, Rate, and Hazards of Stopping Cigarette Purchasing During the Follow-Up Period: Household-Level Cohort Study, United States, September 2014–August 2015

Variable	Risk of Stopping Cigarette Purchasing,[a] No. (%)			Rate of Stopping Cigarette Purchasing, per Household-Month[b]			Unadjusted HR (95% CI)[c]		Adjusted HR[c,d] (95% CI)	
	CVS-Exclusive Purchasers	CVS+ Purchasers	Other-Exclusive Purchasers	CVS-Exclusive Purchasers	CVS+ Purchasers	Other-Exclusive Purchasers	CVS-Exclusive Purchasers	CVS+ Purchasers	CVS-Exclusive Purchasers	CVS+ Purchasers
All purchasers[e]	58 (31)	49 (11)	1582 (19)	0.04	0.01	0.02	2.44 (1.88, 3.17)	0.43 (0.32, 0.57)	1.38 (1.06, 1.81)	0.82 (0.61, 1.09)
≥3 pack purchasers[f]	27 (31)	26 (8)	661 (13)	0.04	0.01	0.02	3.76 (2.56, 5.52)	0.51 (0.34, 0.75)	2.31 (1.55, 3.44)	0.81 (0.55, 1.22)

Note. CI = confidence interval; HR = hazard ratio. CVS-exclusive purchasers only bought cigarettes at CVS, CVS+ purchasers bought at both CVS and non-CVS stores, and other-exclusive purchasers bought exclusively at non-CVS locations.

[a]Unadjusted risks were calculated as the number of households that stopped cigarette purchasing divided by total households.

[b]Unadjusted rates were calculated as the number of households that stopped cigarette purchasing divided by household-months. Household-months were calculated as the sum of the months contributed by each household before having the outcome or being censored.

[c]The reference group for each model is households that exclusively purchased cigarettes at other retailers, "Other-exclusive purchasers."

[d]Model adjusted for head of household's age, gender, race, Hispanic ethnicity, education level, marital status, and employment type; household's income, household size, presence of children in the household, and whether residence is rented or owned; baseline cigarette pack purchasing frequency; and baseline cigarette pack purchasing volume.

[e]All purchasers purchased ≥1 pack of cigarettes during the baseline period.

[f]≥3-pack purchasers purchased ≥3 packs of cigarettes during the baseline period.

tobacco use and purchasing behaviors when CVS removed tobacco. Separate difference-in-differences analyses corroborated these findings. Similarly, at the population level, in the 13 states with greater than or equal to 15% CVS Pharmacy retail market share, consumers purchased 95 million fewer packs of cigarettes over the 8 months subsequent to tobacco removal (equivalent to 5 fewer packs per smoker), representing a 1% reduction in sales in these states. In another population-level analysis, we observed a dose–response relationship between CVS Pharmacy retail market share and reductions in cigarette purchasing that confirmed the directionality and magnitude of the intervention versus control state findings.

We used numerous approaches and data sources, as each had limitations. We characterized households as having stopped purchasing cigarettes, but we were unable to

TABLE 3—Impact of CVS's Tobacco Removal on Stopping Cigarette Purchasing: Household-Level Cross-Sectional Difference-in-Differences Study, United States

Variable	Households Who Stopped Cigarette Purchasing, No. (%)		Difference in Stopping Cigarette Purchasing, %		Likelihood of Stopping Cigarette Purchasing,[e] RR (95% CI)	
	Comparison Follow-Up Period[a]	Tobacco Removal Follow-Up Period[b]	Between Periods[c]	Between Purchasers[d,e]	Unadjusted	Adjusted[f]
All purchasers[g]				10		
CVS-exclusive purchasers	20 (17)	25 (27)	10		1.78 (0.91, 3.49)	2.14 (1.02, 4.46)
Mixed purchasers	578 (12)	589 (12)	0		1 (Ref)	1 (Ref)
≥3 pack purchasers[h]				20		
CVS-exclusive purchasers	3 (5)	13 (25)	20		6.81 (1.79, 25.87)	6.04 (1.45, 25.16)
Mixed purchasers	226 (6)	211 (6)	0		1 (Ref)	1 (Ref)

Note. CI = confidence interval; RR = risk ratio. CVS-exclusive purchasers only bought cigarettes at CVS, and mixed purchasers bought cigarettes at both CVS and non-CVS stores or that bought exclusively at non-CVS stores.

[a]September 2013–February 2014.

[b]September 2014–February 2015.

[c]Between the tobacco removal period and comparison period.

[d]Difference in differences.

[e]Associated with CVS tobacco removal.

[f]Model adjusted for head of household's age, gender, race, Hispanic ethnicity, education level, marital status, and employment type; household's income, household size, presence of children in the household, and whether residence is rented or owned; baseline cigarette pack purchasing frequency; and baseline cigarette pack purchasing volume.

[g]All purchasers bought ≥1 pack of cigarettes during the baseline period.

[h]≥3-pack purchasers bought ≥3 packs of cigarettes during the baseline period.

TABLE 4—Reductions in Cigarette Pack Purchases Per Smoker After CVS Tobacco Removal: State-Level Interrupted Time Series Study, United States

Variable	Cigarette Packs Purchased Per Smoker, Mean (95% CI)		
	Intercept Change, Sep 2014	Long-Term Slope Change, Per Month, Sep 2014–Apr 2016	Total Reduction in the 8 Mo After CVS Tobacco Removal,[a]
Analysis 1[b]	0.52 (−0.12, 1.15)	−0.14 (−0.22, −0.06)	−5.31 (−8.36, −2.25)
Analysis 2[c]	−0.19 (−1.26, 0.87)	−0.15 (−0.29, −0.01)	−5.27 (−10.31, −0.23)

Note. CI = confidence interval. The total reduction in states with ≥ 15% market share in the 8 months after CVS tobacco removal, calculated by multiplying the −5.31 packs purchased per smoker result by the estimated number of adult smokers in all states with ≥ 15% CVS market share, in millions, was mean = −95.2 (95% CI = −38.6, −151.8).

[a]Calculated by using only the statistically significant, long-term slope change from months 1–8 after tobacco removal: (−0.14*1) + (−0.14*2) + (−0.14*3) + (−0.14*4) + (−0.14*5) + (−0.14*6) + (−0.14*7) + (−0.14*8).

[b]States with ≥ 15% CVS market share vs states with no CVS stores (16 states).

[c]Per 5% increase in CVS market share (26 states).

confirm smokers' actual quitting efforts or intentions.[19] We were similarly unable to determine whether single or multiple smokers resided within a household, so our analyses may underestimate effects. Recognizing disparities in baseline characteristics between exposure groups, we explicitly adjusted for cigarette pack purchasing volume, purchasing frequency, and demographics in analyses. Although survey households may not have been generalizable to the broader population of smokers who did not opt in to a household survey or to residents of a particular state, the CVS decision was associated with a reduction in cigarette purchasing among CVS-exclusive purchasers, and this reduction suggests that the decision was effective in tobacco harm reduction.

Several other issues deserve mention. The retail point-of-sale data were more generalizable, but did not allow for the identification of unique individuals or households and their longitudinal cigarette purchasing patterns. However, we estimated the number of adult smokers in a state to determine the denominator, and looked at a comprehensive sample of retailers selling tobacco to assess overall cigarette sales. Moreover, the September 4 tobacco removal date occurred a full month before the timeline communicated to the public, reducing the likelihood that people switched their purchasing behaviors right before the removal date (e.g., stockpiling cigarette purchases from CVS or leaving abruptly, which would have biased the analyses).

We were unaware of any specific tobacco-cessation efforts that occurred at the same time, but we cannot exclude the possibility. In a related vein, 2015 Behavioral Risk Factor Surveillance System data were not available, so we used 2014 data for both 2014 and 2015 smoking prevalence. To address threats to the validity, analyses included both historical and concurrent controls, to take into account the underlying decline in smoking prevalence in the United States,[3] the rising popularity of electronic nicotine-delivery devices, and other trends.

Finally, we were only able to include 26 states in our analyses. Because excluded states might differ from included states in important factors (e.g., greater cigarette purchasing because of higher nicotine consumption), we cannot ensure the generalizability of the study to all 50 states. However, our analyses relied on IRi data, widely regarded as among the best available, highly accurate data to understand consumer purchasing.[20] Taken together, we are reassured that multiple study designs, data sources, and analytic approaches produced consistent results, both in direction and magnitude.

Overall, our results are consistent with those from the broader tobacco literature. Multiple studies examining the impact of restricting tobacco access have observed reductions in tobacco use similar or greater in magnitude to those we observed. In 2011, New York City implemented a sales ban on flavored noncigarette tobacco products (e.g., cigars and smokeless tobacco). Compared with sales in 10 proximal counties, the ban was associated with a 10.2% greater absolute decrease ($P < .01$) in flavored noncigarette tobacco sales.[21] Raising the tobacco purchasing age from 18 to 21 years in 1 suburban Massachusetts community was associated with a 6 percentage point decline in smoking prevalence (from 13% in 2006 to 7% in 2010) among high-school youths, compared with a 3 percentage point decline in 16 surrounding communities.[8]

In this study, we found that a large, nationwide retailer's decision to remove tobacco from its stores meaningfully reduced household-level and population-level cigarette purchasing and, thus, presumably, consumption. Our findings have implications for public health professionals seeking to further reduce tobacco use. Currently, many large retailers in the United States sell cigarettes, including multiple pharmacy chains.[22,23] Our research indicates that if these retailers, particularly pharmacies, stop selling cigarettes, there would be an overall reduction in tobacco consumption, and, as a result, a substantial health benefit. The findings from this study highlight another strategy that can reduce tobacco use and improve the nation's health. AJPH

CONTRIBUTORS

J. M. Polinski conceptualized and designed the study, acquired data, performed analyses, and wrote the article. B. Howell, M. A. Gagnon, and S. M. Kymes designed the study, performed analyses, and revised the article. T. A. Brennan and W. H. Shrank conceptualized and designed the study and revised the article.

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Note. J. M. Polinski, B. Howell, and T. A. Brennan are all employees of CVS Health and hold stock in CVS Health. M. A. Gagnon is an employee of CVS Health. At the time of the study, S. M. Kymes and W. H. Shrank were employees of CVS Health. S. M. Kymes holds stock in CVS Health. IRi was involved in the collection and management of the data, which CVS Health purchased

from IRi. IRi reviewed the article, but CVS Health retained full control over the study's execution, writing the article, and the decision to submit the article for publication.

HUMAN PARTICIPANT PROTECTION

All data were de-identified household panel survey data. There were not individual participants.

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CVSHealth

Impact of the CVS tobacco sales removal on smoking cessation: when CVS Health quit tobacco, many smokers quit, too

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Background

Smoking is the leading cause of preventable death and disease, responsible for more than 480,000 deaths each year and totaling $133 billion in medical costs and $156 billion in lost productivity.[1,2] Quitting smoking is the single best way for smokers to improve their health, and nearly 70 percent of smokers try to quit each year.[2] Comprehensive cessation programs that include quit lines, cessation counseling, nicotine replacement therapy, and/or education increase the likelihood of a successful quit.[3,4] Data shows that restricting access to tobacco, for example, through excise taxes, advertising limitations, and age restrictions, as well restricting the locations where tobacco can be used, also increases successful quitting, with reductions of up to 12 percent.[5,6,7,8,9] Recognizing that the sale of tobacco in a retail pharmacy conflicted with the delivery of health care services and the company's purpose of helping people on their path to better health, CVS Health stopped selling tobacco in its pharmacies on September 3, 2014. On the same day, the company launched a comprehensive program to encourage and support smokers in their efforts to quit, including smoking cessation counseling with MinuteClinic providers and retail pharmacists, nicotine replacement therapy products, smoking cessation medications, a dedicated quit line, and online resources.

As the one-year anniversary of the tobacco sales removal approached, the CVS Health Research Institute evaluated the impact of CVS/pharmacy's tobacco sales removal on nationwide cigarette pack and nicotine patch purchases. There were two specific questions of interest: 1) Compared to states with no CVS/pharmacy stores, what was the impact of the tobacco sales removal on cigarette pack purchases (a proxy for smoking cessation) and nicotine patch purchases (a proxy for quit attempts) in states that have CVS/pharmacy stores?; and 2) Did the impact of the tobacco sales removal vary depending on CVS/pharmacy's market share in a given state?

Methods

We used an interrupted time series design[10] to conduct our evaluation, with 32 monthly measurements in the pre-removal (January 2012 – August 2014) and eight in the post-removal period (September 2014 – April 2015, the most recent month with data available for evaluation). IRi Worldwide provided cigarette pack and nicotine patch purchasing data from drug, food, big box, dollar, convenience, and gas station retailers in 26 states: AL, AR, AZ, CO, FL, GA, IL, IN, KY, LA, MD, MI, MO, NC, NV, NY, OH, OK, OR, PA, SC, TN, VT, VA, WA, and WI.[11] The first outcome, cigarette packs per smoker, was defined for each state as purchased cigarette packs divided by the number of adults in the state (from the American Community Survey)[12] times the state's prevalence of adult smokers (from the Behavioral Risk Factor Surveillance Survey).[13] The second outcome was nicotine patch purchases per smoker, calculated similarly. The cigarette packs per smoker outcome was intended as a proxy for smoking cessation at the population level, while nicotine patch purchases per smoker was a proxy for population-level quit attempts.

To compare the removal's impact in states with CVS/pharmacy stores to states without, we included 13 states where CVS/pharmacy's market share was ≥ 15 percent (obtained from the company's proprietary data) as intervention group states: AL, FL, GA, IL, IN, MD, NC, NV, NY, OH, PA, SC, and VA. Three states with no CVS/pharmacy stores, OR, WA, and CO, were control group states. To assess whether the removal's impact varied depending on CVS/pharmacy's market share, we analyzed data from all 26 states, using the log of CVS/pharmacy's market share (to account for the observed non-linear pattern of diminishing returns as market share increased) as the independent variable. In each of the linear regression models, we adjusted for the known seasonality in smoking quit attempts (e.g., New Year's resolutions to quit occur every January). Finally, in order to assess whether other factors, such as a concurrent health campaign or economic change, and not the CVS/pharmacy tobacco sales removal, were responsible for a change in cigarette purchases, we assessed soda purchases in intervention and control states during the same time period.

Results

In the eight months after CVS/pharmacy stores stopped selling cigarettes, there was an additional 1 percent decrease in cigarette pack sales in intervention states compared with control group states. This decrease represents an on-average decrease of 0.14 cigarette packs per smoker in each month following the tobacco sales removal (95 percent confidence interval, -0.06 to -0.22; p=0.001) in intervention versus control group states (**Table 1**). Overall, in the eight months post-removal, the average smoker in an intervention state purchased five fewer packs.

Table 1.

Post tobacco sales removal reduction in cigarette packs, comparing intervention versus control group states

	Immediate change	Monthly reduction, per smoker after the removal	Total reduction per smoker in the 8 months after the removal	Total reduction in states with ≥15% market share in the 8 months after the removal
States with ≥ 15% CVS/pharmacy market share	Non-significant	-0.14 packs (-0.06 to -0.22) p=0.0010	-5 packs (-2 to -8)	-95,245,308 packs (-38,641,176 to -151,779,816

Extrapolating our 0.14 packs per smoker reduction to all smokers in states where CVS/pharmacy's market share is 15 percent or greater, an estimated 95.2 million fewer cigarette packs were sold in the eight months following the removal.

As expected, the impact of the CVS/pharmacy tobacco sales removal did vary by CVS/pharmacy's market share in a given state. Between August 2014 (pre-removal) and September 2014 (post-removal), there was a two-fold greater reduction in cigarette pack purchases in states with the highest market share as compared to states with the lowest market share, p=0.0404.

Our analysis of nicotine patch purchases provides evidence of the CVS/pharmacy tobacco sales removal's impact on quit attempts. **Table 2** shows that compared with purchase rates in the control group, the tobacco sales removal was associated with an immediate 4 percent increase in purchases in the intervention group, an average of five packages per 1,000 smokers (95 percent confidence interval, 1 to 9; p=0.0284). This surge in nicotine patch purchases immediately following the tobacco sales removal decreased to pre-removal levels over the subsequent months.

Table 2.

Post tobacco sales removal difference in nicotine patch package purchases per 1,000 smokers, comparing intervention versus control group states

	Increase in patch purchases per 1,000 smokers in the first month after the removal	Monthly change in patch purchases per 1,000 smokers after the removal	Immediate increase in patch purchases in states with ≥15% market share
States with ≥15% CVS/pharmacy market share	5 purchases (1 to 9) p=0.0284	-1 purchases (-0.1 to - 2) p < 0.0378	96,700 purchases (19,340 to 174,059)

Extrapolated to all adult smokers in states with ≥15 percent CVS/pharmacy market share, an additional 96,700 (95 percent confidence interval, 19,340 to 174,059) packages of nicotine patches were purchased in September 2014 as a result of the CVS/pharmacy tobacco sales removal.

Finally, our soda analyses showed no statistically significant differences in soda purchases between intervention and control states at the time of or in the eight months following the CVS/pharmacy removal.

Discussion

In this study, we found that the CVS/pharmacy tobacco sales removal was associated with a 1 percent reduction in cigarette pack sales, the equivalent of 0.14 fewer packs per smoker per month. During the eight months following the tobacco sales removal, the average smoker purchased a total of five fewer cigarette packs. Previous studies indicate that the smoking cessation pattern we observed is typical in the setting of efforts to reduce smoking.[14] At the same time, nicotine patch sales increased by 4 percent, or five packages per 1,000 smokers in the month immediately following the tobacco sales removal, returning to pre-removal levels over time. We saw no differences in the consumption of soda which continues to be sold at CVS/pharmacy stores. This evidence indicates that CVS Health's decision to stop selling tobacco and to implement a robust smoking cessation program had a significant, nationwide impact on the public's health.

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MEMORANDUM IN OPPOSITION TO

INTRO. 1585

The Rent Stabilization Association of New York City, representing 25,000 owners and agents of apartment buildings containing one million apartments, submits this Memorandum in Opposition to Intro. 1585.

Intro. 1585 would require owners of apartment buildings with three of more units to adopt and disclose a smoking policy for their buildings which would address interior and exterior locations. The policy, according to the bill, is required to state "in a clear and conspicuous fashion where smoking is permitted or prohibited on the premises of a Class A multiple dwelling."

Owners are required to:

1- Adopt a smoking policy
2- Disclose the smoking policy
3- Provide notification of adoption of the policy or any material change to the policy
4- Make available copies of the policy

The bill provides that the smoking policy "shall not be binding" on a current tenant during the term of their lease, including rent controlled and rent stabilized tenants currently in occupancy. The owner is responsible for disclosing the policy by providing copies of the policy to all tenants annually. The owner is also required to make copies of the policy, as well as any subsequent material changes, available to inspectors.

This legislation is yet another example of good intentions gone awry. Under current law, apartment buildings owners are already required to post "No Smoking" signs in all common areas in their buildings, including entranceways, lobbies, hallways, mailrooms, and laundry rooms, as well in conspicuous locations near elevator entrances and inside elevators.

Intro.1585 simply does not accomplish anything other than impose yet another notice requirement on owners who already are burdened by literally dozens of lease notice and signage requirements. While imposing more legal obligations on owners- and subjecting them to financial penalties for failing to comply- the actual purpose of this legislation is unclear at best.

It is important to remember that in addition to existing legal requirements relating to smoking, owners are already caught in the middle of countless situations where tenants who do not smoke object to the odor of tobacco smoke emanating from the apartments of their neighbors who do smoke. In these situations, the legal and financial burdens are then placed on the owner who, through no fault of his or her own, when the non-smoking tenant alleges that the owner has violated the warranty of habitability

because of the conditions caused by a smoking tenant. Potential claims also arise under other legal theories such as constructive nuisance, negligence, discrimination, infliction of emotional distress, or other potential injuries.

Last but not least, while Intro. 1585 attempts to address different ownership situations, it ignores the reality that the legal ownership and tenancy structure of apartment buildings in New York City is often quite complex. For example, it is not unusual that a building could have been converted from a rental to cooperative or condominium ownership, and living side-by-side in the same building are rent-controlled tenants, rent-stabilized tenants, unregulated tenants, owner-occupied co-op or condo units, or co-op or condo units that have been subleased to sub-tenants. Who is responsible for adopting, disclosing, notifying and making available the smoking policy in these overlapping, real-life scenarios? None of this is clear under the proposed legislation.

Owners are already in an untenable position under existing law and Intro.1585 only makes their situation worse.

Accordingly, RSA opposes Intro. 1585.

Testimony on Tobacco legislation
NYC Council
April 27, 2017
Presented by Mr. Ramon Murphy
President
The Bodega Association of the United States

Good morning council members, my name is Ramon Murphy and I represent the close to 13,000 NYC bodegas that are impacted by many of the bills being debated before you today. Let me say first of all that we know that this proposed legislation is being put forward with the best of intentions; and we all want New Yorkers to be healthier.

In fact, that is why under my leadership the Bodega association has launched the successful "Healthy Bodega" initiative. My store owners want to take the lead at helping their customers to have better food options. But we always make the point that a "healthy bodega" is also a store that can be financially successful, supplying good food to its customers in a good economic environment. A healthy bodega also employs local workers and contributes to the economic wellbeing of the neighborhood.

Now I'm sure that everyone here knows the old saying; "The road to Hell is paved with good intentions." Having good intentions, then, is not

enough. You also must examine whether the intentions will be doing more harm than good-and we believe that with many of these proposed tobacco laws, you will be doing more harm than good.

Let's take the bill that will, once again, raise the price of a pack of cigarettes. Before Mayor Bloomberg raised the tax on cigarettes by over 150% I was selling 25 cartons a week. Now, after all these years, I'm lucky to sell 2 cartons a week.

If the decline in my sales meant that New Yorkers were smoking less, I might not be so upset; but that's not the case. What the NYC tobacco taxes have done-and NY State's as well-is to create a vast and lucrative black market.

Over 60% of all cigarette sales now take place either through the internet or on the street-with very little effort by law enforcement to stop all this illegal activity. The proposed increase will keep this insanity going and soon no bodegas will sell cigarettes, but cigarettes will be smoke nonetheless. So, you see what I mean by the Road to Hell.

Now we turn to the proposed license for the sellers of e-cigarettes-another burden on bodegas, and another excuse for inspectors to violate stores because a sign isn't "prominently" displayed. With store foreclosures and bankruptcies at an all-time high, do we need to add to the burden?

But of all the proposed laws being introduced, the one that will restrict tobacco licenses is the most damaging-and if the details here are addressed it could lead to even more closed stores and higher neighborhood unemployment. Let me suggest that any restriction on licensing should not even be considered until an aggressive law

enforcement effort is underway to curb black market sales. You can restrict the number of legal sellers, but that will only increase the number of illegal sellers.

All bodegueros are aware that smoking is unhealthy and we want to work with NYC to help reduce the number of smokers. All we ask is that the City not try to do this with by only targeting those legally licensed to sell tobacco. Without a greater enforcement efforts, these proposed laws will do more harm than good.

Thank you.

April 27, 2017

Honorable Corey Johnson
Chair, Health Committee
New York City Council
City Hall
New York, NY 10007

Testimony of Asian American Tobacco Free Community Partnership to the New York City Council, Committee on Health
April 27, 2017 • New York, NY

Re: Statement in Support of legislative proposals Int. No. 1547, 1544, 1532, and 1131-2016 (Lander, Johnson, Cabrera, Lander) to reduce smoking and tobacco usage in New York City.

Good morning/afternoon Chairperson Johnson and members of the New York City Council Committee on Health. Thank you for the opportunity to testify today on Intros 1547, 1544, 1532, and 1131-2016, bills that increase the minimum prices for all tobacco products and reducing the number of licensed retailers that will decrease the number of smokers in New York City.

My name is Regina Lee and I represent the Asian American Tobacco Free Community Partnership which is a community-led partnership to address the burden of tobacco use and exposure to second hand smoke in New York City's Asian American community. Our partnership include a Federally Qualified Health Center (Charles B. Wang Community Health Center), one of the nation's premiere academic medical centers, (NYU Langone Medical Center), two well-established community organizations (Asian Americans for Equality, Korean Community Services of Metropolitan New York) and a medical society (Chinese American Medical Society). We strongly support legislation that will reduce tobacco use, raise the minimum price of cigarettes and reduce the number of stores that may sell tobacco products.

New York City has been a national leader in tobacco control and has achieved remarkable reductions in smoking prevalence, from 21.5% in 2002 to 14.3% in 2015. However, not all groups benefit equally from these policy interventions; immigrant communities, for example, face linguistic, cultural and economic barriers that prevent them from accessing and benefitting from the policy interventions and important resources including public health campaigns and smoking cessation counseling and treatment from physicians. Asian American men are the only group in New York City that saw an increase in smoking rate – from 19.6% in 2002 to 25.4% in 2015.

Previous tobacco control policies have had limited impact in Asian American communities. For example, anecdotal evidence suggests that cigarettes may be picked

up by friends and family in duty-free shops.[1] Less expensive Chinese brand cigarettes and "untaxed" US brands are easily available for purchase within the community, both in retail outlets as well as from untaxed sources. Friends and family members also bring home cigarettes when they visit China.[2] Despite New York having the highest excise tax out of the 50 states, cost of cigarettes is not necessarily a barrier for our demographic.[3] In a recent unpublished survey of 250 Chinese American residents of Chinatown and Sunset Park, NYU Langone Medical Center (NYULMC) and Charles B. Wang Community Health Center (CBWCHC) found the average price paid for a pack of cigarettes was $7.62, with some paying as low as $2.[4] This is compared to the average retail price of $10.45 statewide.[5] Raising the minimum prices for all tobacco products may be an effective way to reduce tobacco use among New York City smokers; however, this proposed legislation will not have an impact in our community unless we tackle the availability of untaxed cigarettes.

In addition, when a smoker is ready to quit, cessation resources are not always culturally and linguistically adapted. The NYS Quitline is an essential resource for smoking cessation but it is not readily accessible in Chinese or other Asian languages. Monolingual patients who call the Quitline have complained of being put on hold for 20 minutes and longer to connect to an interpreter or not getting return phone calls when they leave their names and contact information.[15] The Quitline is not widely marketed in the Asian community. As a result, providers in the Asian American community who serve monolingual patients may hesitate to make referrals. Similarly, the NYC Quits tobacco cessation website has extremely limited resources in Chinese.

NYC Council members, especially Chairperson Johnson, have led recent tobacco control efforts. Our smoking partnership is seeking NYC Council's support to continue the forward momentum in making NYC truly smoke free. We propose the following strategies/action steps to be taken by NYC Council and other city agencies in collaboration with our partnership members:

1. Reduce the availability of untaxed cigarettes in Chinatown in Manhattan, and Sunset Park in Brooklyn and Flushing in Queens. Form a task force with agencies such as the United States Bureau of Alcohol, Tobacco, Firearms and Explosives, New York State Department of Taxation and Finance to disrupt the network of cigarette smuggling.

2. Ensure language equity in accessing smoking cessation services for Asian Americans and other populations that are limited in English proficiency. For example, NYCDOHMH could collaborate with NYS DOH to promote referrals to Asian Smokers Quitline, the only quitline in the nation that provides in-language outreach, education and telephone counseling services in Chinese, Korean and Vietnamese.

NYC is widely regarded as a leader in smoking prevention, and successfully implemented several initiatives to reduce tobacco use and sales; however, there is a disparity in terms of who benefits from these policies. Smoking has declined for all racial and ethnic groups across the city except Asian American men. While these bills will help ensure that we continue to decrease smoking rates, we urge the NYC Council to implement policies and program to reduce the tobacco use disparity among Asian Americans which represents the fastest growing racial and ethnic group in NYC.

Sincerely,

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NEW YORK CITY COUNCIL COMMITTEE ON HEALTH COMMITTEE PUBLIC HEARING
APRIL 27, 2017

MY NAME IS PHIL KONIGSBERG, A TOBACCO CONTROL AND SMOKEFREE ADVOCATE FOR 29 YEARS. I RESIDE IN BAY TERRACE, QUEENS

I SUPPORT AND URGE THE COMMITTEE ON HEALTH TO APPROVE ALL 10 INTROS ON THE TABLE, BUT I WANT TO SPECIFICALLY SPEAK ON THOSE NOT MENTIONED IN MAYOR DE BLASIO'S PRESS CONFERENCE. WORKING WITH FELLOW ADVOCATES AND ASSISTING NYC SMOKEFREE, THE QUEENS TOBACCO CONTROL COALITION WAS SUCCESSFUL IN HAVING 13 OF 14 QUEENS COMMUNITY BOARDS PASS A SMOKEFREE MULTIPLE HOUSING RESOLUTION AND IN CONJUNCTION WITH 12 OF THE 14 PASS A SMOKING POLICY DISCLOSURE RESOLUTION WHICH WOULD BE REFLECTED BY PASSAGE OF **INTROS 977 AND 5940**. A SMOKEFREE MULTIPLE HOUSING POLICY SHOULD APPLY FOR ALL TYPES OF APARTMENTS, BOTH MARKET RATE AND SUBSIDIZED. ALTHOUGH **INTRO 977** WOULD NOT AFFECT MARKET RATE MULTIPLE HOUSING AS IT IS WRITTEN, IF THIS COMMITTEE AGREES WITH ME THAT NO MATTER WHERE WE RESIDE, WE SHOULD BE ABLE TO LIVE IN OUR HOME WITHOUT HAVING TO BE EXPOSED TO SECONDHAND SMOKE THEN THIS COMMITTEE SHOULD EXPAND THE SCOPE OF INTRO 977 TO INCLUDE ALL TYPES OF MULTIPLE HOUSING BUILDINGS. HUDS NATIONAL MANDATE THAT ALL PUBLIC HOUSING BE SMOKEFREE BY 2018 MEANS THAT ALL NYCHA APARTMENTS WILL BE SMOKEFREE, WHICH IS A TREMENDOUS, WIN FOR PUBLIC HEALTH. THE NYC SMOKEFREE AIR ACT PROTECTS ALL NEW YORKERS WITH CLEAN INDOOR AIR PROTECTION WHERE WE WORK, EAT, DRINK AND SHOP, SO WHY DON'T WE HAVE THE SAME HEALTH PROTECTIONS WHERE WE ALL LIVE? NEW

YORKERS WANT TO LIVE IN A SMOKEFREE HOME BUT CURRENTLY MANY ARE FORCED TO BREATHE IN SOMEONE ELSE'S TOBACCO SMOKE. 5940 WILL BE AN ADDED INCENTIVE FOR LANDLORDS TO VOLUNTARILY ADOPT A SMOKEFREE POLICY FOR THEIR BUILDING BUT SHOULD HAVE WORDING TO THE EFFECT THAT THE DISCLOSURE POLICY DOCUMENT DOES NOT WAIVE ANY FORM OF PROTECTION THE RESIDENT HAS SHOULD THEY ENCOUNTER ANY EXPOSURE FROM SECONDHAND SMOKE.

NEW YORK CITY IS AN INTERNATIONAL CITY. BY PASSING **INTRO 1140** NYC WOULD JOIN OTHER INTERNATIONAL VENUES THAT ALREADY PROTECT YOUNG AND VULNERABLE LUNGS FROM TOBACCO SMOKE WHILE IN A VEHICLE. THE UNITED KINGDOM, FRANCE, SEVERAL CANADIAN PROVINCES AND AUSTRAILIA'S VARIUS TERRITORIES WOULD JOIN STATESIDE VENUES WHERE SMOKING IS PROHIBITIED WHEN A CHILD IS A PASSENGER IN ARKANSAS, CALIFORNIA, LOUISIANA, MAINE, UTAH AND THE COMMENWEALTH OF PUERTO RICO. ALL OF THESE JURISDICTIONS HAVE ENACTED LEGISLATION TO PROTECT CHILDREN TO THEIR MID-TEENS, THEREFORE I AM REQUESTING THAT THE EFFECTIVE AGE IN INTRO 1140 BE RAISED FROM 8 TO 18, WHICH COULD PROTECT THE HEALTH AND SAFETY OF THE TWO MILLION NEW YORKERS UNDER 18 YEARS OF AGE AND COUNTLESS NON-RESIDENT CHILDREN VISITING WHO TRAVEL IN THIS CITY IN A PRIVATE.

INTRO 484 WOULD REMOVE THE STIPULATION THAT COMMON AREAS OF RESIDENCES WITH LESS THAT 10 APARTMENTS ARE EXEMPT FROM THE NYC SMOKEFREE AIR ACT. THIS LAW IS A NO BRAINER AND SHOULD HAVE BEEN ENACTED SEVERAL YEARS AGO.

ANOTHER NO BRAINER IS TO PASS LEGISLATION PROHIBITING SALES OF TOBACCO PRODUCTS FROM PHARMACIES. THAT IS WHAT **INTRO 1131** WILL ACCOMPLISH. PHARMACISTS WHO WORK IN NEW YORK ARE LICENSED AND REGULATED BY THE NY STATE DEPT OF HEALTH, AND THE AMERICAN PHARMACIST ASSOCIATION HAS STATED THEY ARE OPPOSED TO THE SALE OF TOBACCO PRODUCTS IN PHARMACIES. WALGREENS, DUANE READE AND RITE-AID STORES HAVE HAD ENOUGH TIME TO FOLLOW CVS' VOLUNTARY REMOVAL OF CIGARETTES FROM THEIR SHELVES AND SHOW NO SIGNS OF DOING SO. IT'S TIME THE CITY COUNCIL DOES IT FOR THEM.

IN CLOSING, AT A PUBLIC HEARING A YEAR AGO FEBRUARY I TESTIFIED IN FAVOR OF INTRO 139 TO REGULATE HOOKAH LOUNGES. SINCE THEN THERE HAS BEEN A NUMBER OF REVISIONS AND I ASK THAT THE HEALTH COMMITTEE MOVE FORWARD ON THIS BILL THAT CREATES A FRAMEWORK FOR REGULATION OF EXISTING HOOKAH LOUNGES WHILE IT PROHIBITS THE ESTABLISHEMENT OF ANY NEW ONES.

Notes: Karen Blumenfeld, Executive Director of NJGASP – colleague since the late 1980s
Karen strongly supports the hookah lounge regulations and smokefree cars, and the package of bills, but she reviewed each bill and indicated to me there is a need for uniformity to treat all products the same (licensing, taxation, pricing floors, etc.), which is a procedural matter

Bill -1140-2016
Prohibiting smoking and using electronic cigarettes in vehicles when a child under the age of 8 is present.

My name is Eileen Miller; I am a Nurse Practitioner, and a Smoke Free Advocate.
I am speaking for all of the children and babies who have no say in what Adults do.
When I was younger I had a sister who died of a brain tumor at age 7. I had a brother who devastated our entire family by dying at 2 yrs old from new sudden onset of asthma.
Many years we struggled with this horrendous loss and never understood why this happened.
As an adult I did my own extensive research on second hand smoke in the home. When I advanced with the knowledge of the hazards of second hand smoke, I was shocked to learn the number of carcinogens in cigarettes smoke.
On reflection I quickly realized that my Compassionate loving parents, who smoked non filtered cigarettes their entire life, had no idea of the hazards to their children living in our home. My mother died from lung cancer, my father also died from cancer. How can we allow children with small lungs and babies with smaller lungs to breath in air containing chemicals such as: Arsenic formaldehyde, benzene, ammonia and vinyl chloride, to name a few. The air inside a car with cigarette smoke becomes quickly concentrated and the levels of the chemicals are continually re-circulated. Poisons in tobacco smoke can damage the cell's DNA (The instruction Manual) that controls the cells normal growth. When DNA is damaged the cell can begin growing out of control and can create a cancer tumor. E-Cigarettes causes' constriction in the lungs and the vapor contains nitrosamines that are also carcinogenic. As adults and parents it is our responsibility to protect our children at all costs. With our modern fast paced life, children already have many hurdles to cross. Please don't let the exposure to these deadly chemicals be one of them. Studies have shown second hand smoke is directly related to sudden infant death syndrome, asthma and other childhood ailments.
Please pass this bill for the children who have no say in what adults do.
Thank You,
Eileen Miller RN BS MS Adult Nurse Practitioner
rnmom917@aol.com

The American Lung Association "Key Facts about second hand smoke"
NBC news .com Smoking permanently damages your DNA Study finds.
Centers for disease control and Prevention/Smoking and Cancer
2016
BottomLineinc.com What E-Cigarettes really do to your lungs.10/29/2016

The Consumer Advocates for Smoke-free Alternatives Association

www.casaa.org 4225 Fleur Drive #189, Des Moines, IA 50321 202-241-9117

April 27, 2017

Testimony of Alex Clark, CASAA Executive Director
New York City Committee on Health
RE: Tobacco and E-cigarette Ordinances

Chairman Jones and distinguished members of the committee,

I am writing on behalf of our more than 2400 members in New York City to express concerns and opposition to Int. No. 1532, 1544, 1547, and 1131.

These bills fail to make a distinction between the risks of smoking versus the very low risk of smoke-free tobacco and nicotine products. Regulating low-risk, smoke-free products like e-cigarettes, snus, and smokeless tobacco just like cigarettes places current smokers at risk of continuing to smoke and generally misinforms the public.

We are strongly opposed to Int. No. 1532 which would enact a moratorium on issuing new vapor retail licences 90 days after becoming law. A consequence of this law will be to prohibit new independent vapor retail shops (vape shops) from opening and effectively freezes existing shops in place. This puts consumers at a disadvantage as the most accessible places to purchase vapor products will be the same places that sell cigarettes--a product that former smokers should, obviously, avoid.

Vape shops play a vital role in the effectiveness of vapor products. By way of background, vapor retailers and manufacturers are prohibited by federal law from marketing e-cigarettes as smoking cessation products or even less harmful than cigarettes. Despite this, the vape shop has provided a space for peer-to-peer support for former and transitioning smokers to develop.

Although vape shop employees are restricted to attending to customer service and technical assistance issues, customers are bound by no such law. It is not uncommon to hear successful quit smoking stories exchanged between customers in a vape shop. To the casual observer, sharing such a story might not seem like much but, between people who are recovering from a multi-year or multi-decade cigarette addiction, it can mean the difference between living a smoke-free life or returning to the devil they know.

We are opposed to Int. No. 1547 which, in addition to establishing licensing caps, expands the "retail dealer" definition to include retailers who sell any type of tobacco product. The broad definition of tobacco products captures low-risk, smoke-free tobacco products that many smokers use as a safer alternative to cigarettes. We recommend that the committee remove smokeless tobacco and snus from the definition of "tobacco product" in favor of a separate definition for smoke-free tobacco products.

Although retail dealers that sell smoke-free tobacco products exclusively are rare, it is a business model that should be encouraged. By including smokeless tobacco and snus in the tobacco products definition, the city will be taking away any motivation for retailers to transition or establish shops that do not sell combusted cigarettes.

Similar to our objection regarding 1547, we urge the committee to remove the price floor proposed for smokeless tobacco in Int. No. 1544. Ostensibly, the intent of minimum pricing is to discourage youth from purchasing harmful products. But, this regulation also has an affect on the purchasing decisions of adults--specifically, smokers who might otherwise switch to a safer tobacco product. By subjecting smoke-free products to regulations intended to discourage use, the city is misinforming consumers about the low risks of smokeless tobacco compared to smoking.

Generally, CASAA does not agree that raising the price floor for cigarettes and other tobacco products will benefit public health in New York City. The excessive cost of tobacco products in New York City and state is driving a robust and lucrative black market. We know from recent and past experience that black markets for alcohol and drugs have created more problems for public health and safety. Specifically, there is no expectation that minimum legal sales age regulations are enforced and consumers have no assurances regarding the authenticity or quality of the products they buy. Arguably, New York has gone beyond a point of diminishing returns on raising the price of tobacco products.

We urge the committee to consider the consequences of continuing to support aggressive tobacco regulations that broadly include all tobacco and nicotine products. Science and technology are driving innovation of safer alternatives to cigarettes and other combusted products. CASAA is hopeful that we can work with health professionals and policy makers to implement harm reduction strategies that will significantly reduce the early death and disease attributed to smoking.

Thank you for considering our comments on this issue. I am available for any questions you may have.

Alex Clark
CASAA Executive Director
aclark@casaa.org
201.310.0941

April 27, 2017

Re: In opposition to Int. 1131, Int. 1462, Int. 1532, and Int. 1547

Distinguished Members of the New York City Council Committee on Health:

Logic Technology Development LLC, headquartered in Princeton, New Jersey, is one of the largest suppliers of electronic cigarettes in the USA.

On behalf of our employees, customers, and consumers, I am writing to urge you to reconsider your proposed legislation, and I lay out the reasons for our opposition below.

Int. 1131-A & 1547

Logic fundamentally disagrees with restricting adults' access to tobacco products through prohibiting sales in pharmacies and creating a cap on tobacco retail licenses.

Logic shares a common goal with the Mayor - minors should neither vape nor smoke, and should not be able to obtain tobacco products. Everyone should be appropriately informed about the health risks of smoking. These core principles are central to the way we operate our business.

However, it is important to be clear that, while one of the stated objectives of this proposal is to reduce youth smoking rates, in practice, this measure affects only adult consumers. It is already unlawful for retailers to sell tobacco products to minors, regardless of whether pharmacies are allowed to sell tobacco products or of the number of licenses available.

We believe that concerns over youth access would be better addressed by stricter enforcement of the 21 year old minimum purchase age and harsher penalties for anyone found to be breaching the law.

Tobacco products are legal for adults to purchase, and vaping is an adult choice. Adults who choose to vape are entitled to be treated fairly and equally, and to have the right to choose – and the ability to obtain – the products they prefer. Legal tobacco products should therefore be available to purchase and very clear and convincing reasons, based on credible evidence, are necessary to restrict the existing means by which adult smokers access tobacco products.

Logic is not aware of any clear and compelling evidence that the measures proposed would in any way reduce the smoking prevalence in adults or minors.

In sharp contrast, we are concerned that the proposed regulation would have serious and widespread negative effects, including:

- Creating further incentives for unregulated, black market sales of tobacco products. It appears at odds that the City would wish to reduce the number of legitimate, licensed and responsible retailers, who care about ensuring that tobacco products do not end up in the hands of minors, only for these to be replaced by unlicensed criminals who will exploit the reduction in legitimate supply, thus exacerbating the existing illicit trade in New York City. The criminals involved in the

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supply of illegal tobacco products have no concern for the law, regulatory compliance or age verification. Efforts to reduce the number of licensed retailers will make the job of enforcement and control much harder.

- Restricting the number of stores selling electronic cigarettes may push consumers towards the internet, which remains a largely unregulated space and an opportunity for the circumvention of regulation and sales tax.

- Logic is aware that the availability of counterfeit e-cigarettes has already started to become a problem. In our capacity as a major e-cigarette company, we are working with law enforcement to support its efforts in this regard. However, we are concerned that, should an environment be created that restricts the sales of legitimate products through traditional channels, the problem of counterfeit electronic cigarettes may worsen.

- Reducing the means by which adult consumers can access electronic cigarettes in New York City amounts to overly burdensome interference with distribution channels. This interference involves artificial changes that will prefer certain channels over others, to the benefit of some operators and the detriment of others without justification, and will invariably restrict consumers' options for accessing legal tobacco products. The choice of whether to sell tobacco products should rest as a commercial decision with the retailers, in compliance with the regulatory requirements at play. For example, some pharmacy chains have taken the decision on their own not to sell tobacco products. This same free choice should be available to pharmacies that do wish to sell these products.

- The proposed measure could have unintended consequences for economic development. The possible effect of the measure is that businesses could be unable to establish themselves in certain areas, where legitimate demand exists, if they wish to sell tobacco products. This may in turn limit economic growth and job creation in those areas and may also result in reduced competition in the market place and the availability of other products sold in these stores. As such, the proposal may negatively affect all consumers in the area, not just adult tobacco consumers.

Int. 1462

Logic does not believe that the introduction of a display ban in New York City is either appropriate or necessary.

Despite several countries having enacted a display ban, there remains no reliable evidence to justify the effectiveness of such a measure. Its introduction would have serious negative effects on competition, retailers, consumers' informed choices and legal trade, without causing a reduction in tobacco product use.

Display bans freeze and damage competition by creating significant barriers for new market entrants/brands, making "brand switching" much harder and impairing innovation by manufacturers. This is even more important for the e-cigarette category, which remains in its infancy and is still meeting the recent costly and burdensome regulations by the Food and Drug Administration.

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Consumer choice will be severely impaired, along with their ability to switch between brands, as without product display, consumers will request and purchase only those brands familiar to them. Our ability to encourage adult smokers to purchase and try e-cigarettes through the ability of consumers to see our products at retail will be eliminated.

As adults are entitled to purchase and consume tobacco products, like all other legal consumer goods, they should have access to information that would assist them in their choice, including which products are on sale at a given time.

Additionally, the perception of the differences between legal and illegal tobacco products will be blurred, which may result in a higher illegal consumption. Such a situation would serve to further undermine public policy objectives.

Int. 1532

Logic agrees with the Mayor that retailers of tobacco products, including electronic cigarettes, should be known, identified, and appropriately licensed. We believe, however, that brick and mortar stores that already possess a tobacco retail license should not be required to obtain a second license, and that existing tobacco licenses be expanded to encompass the retailing of electronic cigarettes. It is our firm belief that it would be wrong for responsible and hardworking retailers to be punished by requiring them to apply and pay for two separate licenses that serve a practically similar function.

We believe that a better solution would be for all retailers of tobacco products, whether or not these are solely electronic cigarettes, to be required to obtain and hold a single, valid tobacco retailing license that reflects the types of tobacco and/or vapor products they offer for sale.

As referred to above, Logic does not agree that pharmacies should be excluded from obtaining and holding a tobacco retailing license, as we believe that the decision as to whether to sell tobacco products or not should remain a commercial decision. Pharmacies are extremely well accustomed to selling age-restricted products and have the necessary checks and balances in place to ensure that these products do not end up in the hands of minors.

We believe that adult smokers should be given the choice and have the opportunity to purchase and try electronic cigarettes as an alternative to smoking combustible products and we feel that pharmacies play a significant role in this.

In conclusion, Logic is proud to be a regulatory and compliance-led organization. As a responsible company, we fully support science and evidence-based regulation. We operate self-imposed marketing restrictions, voluntarily place health warnings on our products and marketing materials and operate a stringent age-verification system for any online sales through our website. To reinforce our position against youth access to electronic cigarettes, Logic sponsors the *We Card* Program and serves on its Manufacturers Advisory Council. Logic supports and promotes *We Card's* ongoing efforts to raise awareness of responsible retailing and age verification requirements and to educate and train retail employees to identify and prevent underage attempts to purchase age-restricted products.

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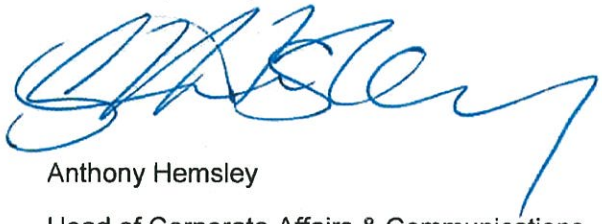
We look forward to continued participation in this debate and would ask that the points we raise be taken into full consideration. We remain at your disposal to meet with you or your staff, or to provide further information at any stage.

Yours respectfully,



Anthony Hemsley

Head of Corporate Affairs & Communications

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YAMA

YEMENI AMERICAN MERCHANTS ASSOCIATION

Testimony – Zaid Nagi

My name is Zaid Nagi. I am a businessman and a board member of the Yemeni American Merchants Association (YAMA). YAMA was formed after the Bodega Strike and rally we organized on February 2, 2017 in response to the Muslim Ban. The YAMA serves as a nonprofit organization providing education and advocacy services for Yemeni American merchants.

First, I would like to thank you for giving me this opportunity to speak on behalf of approximately 4000 Yemeni American merchants. We would like to go on record in opposition of the recent tobacco regulation legislation that has been introduced in City Council (Intro. Nos. 1131, 1462, 1544A and 1547).

We recognize the noble goals behind these proposed regulations; however, I and most Yemeni-American merchants believe, drawing on our long experience, that these bills, if passed, will lead to business closures, devalued businesses, loss of jobs, increased prices of other goods, and most importantly, it will lead to more crimes.

Without a cigarette license, which will become a reality for many businesses if the Intro. 1547 – License Cap is passed, it is almost impossible for bodegas to survive, especially when the sales of cigarettes contribute an important percentage of income and it will be equally difficult to start new bodegas and similar types of business.

Needless to say, that if businesses are closing, and no new businesses are opening, not only jobs will be lost, but also new jobs will not be created.

Additionally, when businesses are closed, this will lead to increased prices of other goods as well due to semi-monopoly that will exist in most neighborhoods because of licenses being kept by only a few as this proposed regulation calls for.

Yemeni American Merchants, who are in the front lines, have zero doubts that these proposed regulations, if passed, will expand the illegal trade of tobacco and other related products which in turn will create competition in the streets between criminals who will seize this golden opportunity which these regulations are handing to them.

And of course, when that happens and it is bound to happen as a direct result of enforcing Intro. 1547 and Intro. 1544A, our police will be preoccupied by working to limit these illegal activities. This will also lead to wasting resources as they work toward diffusing the growing conflicts as a result of the fighting between the illegal traders.

In short, we do not want other Eric Garners' moments.

Once again, we appreciate the noble intentions of this bill, but not only the Yemeni American community will be hit, but a variety of small businesses will be affected.

Thank you

Legislative Memo
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APRIL 27, 2017

LEGISLATIVE MEMORANDUM: SMOKING IN HOUSING ACCOMODATIONS

INTRODUCTION

The Real Estate Board of New York (REBNY), representing more than 17,000 owners, developers, managers and brokers of real property in New York City, appreciates the opportunity to comment on the Council's efforts to curb smoking in housing accommodations. A number of our residential property manager and owner members have already taken steps to restrict, and in some instances, prohibit smoking throughout their buildings, including private residences. However, these steps were only taken after careful planning and consideration of tenant needs and market conditions. Similarly, REBNY appreciates the Council's efforts to promote the well-being of New Yorkers but cautions that governmental regulation to private behavior should be carefully balanced so as not to inhibit personal freedoms.

INTRO NO: 484

SUBJECT: Banning Smoking in the Common Areas of All Multiple Dwellings

SUMMARY: Broadens the current prohibition of smoking in common areas to include all multiple dwelling buildings, incorporating buildings with fewer than 10 units.

SPONSORS: Vacca, Barron, Constantinides, Gentile, Johnson, Kallos, Koo, Richards, Rodriguez, Vallone, Cohen

REBNY TAKES NO POSITION ON INTRO No. 484 in large part because REBNY's members already comply with the provisions drafted by this bill, as outlined in the Residential Management Council's smoking guidelines.[1] REBNY's membership readily recognizes the health hazards associated with smoking and second hand smoke and recommends that the Council consider expanding the definition of "smoking" under NYC Administrative Code §17-502(y) to include substances other than tobacco.

INTRO NO: 977

SUBJECT: Banning Smoking in City-Financed Housing Multiple Dwellings

SUMMARY: Prohibits smoking in all areas of multiple dwellings receiving financing from the City.

[1] *Issues to Consider - Smoking and Second Hand Smoking in Multi-Unit Residential Buildings.* REBNY, Residential Management Council. April 2, 2012. Web. Accessed April 26, 2012. <https://www.rebny.com/content/dam/rebny/Documents/PDF/Rules%20%26%20Regulations/RMC_Subcommittee_Smoking_Policy.pdf>

Legislative Memo
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SPONSORS: Richards, Chin, King, Koo, Rodriguez, Salamanca, Jr., Cabrera , Grodenchik, Vacca, Gentile

REBNY OPPOSES INTRO No. 977. Because of the bill's broad definition of "City-financed housing," this bill affects a large swath of New York City's existing and yet-to-be-built housing stock. Captured in this definition will be developments that include mixed developments with market-rate and affordable units. The inability to smoke within the private residence in these buildings could devalue units and affect persons that are not beneficiaries of such "financial assistance." The potential of this bill to affect existing buildings would mean that many current tenants would be restricted in exercising their personal freedom to smoke.

Furthermore, our members monitor and enforce no-smoking policies primarily by managing complaints from neighbors and from reports from building staff. However, many housing complexes simply do not have the staff to adequately monitor smoking activity throughout a building. Finally, while building owners may adopt a no-smoking policy, a tenant-based violation of that policy should be enforced against the tenant – not the building owner as envisioned by this bill.

INTRO NO: 1585

SUBJECT: Disclosure of Smoking Policies for Class A Multiple Dwellings

SUMMARY: Requires owners to develop and provide an annual disclosure of a smoking policy within lease agreements and/or governing bylaws clearly stating where smoking is permitted and prohibited, relating to common areas and outdoor spaces in a Class A multiple dwellings. Owners must provide any changes of the policy in writing to their tenants. Penalties for these new provisions will result in fines of $100 for each infraction, in addition to existing penalties.

SPONSORS: Torres, Salamanca, Jr.

REBNY OPPOSES INTRO No. 1585. As noted in the introduction, REBNY's membership has already begun to adopt no-smoking policies throughout their portfolios, with the exception of tenants who smoke that have been grandfathered in. To enforce a smoking policy upon each residential building, which has to be verified by documentation–or face the consequence of a civil penalty, is simply too draconian. Moreover, with the Smoke Free Air Act of 2002, there is already a clear delineation stating where smoking is permitted and prohibited.[2] There is simply no need to further encumber property managers and self-managed cooperative boards to this needless regulation and paperwork.

[2] See, § 17-503-506, 17-513-513.4. New York City Administrative Code
See, §10 of Title 24. Rules of the City of New York.

NEW YORK CITY
C.L.A.S.H
Citizens Lobbying Against Smoker Harassment
P.O. Box 1036
Brooklyn, New York 11234
917-888-9317

April 27, 2017

Testimony of Audrey Silk, Founder

NYC Council Health Committee:
Int. No. 0139-2014: In relation to the regulation of non-tobacco smoking products, and to amend the fire code of the city of New York, and the New York city mechanical code, in relation to the operation of non-tobacco smoking establishments.
Int. No. 0484-2014: In relation to banning smoking in the common areas of all multiple dwellings.
Int. No. 0977-2015: In relation to banning smoking in city-financed housing.
Int. No. 1131-2016: In relation to the sale of tobacco products in pharmacies.
Int. No. 1140-2016: In relation to prohibiting smoking and using electronic cigarettes in vehicles when a child under the age of eight is present, and to repeal subdivision f of section 17-505.
Int. No. 1471-2017: In relation to increasing the retail cigarette dealer license fee.
Int. No. 1532-2017: In relation to the licensing of electronic cigarette retail dealers.
Int. No. 1544-2017: In relation to the regulation of retail dealers of tobacco products and of electronic cigarettes, the establishment of price floors and minimum package sizes for tobacco products and shisha, and the establishment of a tax on tobacco products other than cigarettes.
Int. No. 1547-2017: In relation to expanding the retail dealer license to include retailers of tobacco products and setting caps on retail dealer licenses.
Int. No. 1585-2017: In relation to disclosure of smoking policies for class A multiple dwellings.

My name is Audrey Silk and I speak on behalf of myself, as founder, and members of our organization.

Mayor de Blasio's, Health Commissioner Mary Bassett's and NYC Council Member's utter failure to look private individuals in the eye or to acknowledge their own interests in this matter -- treating them as if they are no more than damaged wards of the state in regard to measures intended to force them into behaving the way the aforementioned parties dictate in regard to the purchase and use of a legal product -- is beyond contempt.

One of the most progressive justice's on the U.S. Supreme Court, Judge Sandra Day O'Connor, has even recognized that adults are entitled to protection from the guise of "protecting the children" when she wrote, "The State's interest in preventing underage tobacco use is substantial, and even compelling, but it is no less true that the sale and use of tobacco products by adults is a legal activity." [1] In other words, adults demand respect. Their interests are not expendable at the expense of "the children."

The ultimate law addressing the desire to restrict tobacco access to minors already exists: the ban on sales.

You frame the issue as strictly one between government and industry and the related business interests (i.e. stores) with zero acknowledgement of private citizens who willingly choose to purchase and enjoy this legal product. It's not only a false assertion but intolerable.

Despite the decades of measures intended to defeat the "evil" industry, news this weeks says, "Against All Odds, the U.S. Tobacco Industry Is Rolling in Money." [2] Nothing you do is hurting them. The convenience stores (including so-called "pharmacies" that are no more than a store with a pharmacy counter in it) and bodegas are collateral damage of this so-called "public health" zealotry. That's as far as any of this is meaningful in regard to them in terms of the true injured party. The ultimate target, the ultimate victim, the party that government is oppressing is we the people. Pretend that we are not but we know better. And we despise your maltreatment. Anyone can say no to lighting a cigarette. Only *you* are the ones using force – of law – to control us… while ignoring our existence as autonomous adults.

At the end of 2010 when I testified against the council's plan to ban smoking in parks and on beaches I ended my statement with this: "Approve this and soon I'll be here again testifying against your plan to ban smoking in homes. Well I don't think so."

Of course we were assured it would never come to that. But today, this hearing includes a bill to ban smoking inside apartments of city-financed apartment buildings and another creates the conditions for privately owned multi-unit dwellings to consider doing the same by forcing owners to single out the subject of smoking in lease documents.

Our previous concerns vindicated we now stand by our word that airing objections at what amounts to no more than a pro forma proceeding on a preordained conclusion is not only a waste of time but beneath our dignity. Rather, C.L.A.S.H.'s position, as further stated at that last time at bat, is to advocate peaceful individual resistance. Good men disobey bad laws. One need only to take a stroll in a park or on a beach today to see this is what has unfolded.

Our disgust registered, I turn to the discussion of the actual bills being introduced today:

- Int 1140-2016, sponsored by Council Member Fernando Cabrera, seeks to prohibit smoking and vaping (of electronic cigarettes) in vehicles when a child under the age of 8 is present.

Congratulations for giving police officers a beautiful way to get around the clamp down on stop, question and frisk! Pulling people over for something as inane as smoking as an excuse to probe for more is a gift. I should know. I'm retired NYPD.

- Int 0977-2015, sponsored by Council Member Donovan J. Richards, will ban smoking inside apartments of city financed buildings.

Congratulations for putting more minorities out of their homes to loiter on the sidewalks and attract the attention of the police while the more affluent get to remain comfortably and safely in their homes! (We will be suing HUD over the federal smoking ban in public housing apartments so it's premature to try to fall back on that.)

- Int 1544-2017, sponsored by Council Member Corey D. Johnson, increases the floor price on a pack of cigarettes from $10.50 to $13.00. It also raises the price and tax on cigars, little cigars, smokeless tobacco, shisha and loose tobacco.

Congratulations for increasing the number of "buttleggers" ready to meet the demand for lower cost smokes (New York already has the highest rate of cigarette smuggling at over 55% [3]).

So congratulations too for making it easier for minors to buy cigarettes! Teens know better than anyone else where to get "the goods." (Where do you think they get their pot?) And unlike stores no carding!

Congratulations for helping to fund terrorism and using those minors and adults to do so! Terror-tied individuals are well known to take advantage of this lucrative endeavor created by our politicians. [4] Better a bomb that no one invites than freedom to make an invited, informed legal choice, right?

Congratulations for creating an even greater incentive to burglarize and rob bodegas and convenience stores! Many times the details in a news report include the fact that cartons of cigarettes were targeted during these crimes. And hey, that's more illicit street sales to minors. Way to go!

And a really hearty handshake and congratulations for beating out your competitor – the tobacco industry – by making more money off the sale of a pack of cigarettes than they do! [5] Who is it really that is in the business of selling cigarettes these days?

One need only to turn to the stories coming out of the Mid East to understand what is really going on here despite the assertions to the contrary coming from men and women abusing their white coats and men and women abusing the power of their elected office to coo that they are only trying "to save lives" while snuffing out one's choice of how to live.

Not the only but the latest, the NY Times headline reads, "After ISIS, Smoking Openly to Feel Free." [6] It speaks for itself. Nevertheless, the story of this Iraqi man, liberated from the Islamic State, explains the state of his own being under their rule -- one that included being subjected to the anti-smoker mindset. You'd no doubt have the nerve to say that it's only the nicotine talking!

Oppression is oppression. We New Yorkers yearn to express the same freedom because when it comes to smoking we are being treated the same way. It's a matter of being let alone to live freely rather than the way the group in power demands.

About NYC C.L.A.S.H.:

Citizens Lobbying Against Smoker Harassment is a grassroots organization established in 2000 dedicated to advancing and protecting the interests of adults who choose to smoke cigarettes or enjoy other forms of tobacco or use electronic cigarettes.

Endnotes:

1. Lorillard Tobacco Co. v. Reilly, 533 U.S. 525 (2001)
https://casetext.com/case/lorillard-tobacco-co-v-reilly

2. Wall Street Journal, April 23, 2017
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WRITTEN TESTIMONY
FOR THE APRIL 27, 2017 HEARING OF
THE NEW YORK CITY COUNCIL HEALTH COMMITTEE
ON ITS SERIES OF ANTI-SMOKING PROPOSALS

SUBMITTED BY
LINDA STEWART, NEW YORK CITY

> ***"The crusade against smoking...is now entering the danger stage... For this is a real crusade, make no mistake, and the true crusader doesn't stop at burning the village, killing the women and children and making off with the cattle if that's what it takes to purify the world."***
>
> -- Russell Baker, the New York Times (1)

Though I hope you'll include this statement in the record, it 's simply "for the record" since you've made up your minds to enact these proposals, and your hearings--at which you won't listen to objections-- are simply pro forma.

That said, I'm still bound by conscience to object to this ongoing persecution of smokers that's become no more rational than the Salem witch hunts, that tramples the traditional notion of civil liberties, and seeks to impose its will by demonizing, pauperizing, isolating, and ultimately evicting from its presence those whose will it doesn't break.

I'll concentrate here on the two most egregious of your punitive propositions--the infringement on the constitutionally-protected right to privacy in the home. To start with:

Int. O977-2015

> Proposed by Mr Richards , it would threaten city tenants with eviction and homelessness for the newly-invented crime of smoking in their own private apartments in buildings that are subsidized so tenants can afford to have a roof over their heads. These residents are the poor; many hard-working, and others are elderly and/or disabled.

I must first begin by asking *you*, Mr. Richards--as well as the rest of you who'll vote for his proposal**:**

> **How ruthlessly cruel are you really willing to be?**
>
> **What Cause is so great that *you*-- yes, *you*, because you're the ones who'll do it-- will be willing to dispossess unfortunate people, to ruin their lives, to deprive them of pleasure or a respite from stress, to add to their stress, to sacrifice--no, not yourselves, but *them*--to your personal and allegedly noble crusade?**

And please don't claim that it's "for their own good." You have no way of knowing what's "good" for the millions of people you've never met and, most likely, don't even know what's "good" for yourselves--and if you do, you most likely don't do it very often.

And the secondhand smoke thing really won't wash. There's zero science to justify this ban. In context, what you're calling secondhand smoke doesn't even contain smoke. And indirect "exposure" to the small number of stray, air diluted molecules that conceivably might escape under a doorway or through a vent has never been shown--by any study, or any objective means-- to threaten people's health. The only real threat, in fact, comes from the hysteria that's been carefully and endlessly fomented around it and which causes anxiety and the symptoms thereof.

Historically, the only studies ever done on the health effects of actual--not molecular-- smoke were done on married couples who'd been living together for 30-40 years (direct exposure to actual smoke) and on workers sharing the same (not separated) space for 20-25. Even then, the few studies that showed an increase in risk (you're never told about the peer-reviewed studies that didn't) showed an increase so small that in other contexts it's been called "never mind."

Not that you're interested in counter-intelligence--if you were, I could write a book--but just for the record, here are but a few of the scores of major studies you don't want to know about:

> A 1998 study conducted by the World Health Organization which ran for 10 years in 7 European countries concluded there was no statistically significant risk for non-smokers who either lived with or worked with smokers. (2)
>
> A study under the aegis of the American Cancer Society that for 39 years followed over 35, 000 nonsmokers who were married to smokers showed absolutely no extra lung cancer risk. (3)

And again, we're talking about exposure to actual full-bore smoke within the same four walls for up to 39 years!

And yet here you are-- trying to make a mountain out of a molecule.

Perhaps you're concerned about about respirable particulates (RSPs) that might float through the air?

> A experiment by the government's Oak Ridge National Labs that hung air monitors from the necks of 173 bartenders and wait staff working in traditionally smoky environments, recorded a measured level of RSPs that was 85% safer than OSHA's own standard for safe-to-breathe air, and reported about the same for environmental nicotine. The study was then repeated with 1500 subjects in 16 cities and reported the same results.(4)

So in other words, by actual empirical measurement, the air in smoky bars is officially *not* harmful but you're nonetheless willing to persecute the tenants of "affordable housing" on account of a few molecules that might, on occasion, contrive to insinuate themselves through a vent. And which could, in any case, be stopped by proper caulking or an air-cleaning machine.

And what will you do with these homeless smokers?

Leave them on the streets?

House them in one of your unsafe shelters?

Deport them to Mexico?

Or how about a ghetto?

There's an idea! After all, you've spread the word that they're vectors of disease, carriers of death, folks to be feared by all decent nonsmokers who'll be glad to be rid of them.

Rings a faint bell.

Seems to me the council is attempting to achieve a smoker-free city in the same way that Warsaw got a Jew-free city:

Quote: Hans Frank, Nazi governor of occupied Poland, April 1940:

> It is unacceptable that representatives of the Reich should be obliged to meet Jews when they enter or leave the house and are, in this way, liable to infection from epidemics." [Result: The Warsaw Ghetto]

Quote: Joseph Goebbles, Reich Minister of Propaganda, August 1941

> The Jews have always been carriers of infectious disease.They should either be concentrated in a ghetto and left to themselves or liquidated, for otherwise they will infect the population." (5)

Yes, I know. You hate that analogy but, still, there it is.

So on to Round Two.

"The missionary impulse of people blessed with higher wisdom can be a terrifying force." -
Baker, op cit

Not far removed is the second proposal also affecting housing--and based on the same inflammatory premise:

Int T2017-5930

> Proposed by Mr Torres. it would demand that all apartment buildings in the city include a "policy" about smoking in leases and sales (thus making violations a cause for eviction), or else, on the off-chance that smoking's still allowed, to serve as a warning to innocent nonsmokers that somebody somewhere in the building might smoke, with the clear implications that this fact alone will "endanger their health."

Despite the several centuries of smokers and nonsmokers coexisting in harmony, neither knowing nor caring who smoked and who didn't (and not falling ill because somebody else did). you've managed to manufacture, not a Brave New, but rather a Frightened New World.

To whatever extent you've made the public believe--through a decades-long stream of libelous propaganda --that smokers are dangerous and toxic human beings-- or sub-human beings--you've created the nasty and irrational demand for smoker-free housing. Vicious circle defined --accent on the "vicious." (See Goebbels, above.)

What else you're doing with this seemingly neutral and innocent proposal has broader implications. You're forcing landlords to HAVE a policy on matters of personal and legal behavior that, traditionally at least, have been none of their business and certainly none of yours. Opening the door to all manner of invasive "lifestyle" control.

In the matter at hand here, your goal is transparent: to nudge all buildings to become "smoke-free" --another way of saying to go "smoker-free," --to remove the last redoubt where a smoker can still smoke in this once most metropolitan of cities.

Smokers, start packing. The signal has been sent. We don't want you here among the kale-eating joggers. We'll continue to make you objects of hatred and fear. We'll drum you out of town. No room at our inns.

And as for the rest of your extortionate program, perhaps this applies:

In an article in *The New Republic*, on the subject of smoking and civil liberties, Michael Kelly described your efforts as The Nurse Ratched State:

> "Nanny state" is far too kind a term. It is too cold, too cruel, too implacable, too illiberal to be a nanny. It is the Nurse Ratched state
>
> This new model of statism is devoted to spectacular schemes of social engineering-- and it has added the awful idea that these schemes may be achieved ..through a creative and brutal system of mandated behaviorism, in which the state uses its immense powers to force targeted citizens and entities to "voluntarily" accept a violation of their rights and an encroachment upon their liberties -- and to pay for this privilege.
>
> The two principal methods by which the Nurse Ratched state achieves its aims are rooted in that power which the Framers wanted most to limit, the power to criminalize and punish, to deprive a citizen who violates the state's wishes of his liberty or his property. The methods are the expansion of the definition of actions as illegal behavior, and the exploitation of this power to win submission through extortion -- by threatening to extract or to deny large amounts of money from noncomplying individuals and entities."(6)

Q.E.D.

Footnotes

(1) "The Danger Stage" Baker, NY Times, 5/31/94

(2)" Multicenter Case-Control Study of Exposure to Environmental Tobacco Smoke..." Bofetta et al, Jnl of the NCI, vol 90, No. 19, 10/7/98

(3) "Environmental Tobacco Smoke and Tobacco-related Mortality in a Prospective Study of Californians, 1960-1998.," Enstrom and Kabat, BMJ, 5/13/03

(4) "Determination of Exposure to Environmental Tobacco Smoke in Restaurant and Tavern Workers..." Jenkins et al, Jnl of Exposure Analysis and Environment Epidemiology, 2/x/2000

(5) [Source: "Statements of Hitler and senior Nazis concerning Jews" http://www.ess.uwe.ac.uk/genocide/statements.htm

(6) "The Nurse Ratched State," Kelly, TNR, 6/27/97

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To Whom It May Concern:

The Arab American Association of New York respectfully submits this letter of support regarding the legislation in the City Council about hookah smoking. We recognize that hookah smoking has been an alarming health problem in New York City. Hookah lounges incorporate tobacco into their hookah, allowing underage youth entry, and emit toxins. One hookah smoking session is equivalent to 80-100 cigarettes which continues to remain unregulated under New York City Law. The Arab American Association of New York is invested in supporting the legislation to help combat the hookah epidemic and supports a bill that would take a more health and safety orientated approach while remaining sensitive to the cultural and small business model, especially to those within our own community.

AAANY recognizes that hookah smoking does pose a health risk to smokers and nonsmokers alike, including employees at establishments that serve hookah. Hookah establishments should meet the same ventilation requirements as smoking lounges to improve the air quality in these establishments to further support the City's Smoke-Free Air Act to further provide all New Yorkers with access to clean air in public places and workplaces, and by discouraging smoking and reducing exposure to secondhand smoke for nonsmokers it continues efforts to de-normalize smoking and reduce citizen's tobacco dependence.

Sincerely,

Dr. Ahmad Jaber, President

AMERICAN COUNCIL OF MINORITY WOMEN

Bazah Roohi
Founder/Executive Director

Dear Council Member,

I represent American Council of Minority Women, which opposes the use of hookah in establishments within New York City. **We find that hookah is a severe health risk both to those who directly inhale the shisha smoke and to those who inhale it secondhand.** It has been found that the use of hookah results in the intake of more toxic chemicals and harmful substances, including tar and carbon monoxide, than smoking cigarettes. In fact, the same cancer-causing chemicals found in cigarettes are found in abundance in hookah. **There is no reason why hookah should not be included in NYC's Smoke Free Air Act ("SFAA").**

We formally grant our support to Int. 139 by Council Member Vincent Gentile and others in the Council, which would add hookah to the SFAA.

In addition, we are aware that, as an investigation by DOHMH brought to light, many hookah bars illegally mix tobacco with the shisha that is smoked on the premises. Enforcement against this is currently difficult due to the extensive effort needed to prove that the compounds being smoked include tobacco. The bill would also curtail the expansion of this illegal activity. Since hookah bars would have to be licensed, they would need to comply much more with government inspections and be less likely to add tobacco.

It is for the overall health concerns caused by hookah, including that of added tobacco, that we emphatically urge you to support Int. 139. Hookah is dangerous to people of all backgrounds and needs to be regulated like all other forms of smoking!

Sincerely,

Bazah Roohi
Executive Director
American Council of Minority Women

ANR AMERICANS FOR NONSMOKERS' RIGHTS

Defending your right to breathe smokefree air since 1976

April 26, 2017

MEMORANDUM IN SUPPORT
New York City Intro 139B, Gentile et. al

On behalf of our members in New York City, Americans for Nonsmokers' Rights encourages the City to amend the administrative code in relation to the regulation of nontobacco smoking products, and to amend the fire code of the City of New York in relations to the operation of non-tobacco smoking establishments. Prohibiting the use of hookah in smokefree venues would protect workers and patron from exposure to the secondhand smoke that hookah pipes and devices emit into the air.

The City of New York would be in good company in prohibiting the use of hookah in enclosed public places and workplaces in accordance with the City's Smoke Free Air Act (SFAA). Currently,more than 150 localities as well as 3 states, Delaware, Illinois, and Utah, prohibit hookah smoking in smokefree environments.

This legislation will update the SFAA to continue the progress the City has made in reducing use and exposure to tobacco. Given these facts, Americans for Nonsmokers' Rights urges the City of New York to prohibit hookah smoking in all smokefree places and workplaces, at all times, without exception.

Thank you for your leadership and desire to make New York the best place to live, work, and visit. Please feel free to contact me at 510-841-3045 if you have any questions, comments, or feedback.

Sincerely,

Cynthia Hallett

Cynthia Hallett, MPH
President and CEO

Americans for Nonsmokers' Rights is a national, member-based, not-for-profit organization based in Berkeley, CA that is dedicated to helping nonsmokers breathe smokefree air since 1976.

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cphs*

*putting the public back in public health

April 26, 2017

MEMORANDUM IN SUPPORT
New York City Intro 139B, Gentile et. Al

The Commission on the Public's Health System, a citywide health advocacy organization supports New York City Intro 139B, which would include on-tobacco hookah smoking to the city's Smoke Free Act (SFAA.

We support for the following reasons:

1. A hour of smoking hookah, is the same as smoking a pack of cigarettes. That's how much tar and nicotine you'll be exposed to. Studies have shown how addictive Nicotine is.

2. Many teens believe this is safe, and of course, we know it's not safe. Hookah smoking has many of the same health risks as cigarette smoking. The charcoal used to heat the tobacco can raise health risks by producing high levels of carbon monoxide, metals, and cancer-causing chemicals. Hookah tobacco and smoke contain several toxic agents known to cause lung cancer and other respiratory illnesses, bladder, and oral cancers., periodontal diseases, and low birth rate

3. Traditional (e.g., cigarettes, cigarillos) and new tobacco products (e.g., e-cigarettes, flavored cigars) are so more widely available and more affordable to purchase in low-income, immigrant and communities of color

4. Tobacco-related health disparities (TRHDs) affect individuals, children and families, communities, and the economy in shattering ways.

In 2016, 14.3% of New York City residents smoke and more than 200,000 children were exposed to secondhand smoke at home. It is costing New York City about $1,488 dollars per household for smoking-related health care cost.

We know nationwide that tobacco control efforts have been credited with preventing about eight million premature deaths. Yet control efforts are still weak in many parts of the country. Despite progress being made, black and Latino smokers continue to be less likely than whites to receive and use tobacco-cessation interventions, even after control for socioeconomic and healthcare factors.

Sincerely

Anthony Feliciano
Director

DOCTORS COUNCIL
a national affiliate of SEIU

A United Voice for Doctors, Our Patients, & the Communities We Serve

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MEMORANDUM IN SUPPORT
New York City Intro 139B

To amend the administrative code of the city of New York, in relation to the regulation of non-tobacco smoking products, and to amend the fire code of the city of New York, in relations to the operation of non-tobacco smoking establishments.

Doctors Council SEIU supports New York City Intro 139B, which would include non-tobacco hookah smoking to the city's Smoke Free Air Act (SFAA). Doctors Council SEIU represents thousands of doctors in the Metropolitan area, including in every NYC Health + Hospitals facility, the New York City Department of Health and Mental Hygiene, correctional facilities including Rikers Island, and other New York City agencies.

Currently, hookah lounges are mostly unregulated, with very few measures in place to ensure that patrons and employees at these locations are safe from toxins produced by smoking hookah. This bill will firmly regulate establishments like hookah lounges and give New Yorkers more access to clean air in public places.

Smoking hookah produces severe risks and similar hazards from smoking cigarettes. These risks include but are not limited to oral cancer, lung cancer, stomach cancer and reduced lung function. The World Health Organization has reported that, "Contrary to ancient lore and popular belief, the smoke that emerges from a waterpipe contains numerous toxicants known to cause lung cancer, heart disease, and other diseases."

Hookah smokers are not the only people at risks for these concerns. Secondhand smoke poses similar threats for nonsmokers as well.

We recognize the important cultural and social role that hookah establishments play in the City of New York and this legislation acknowledges that role while recognizing that "hookah smoke is not safe smoke."

The majority of hookah lounges are unregulated with hookah products containing tobacco. However, hookah lounges are not the only establishments that contribute to the use of hookah tobacco products. This legislation will regulate all these participating establishments to help provide New Yorkers with clean air and reduce tobacco related health problems. As a union comprised of dedicated health professionals, Doctors Council SEIU strongly supports Intro 139B because all New Yorkers deserve clean air.

April 27, 2017

Honorable Corey Johnson
Chair, Health Committee
New York City Council
City Hall
New York, New York 10007

Dear Mr. Johnson:

My name is Michael Weitzman and it is a great honor for me to testify before you today. I congratulate our City Council and Department of Health and Mental Health for their continued efforts to protect the public from a profound public health threat. I believe that the upcoming bill to be discussed today regarding waterpipes (hookahs) is a needed next step in the regulation of hookah use in New York City that I support wholeheartedly.

I am a pediatrician by training who is a professor of Pediatrics, Environmental Medicine and Global Public Health at New York University. I have more than 40 years of caring for and training thousands of others to care for children, adolescents and young adults; conducting research; and consulting to a large number of city, county, state and federal agencies, including the Centers for Disease Control (CDC) and Prevention, the Environmental Protection Agency, and most recently the Federal Food and Drug Administration on the effects of environmental contaminants such as lead and tobacco smoke on health. For the past 5 years my work has largely focused on water pipes, also known as hookahs. These studies have clearly indicated markedly dangerous levels of multiple chemicals in the air of hookah bars that cause cancer and heart disease, among other illnesses. They also have shown that hookah bar workers have evidence of widespread reactions, called “inflammatory” reactions, that indicate that the entire bodies of these individuals are adversely affected by

smoke generated by hookah smoke, even though they are not smoking hookahs themselves. We also have found that hookah smoke in homes permeate the entire home, far more than does smoking cigarettes, thereby endangering the health of non-smokers in those homes. Others have found that one hookah session, usually 45minutes to one hour, results in exposures to toxic agents equal to 5 packs of cigarettes. The epidemic of use of these agents is increasing at epidemic rates, posing a profound public health threat to New York City's (and the world's youth).

I fully support adding non-tobacco hookah smoking to the Smoke Free Air Act. In addition to nicotine, smoked vegetative matter contains over 6,000 chemicals, more than 60 of which have been found to cause 17 different cancers, and more chemical constituents and more cancers are likely to be identified. There is little about tobacco (combustible vegetative materials with nicotine) that makes it more dangerous to health than non-tobacco containing products that are smoked.

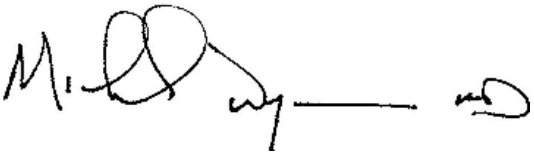
Prohibiting individuals under the age of 21 to enter establishments where hookahs are used is a markedly logical and needed regulation. More than 98% of cigarette smokers in the US begin to smoke before age 18. To the extent that hookah smoking may lead to cigarette addiction, it is imperative that we regulate young people's exposure to and use of agents that may lead them to use cigarettes.

Hookahs have been found to be terribly unsanitary, and as such very effective vehicles for transmitting truly terrible infectious diseases, including, but not restricted to Tuberculosis. I thus fully endorse your strengthening regulations aimed at keeping hookahs germ free.

Work that Drs. Gordon, Sherman and I have done clearly shows that hookah smoke in homes is far more dangerous to children and others than is smoking cigarettes in homes. I applaud and support the portions of the proposal that impose stringent ventilation and Air Quality /Flow Standards that non-tobacco smoking establishments have to follow. This is a truly important part of the proposed legislation.

By virtue of the proposed legislation New York City remains at the forefront of public efforts to prevent our children and population as a whole from the most pernicious and ubiquitous exposures. I applaud and support this proposal wholeheartedly and without reservation.

Respectfully,



Michael Weitzman MD
I
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April 27, 2017

Re: Tobacco control bills for consideration at today's NYC Council Health Committee Hearing

Dear Health Committee Chairman Corey Johnson and Committee Members,

I am the Executive Director of Global Advisors on Smokefree Policy ("GASP"), a nonprofit that serves as an educational resource provider on emerging trends and issues in tobacco control. Thank you for the opportunity to provide written testimony today to your Committee hearing, since I am unable to be present to testify and have some suggestions for improvement and parity.

With smoking being the #1 cause of preventable death and disease, we greatly appreciate the Committee's interest to curb access and use of tobacco products and e-cigarettes, create a framework for existing hookah lounges to use non-tobacco shisha, and to ban smoking in cars when children are present.

It is our understanding based on Mayor DeBlasio's press conference last week, that he is interested in fast-tracking a package of certain bills to help curb access, sales and to increase taxation and create licensing. We agree that these are important components of a strategic plan to curb tobacco and e-cigarette use and exposure. But in addition to this package of bills, it is equally important to fast-track the bills previously introduced more than a year ago in this Committee that (1) create a framework for regulating existing hookah lounges and not allow for new hookah lounges, and (2) ban smoking in cars when children are present.

Below are our comments per bill with suggestions to create uniform policies that apply to all products.

Bill # Int. 139-B: We applaud Councilman Gentile for his leadership to restrict the opening of any new hookah lounges, to limit the product used to non-tobacco shisha, and to have strict penalties for violations (license revocation for selling shisha containing tobacco, or if selling product to a person under age 21). In addition, we are pleased to see that based on GASP's testimony last year, the bill was amended to require sanitizing hookah apparatus between sessions, since sharing hookah increases the risk of spreading communicable diseases. New York City would become the first city in the nation to require sterilizing the hookah apparatus.

Please note that Int. 139 is stricter than the proposed bill to license e-cigarette retailers: Int. 139 only allows smoking in hookah lounges if proven that 50% of LAST year's sales are from hookah product. The new proposed e-cigarette retailer license does not have an existing cut-off date based on last year's revenues. So new e-cigarette retailers can apply for the license up to the effective date of the proposed bill, thus not reducing the # of e-cigarette retailers that allow vaping inside.

Bill # Int. 1140-2016: We applaud Councilman Cabrera for his leadership to ban smoking in cars when children are present. There is no safe level of secondhand smoke, especially for children who are more susceptible to negative health impacts from exposure. Many jurisdictions already ban smoking in cars, including when foster children are present, since it is in the best interest of the child. In addition, child custody legal decisions also ban smoking in cars when children are present, again in the best interest of the child. Even though cars may be private locations, sound public policy dictates that government protect children if they are in harm's way. In fact, HUD's recent regulation will require all HUD public authority housing be 100% smokefree.

Infants, toddlers and young children do not have the verbal skills to communicate that secondhand smoke is harming them in a car. Secondhand smoke is a class A carcinogen, the same class as asbestos and benzene. If private cars had asbestos in the air, the government already has regulations to prevent that exposure. Secondhand smoke should be treated the same. In addition, third-hand smoke, which is lingering secondhand smoke that adheres to vehicle surfaces like the seats and carpeting, continues to gas off the carcinogens and exposes children to toxins. We hope that your Committee supports measures to protect youth from involuntary exposure to smoking in vehicles.

Bills #484-2014, 977-2015. As noted above, HUD recently moved forward with a regulation to ban smoking in all public housing authority buildings throughout the nation. To reiterate, there is no safe level of secondhand smoke, and secondhand smoke travels within rooms of individual units, as well as into other units and common areas. Any bills that this Committee is considering that would eliminate secondhand smoke exposure, are to be commended, and we thank Council Members Vacca and Richards for their leadership on these two bills related to housing.

Bill #1585-2017: We commend Council Member Torres for his leadership on this bill that requires disclosure of the smokefree policy to tenants. However; there are two caveats:

(1) Tenants of lower economic status may not be able to afford to live in a 100% smokefree building, since many of the 100% smokefree resident buildings in New York City are market rate and not affordable housing. Thus, the proposed

disclaimer notice may work against such tenants if they have an issue with wafting secondhand smoke migrating into their unit, since they have few if any choices to have 100% smokefree affordable housing.

(2) The proposed bill may waive a tenant's rights to remedy secondhand smoke migration into their unit and common area. An analogy is how the warning labels required on cigarette packs can waive the rights of smokers to sue the tobacco industry, because they had notice that the products are dangerous to their health. To rectify this unintended waiver issue with this bill, we STRONGLY RECOMMEND that language be added explicitly state that a tenant's rights to remedy any concerns with secondhand smoke are not nullified or waived by acknowledging the landlord's disclosure of the smoking policy, including no waiver of their covenant of quiet enjoyment, warranty of habitability and any other remedy.

Bill #1131-2016: We commend Council Member Lander for his desire to have pharmacies not sell tobacco products, since the sale of such products contradicts the inherent purpose of a pharmacy which is to provide healthful products to the community. CVS Health decided to go tobacco-free, and garnered much goodwill from the public at large and health advocates, and did not result in long-term negative sales impact.

Bill #1532-2017: We commend Council Member Cabrera for proposing to license e-cigarette retailers, and for not allowing pharmacies to sell such products. It should be noted:

(1) The 2013 amendment to the City's smokefree air law requires such retailers "register" with the City health department, if their sales are 50% or more from such products. However, the definition of an electronic cigarette retail dealer under proposed 1532-2017 is different, in that a retailer needs to be in possession of at least 20 e-cigarettes with no reference to a 50% minimum in sales. We suggest that it be clarified whether there will be two different standards for registering vs. licensing an e-cigarette retailer. Or in the alternative, if the minimum of possessing 20 e-cigarettes will supercede the 50% requirement for registration.

(2) The proposed bill does not limit the USE of e-cigarettes in the e-cigarette retail store. To be consistent with the proposed bill to license only existing hookah lounges and not allow new hookah lounges, we suggest that 1532-2017 only permit existing electronic cigarette retail dealers currently registered with 50% or more in sales from such product to apply for the license. As noted by health experts, there is an exponential increase in the use of electronic smoking devices amongst youth and young adults, with many scientific studies in peer-reviewed journals concluding that the use of and exposure to e-cigarette vapor is harmful.

Bill #1547-2017: We commend Council Member Lander for their desire to reduce points of retail access for cigarettes and other tobacco products in communities. We recommend that the bill also consider retailer caps for e-cigarettes and related

products, since their usage is increasing exponentially especially amongst youth and young adults.

Bill #1544-2017: We commend Committee Chair Johnson for proposing to increase the price floor and taxes on cigarettes and other tobacco products. However, since there is an exponential increase in e-cigarette use by youth and young adults, and studies show an inverse relationship between pricing and usage for tobacco consumption (when prices rise, consumption declines), we suggest that the bill also create parity on price floors and taxes for e-cigarettes and related products. If the cost to purchase e-cigarettes and related products is not increased, there is the likelihood that their consumption will continue to increase.

Thank you for your time to review our comments, and we greatly appreciate all of the bill sponsors for their contributions.

Sincerely,

Karen Blumenfeld, Esq.

Executive Director

KAB/ms

Testimony to the New York City Council
Committee on General Welfare
Scheduled for April 20, 2017

Thank you for taking the time to read this written testimony, and I apologize for being unable to attend the hearing in person. My name is Josh Dean and I'm the Executive Director of a small grassroots organization called Hakook. Our mission is to serve and understand the street homeless population in New York City. To date, we've spoken to over 400 people and donated over $15,000 worth of winter coats, socks, snack bars, tampons and pads. Myself, along with my colleagues Audrey McCabe and Amelia Murray, are writing to support Int 1066-2016, which we feel is a step forward in understanding the scope of New York's street homelessness issue.

When we make deliveries to people on the street, we stay to talk about their experiences in shelters and drop-in centers, and also about their experiences trying to access supportive housing. While our testimony today will focus on the size of the street homeless population, it's worth briefly noting the trends we've identified within the street homeless population.

Almost every person we have spoken to has visited the shelter system, had a poor experience, and decided they feel safer and/or more comfortable living on the streets. Experts have told us that 85-95% of street homeless New Yorkers have at one point visited a shelter. People cite violence, drugs, and theft, both from other residents and from staff.

Their stories are frightening. One man told us about entering the shelter system sober and leaving with a drug addiction. He's currently on the waiting list for Breaking Ground's supportive housing, but he stayed outside during the snow storms in the winter as he waited to be sighted by the street outreach teams enough to become eligible for supportive housing.

One woman told us about waking up with a knife to her face. She was able to wrestle her way free, but has since decided she feels safer living on the streets than in the shelters.

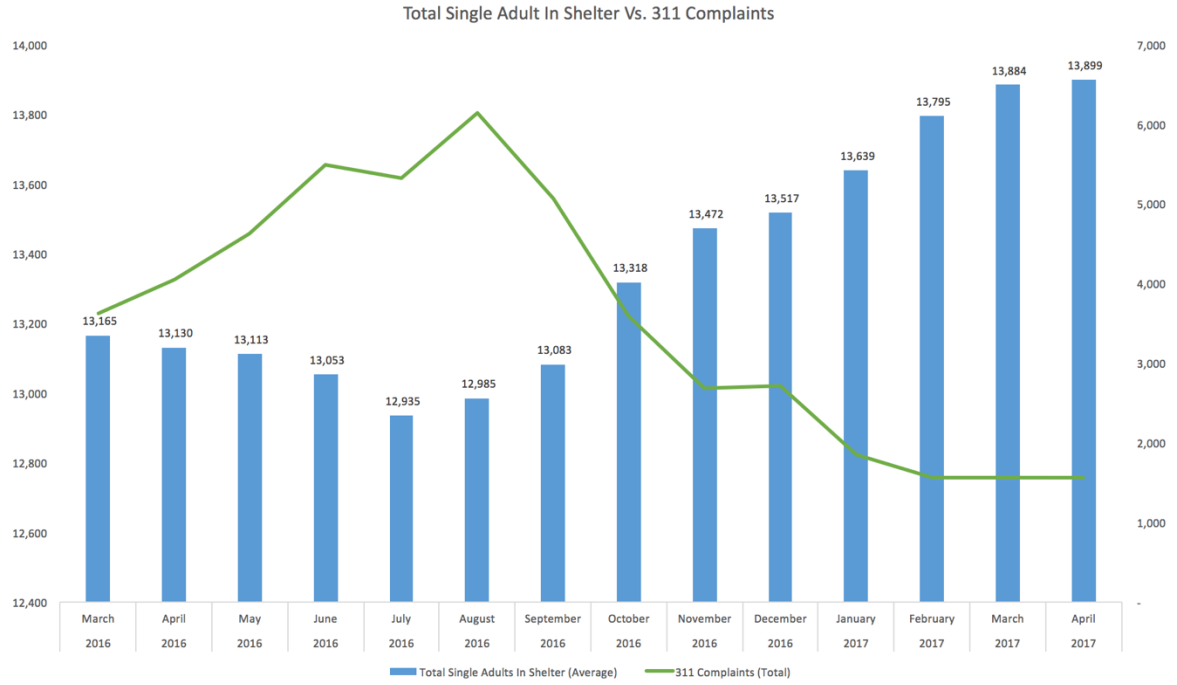
A veteran told us he was dragged into the bathroom and beaten at 30th Street Bellevue. He shared his medical record, which listed seven cracked ribs and nearly all his teeth knocked out.

We've also met adult families without children who have had trouble documenting their housing histories (or lack thereof), and have been denied a place in adult family shelters. They, too, are left with the choice of living apart from their loved one or staying on the streets.

Every night, homeless New Yorkers without children are forced to choose between sleeping on the streets or the subway, sleeping in a shelter, or sleeping somewhere else. This complex choice often boils down to a few questions:

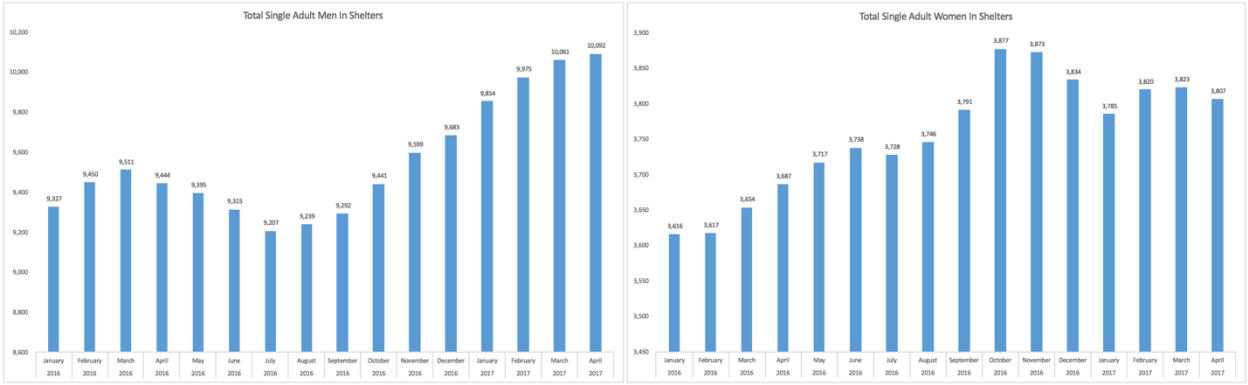
- What is the temperature and the weather tonight?
- How much money were they able to solicit today?
- Where do they feel the safest and the most comfortable?

Often times, the weather determines where someone decides to stay. In the graph below, the blue bars illustrate the decrease in single adults in shelters per night (average) as the weather gets warmer, and the subsequent increase in the shelter population as the weather gets colder. In green, the trend illustrates the number of 311 complaints to the Department of Homeless Services increasing as the weather gets warmer and decreasing as the weather gets colder. Both trends highlight the notion that there are more people on the street when the weather is warmer. Note that for April 2017, we took the data with 11 days remaining in the month.



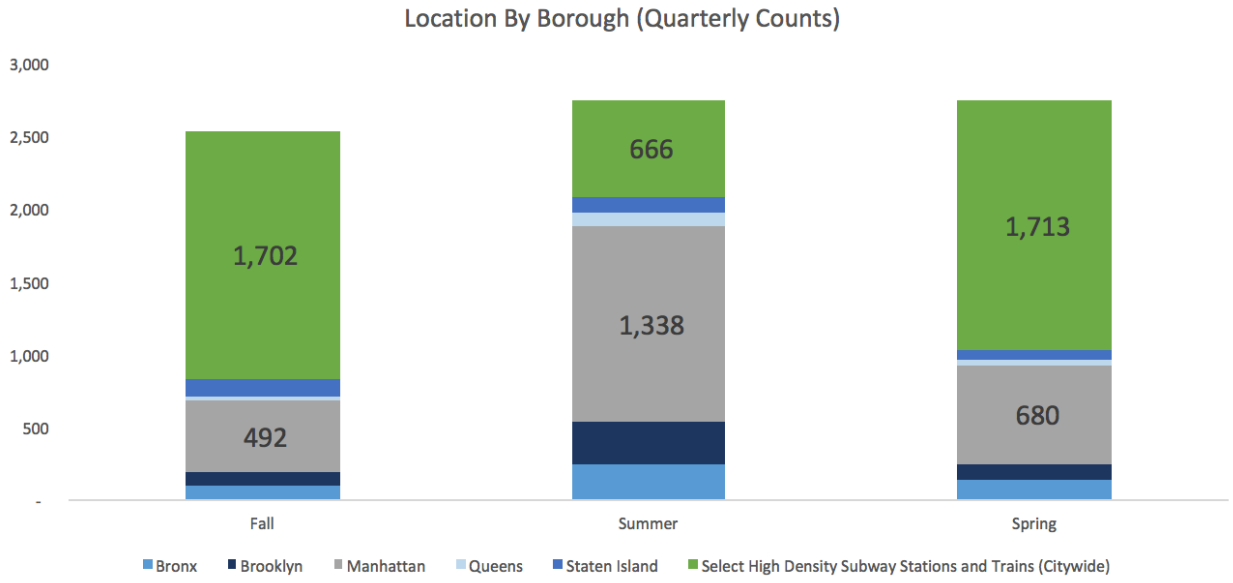
Sources: NYC Open Data – 311 Service Requests from 2010 to Present, DHS Homeless Shelter Census

This trend is especially strong for single adult men. We know that a subpopulation of homeless New Yorkers will stay in the shelters during the winters and then return to the streets during the warmer weather. For single adult women, the trend is less apparent.



Sources: NYC Open Data – DHS Homeless Shelter Census

The current quarterly counts show a similar trend. In the colder seasons (spring and fall), the count found more people on the subways (in green), whereas in the summer, the majority of people were found in Manhattan (grey). If nothing else, this trend illustrates our general thesis: people will sleep where they feel most comfortable and most safe.



Source: NYC DHS Quarterly HOPE Counts

For this reason, we believe Int 1066-2016 is a step in the right direction in estimating the true street homeless population.

Conducting quarterly counts is imperative to understanding the population of street homeless New Yorkers. A count in the winter, on one of the coldest days of the year, will inevitably understate the true population. The current quarterly counts are a positive step forward, but they use different methodologies to collect the data. Experts have told us, off the record, that these counts cannot and should not be compared like for like to the federally mandated HOPE Count, where more than 3,000 volunteers canvas every block of the city and high volume subway stations between midnight and 4AM.

In addition to conducting the counts in warmer months, counting people in “non-visible” locations is key to developing a true estimate of the street homeless population. Days after our team volunteered in the HOPE Count, we asked more than a dozen people if they spoke to volunteers, and the majority of them do not recall being counted, although some said they may have been asleep.

One gentleman raised enough money that day to sleep overnight in an Internet café in Chinatown. In the Internet café, he’s able to lean back and stay indoors in a relatively private area.

Another man slept in a movie theatre, after someone bought him a ticket for a movie. He was able to stay inside the theatre the entire night.

One gentleman who we are especially close with, a veteran who had previously volunteered with the HOPE Count but is now homeless, simply went for a walk. He didn't see any of the volunteers.

People will sleep wherever they can. While they have their concerns with the shelter system, the streets are not especially safe or comfortable either. Over the course of our time volunteering, people have told us they have slept inside ATM vestibules, inside McDonald's, or inside hotels if they are able to raise enough money on a given day (especially those with pets who are not allowed in shelters). Some people have friends who open their doors when the temperature gets especially low.

While determining the true population of street homeless New Yorkers will not in and of itself get more people the support they need, we believe it is a necessary step towards truly understanding the scope of the problem. As such, we believe Int 1066-2016 is a step in the right direction.

Muslim American Society

New York Chapter

1933 Bath Avenue, Brooklyn, NY 11214 - Tel: (718)232-5905 / Fax: (718)232-5103
E-mail: masyouthcenter@hotmail.com
www.masnewyork.org

Dear Councilman Vincent J. Gentile / New York City Council,

I represent Muslim American Society, which opposes the use of hookah in establishments within New York City. **We find that hookah is a severe health risk both to those who directly inhale the shisha smoke and to those who inhale it secondhand.** It has been found that the use of hookah results in the intake of more toxic chemicals and harmful substances, including tar and carbon monoxide, than smoking cigarettes. In fact, the same cancer-causing chemicals found in cigarettes are found in abundance in hookah. **There is no reason why hookah should not be included in NYC's Smoke Free Air Act ("SFAA").**

We formally grant our support to Int. 139 by Council Member Vincent Gentile and others in the Council, which would add hookah to the SFAA.

In addition, we are aware that, as an investigation by DOHMH brought to light, many hookah bars illegally mix tobacco with the shisha that is smoked on the premises. Enforcement against this is currently difficult due to the extensive effort needed to prove that the compounds being smoked include tobacco. The bill would also curtail the expansion of this illegal activity. Since hookah bars would have to be licensed, they would need to comply much more with government inspections and be less likely to add tobacco.

It is for the overall health concerns caused by hookah, including that of added tobacco, that we emphatically urge you to support Int. 139. Hookah is dangerous to people of all backgrounds and needs to be regulated like all other forms of smoking!

Hisham Morgan
Director of Administration
Muslim American Society of New York

Moroccan American Council to Empower Women

Dear Council Member,

I represent Moroccan American Council to Empower Women, which opposes the use of hookah in establishments within New York City. **We find that hookah is a severe health risk both to those who directly inhale the shisha smoke and to those who inhale it secondhand.** It has been found that the use of hookah results in the intake of more toxic chemicals and harmful substances, including tar and carbon monoxide, than smoking cigarettes. In fact, the same cancer-causing chemicals found in cigarettes are found in abundance in hookah. **There is no reason why hookah should not be included in NYC's Smoke Free Air Act ("SFAA").**

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It is for the overall health concerns caused by hookah, including that of added tobacco, that we emphatically urge you to support Int. 139. Hookah is dangerous to people of all backgrounds and needs to be regulated like all other forms of smoking!

Sincerely,

Hafida Torres
President
MACEMW

New York State Academy of Family Physicians
260 Osborne Road • Albany, NY 12211 • 518.489.8945 • 800.822.0700 • Fax: 518.489.8961
E-mail: fp@nysafp.org • Home page: http://www.nysafp.org

MEMORANDUM IN SUPPORT
New York City Intro 139B, Gentile et. al

To amend the administrative code of the city of New York, in relation to the regulation of non-tobacco smoking products, and to amend the fire code of the city of New York, in relations to the operation of non-tobacco smoking establishments

The New York State Academy of Family Physicians supports New York City Intro 139B, which would include non-tobacco hookah smoking to the city's Smoke Free Air Act (SFAA). Currently, hookah lounges are mostly unregulated, with very few measures in place to ensure that patrons and employees at these locations are safe from the toxins produced by smoking hookah. This bill promotes compliance with the SFAA and enhances the City's ability to provide all New Yorkers with access to clean air in public places.

The number of establishments in the City that advertise hookah has nearly tripled since 2012. Many of these hookah lounges have been providing hookah that contains tobacco. Not only is this in violation of the SFAA, but patrons at these establishments may not be aware that they are smoking tobacco, in addition to the toxic substances emitted by the charcoal.

Alarmingly, hookah is gaining popularity and accessibility among the city's youth. In 2014, 16.1 percent of high schoolers and 8.5 percent of middle schoolers had tried hookah. Studies suggest that youth, especially those under the age of 18 who try these products are much more likely to try cigarettes. Forming habits like these can be extremely detrimental for youth because the adolescent brain is far more susceptible to the addictive nature of nicotine.

As family physicians promoting and advocating for patient health and wellbeing, we support all measures to prevent the use of tobacco or any products that can serve as a gateway to tobacco, given the lifelong negative health effects it causes, including heart disease, stroke, and lung cancer.

This law would ensure that non-tobacco smoking establishments are compliant with the SFAA by prohibiting entry to anyone under the age of 21, requiring sanitization of all hookah equipment, and more clearly banning the use of tobacco or nicotine. Establishments in violation would have permits revoked.

This legislation will update the SFAA to continue the progress the City has made in reducing use and exposure to tobacco. For these reasons, **the New York State Academy of Family Physicians, which represents over 6,000 family physicians, residents and students throughout the State supports New York City Intro 139B, Gentile.**

MEMORANDUM IN SUPPORT

New York City Intro 139B, Gentile et. al

To amend the administrative code of the city of New York, in relation to the regulation of non-tobacco smoking products, and to amend the fire code of the city of New York, in relations to the operation of non-tobacco smoking establishments.

The New York Academy of Medicine supports New York City Intro 139B, which would add non-tobacco hookah smoking establishments to the city's Smoke Free Air Act (SFAA). Currently, hookah lounges are mostly unregulated, with very few measures in place to ensure that patrons and employees at these locations are safe from the toxins produced by smoking hookah.

The number of establishments in the City that advertise hookah has nearly tripled since 2012. Many of these hookah lounges have been providing hookah that contains tobacco. Not only is this in violation of the SFAA, but patrons at these establishments may not be aware that they are smoking tobacco, in addition to the toxic substances emitted by the charcoal used in the hookah.

As a private non-profit health policy and research institution devoted to improving the health of people living in cities, we support measures that discourage the use of tobacco. This law would ensure that non-tobacco smoking establishments are compliant with the SFAA by prohibiting entry to anyone under the age of 21, requiring sanitization of all hookah equipment, and more clearly banning the use of tobacco or nicotine.

This legislation will update the SFAA to continue the progress the City has made in reducing use and exposure to tobacco. For these reasons, the New York Academy of Medicine supports New York City Intro 139B.

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April 26, 2017

New York City Council Committee on Health

Dear Members of the Committee:

The New York Lawyers for the Public Interest writes in support of Proposed Int. No. 139-A, which would "amend the administrative code of the city of New York, in relation to the regulation of non-tobacco smoking products, and to amend the fire code of the city of New York, and the New York city mechanical code, in relation to the operation of non-tobacco smoking establishments." Our Health Justice program seeks to improve New Yorkers' health and the environments they live in and among.

For the past 40 years, New York Lawyers for the Public Interest (NYLPI) has been a leading civil rights and legal services advocate for New Yorkers marginalized by race, poverty, disability, and immigration status. Through our community lawyering model, we bridge the gap between traditional civil legal services and civil rights, building strength and capacity for both individual solutions and long-term impact. Our work integrates the power of individual legal services, impact litigation, and comprehensive organizing and policy campaigns. Guided by the priorities of our communities, we strive to create equal access to health care, achieve equality of opportunity and self-determination for people with disabilities, ensure immigrant opportunity, strengthen local nonprofits, and secure environmental justice for low-income communities of color.

Our full-time staff of 32 includes lawyers, community organizers, social workers, legal advocates, development professionals, and administrators.

In the past five years alone, NYLPI advocates have represented thousands of individuals and won campaigns improving the lives of millions of New Yorkers. Our work with community partners has led to landmark victories including integration into the community for people with mental illness; access to medical care and government services for those with limited English proficiency; increased physical accessibility of New York City public hospitals for people with disabilities; cleanup of toxins in public schools; and equitable distribution of environmental burdens.

In addition, NYLPI's Pro Bono Clearinghouse provides critical services to strengthen non-profits throughout every community in New York City. Drawing on volunteer lawyers from New York's most prestigious law firms, we help nonprofits and community groups thrive by providing free legal services that help organizations overcome legal obstacles, build capacity,

and develop more effective programs. Through educational workshops, trainings for nonprofit leaders, individual counseling and a series of publications, the Clearinghouse is at the forefront of helping nonprofits maximize their impact on communities in each of your Districts.

NYLPI's Health Justice Program brings a racial justice and immigrant rights focus to health care advocacy in New York City and State. We work to: (1) challenge health disparities; (2) eliminate racial and ethnic discrimination and systemic and institutional barriers that limit universal access to health care; (3) promote immigrant and language access to health care; and (4) address the social determinants of health so that all New Yorkers can live a healthy life.

Thank you for your time and attention.

Sincerely,

Laura F. Redman
Director, Health Justice Program

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

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April 25/2017

In Support of Intro 139

NYSAAP Chapters 2 & 3 representing more than 3,000 pediatricians across the five boroughs of New York City, strongly supports Intro 139 which would require the City to create and implement a health and safety approach to address the expansion of hooka smoking throughout the City.

Intro 139, revised, would send a clear message to the public that "Hookah smoke is not safe smoke".

NYSAAP Chapters 2 & 3 fully support adding hookah smoking to the Smoke Free Air Act so that it will be treated as the real health challenge that it is, most especially to young people and to those who would be exposed to second hand smoke.

We also fully support the health and safety requirements as outlined in the proposal.

For further information contact:

Elie Ward, MSW
Ex. Director NYSAAP Chapters 2 & 3
Director of Policy & Advocacy NYSAAP

Oral Health America
Bringing Healthy Mouths to Life

MEMORANDUM IN SUPPORT
New York City Intro 139B, Gentile et. Al

To amend the administrative code of the city of New York, in relation to the regulation of non-tobacco smoking products, and to amend the fire code of the city of New York, in relations to the operation of non-tobacco smoking establishments.

Oral Health America, a national nonprofit dedicated to changing the lives by connecting communities with resources to increase access to care, health literacy, and advocacy for all Americans, especially those most vulnerable; supports New York City Intro 139B, which would include on-tobacco hookah smoking to the city's Smoke Free Act (SFAA). Currently, hookah lounges are mostly unregulated with very few measures in place to ensure that patrons and employees at these locations are safe from the toxins produced by smoking hookah. This bill promotes compliance with the SFAA and enhances the City's ability to provide all New Yorkers with access to clean air in public places.

Hookah is also an emerging threat to the health of young adults. In 2014, teen use of hookah tripled and has continued to grow in popularity and accessibility among the city's youth. Targeted marketing with candy-like flavors appeal to young people and those who would normally avoid traditional cigarettes are drawn to hookah and other, more appealing substitutes. Studies find many smokers move from experimental smoking to regular, daily use between the ages of 18 and 21. Each day, about 580 teens under the age of 18 become regular smoker, and 1-in-3 will eventually die as result.

Young adults may not consider smoking's harmful effects on their oral health or the addictive qualities of hookah tobacco. Smoking hookah results in stained teeth and bad breath but it's more serious side effects include an increased risk of gum disease, cancer and a lifetime dependence on tobacco.

Oral Health America is committed to helping Americans of all ages to have a healthy mouth and to understand the importance of oral health to overall health. We support New York City Intro 139B and its inclusion of hookah into the city's Smoke Free Act because we believe it is one step closer to decreasing the rate of tobacco-related health problems and improving the health of our nation.

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www.oralhealthamerica.org

NYU School of Medicine
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Department of Population Health

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Scott.sherman@med.nyu.edu

April 24, 2017

Honorable Corey Johnson
Chair, Health Committee
New York City Council
City Hall
New York, NY 10007

Dear Mr. Johnson,

I am writing in strong support of the upcoming bill before the City Council regarding hookah (waterpipe) use in New York City. I have provided a separate letter regarding the regulations proposed for cigarettes and electronic cigarettes. I am an Associate Professor of Population Health, Medicine and Psychiatry at NYU School of Medicine and an Associate Professor at the New York University College of Global Public Health.

I am an international expert on hookah use. I was Co-Chair of the First International Conference on Waterpipe Tobacco Research in 2013, and was on the Planning Committee for the Second International Conference in 2014, as well as for the upcoming Third International Conference in 2017. Over the last 3 years, I have published a dozen scientific papers on waterpipe smoking, and I led the only scientific study to date worldwide examining hookah businesses. The hookah research builds on my career and work for the previous two decades focused on helping people to stop smoking cigarettes. My research has been funded by the National Institutes of Health, Veterans Health Administration and California Tobacco-Related Diseases Research Program.

The bill being considered by the City Council has several important and fundamental issues for regulating hookah use to protect the health of the public. First and foremost, it adds hookah smoke (regardless of whether it is tobacco or non-tobacco) to the Smoke Free Air Act. Second, it requires hookah smoking establishments to be registered with the Department of Health and Mental Hygiene (DOHMH), a necessary first step in monitoring this business which affects people's health. Third, it gives DOHMH the ability to revoke an establishment's permit if they are found to be selling tobacco for use in the hookah, a violation of New York City policies. Finally, it requires hookah businesses to clean the waterpipes between uses, to prohibit sales to people under age 21 and to comply with the New York City General Fire Code Provisions.

Each of these provisions is important and will help to protect the health of New York City residents. Our research has shown that hookah smoke is hazardous, both to the individual smoker and to non-smokers who breathe in the smoke (secondhand smoke). The US Surgeon General's Report has unequivocally stated that secondhand cigarette smoke is dangerous, causing both disability and death. We recently showed that secondhand hookah smoke causes high levels of the same compounds shown to be harmful from secondhand cigarette smoke. In fact, in homes where people smoke hookah, the level of harmful compounds in the air of adjacent (non-smoking) rooms was worse than in the actual room where people were smoking

cigarettes. Put differently, even being one room away from a hookah smoking session leads to exposure to levels of airborne compounds that we already know to be dangerous.

In two separate projects, my colleagues have examined what is being served in hookah establishments in New York City, with one colleague measuring the air and the other sampling the material being combusted in the hookah pipe. Each of them found that nearly all – approximately 90% – of establishments were serving tobacco, in direct violation of current New York City regulations. Giving DOHMH the ability to enforce compliance with New York City regulations is crucial to protecting the health of people who visit hookah establishments.

Finally, when I have given talks at universities on hookah, I have had multiple people come up to me afterwards saying that they used to go to hookah establishments when they were under age 18 because the establishments served them alcohol without requiring proof of age. Needless to say, this is terrible for public health, as not only does it allow illegal sales and consumption of alcohol, but it also encourages hookah smoking as a way to do so.

I strongly encourage the City Council to endorse and pass this bill regulating hookah establishments.

Sincerely,

Scott E. Sherman, MD, MPH
Co-Chief, Section on Tobacco, Alcohol and Drug Use
Associate Professor of Population Health, Medicine and Psychiatry
212-686-7500 x3018 (O) / 212-951-3269 (F)

RWDSU
Retail, Wholesale and Department Store Union

Stuart Appelbaum, *President*
Jack C. Wurm, Jr., *Secretary-Treasurer*
Joseph Dorismond, *Recorder*

Testimony by Stuart Appelbaum, President of the Retail, Wholesale and Department Store Union (RWDSU), UFCW

Before the New York City Committee on Immigration

April 26, 2017

Good afternoon, Committee Chair Carlos Menchaca and members of the Committee on Immigration. As president of the Retail, Wholesale and Department Store Union/UFCW (RWDSU), I submit this testimony on behalf of the thousands of immigrant RWDSU members who make a living in New York City's car washes, grocery stores, retail stores, food processing centers and other low-wage sectors.

I am testifying in support of Intros: 1557, 1558, 1565, 1566, 1568 and 1578. Together, these bills boldly codify New York City as a more protective, inclusive sanctuary city and send a clear message to the Trump Administration that we will stand with and defend those who make up the backbone of our economy and enrich our city's culture.

New York City was built by immigrants and flourishes because of immigrants' labor. Some of our most important industries and sectors rely heavily on the immigrants to sustain themselves. Indeed, many industries – retail, food service, wholesale and distribution centers included -- would find it difficult to operate without the vital labor of immigrant workers, regardless of documentation.

Given the current political climate, it is important for the City to establish laws that can transcend beyond the next four years. We need our city-owned spaces, our city agencies and our schools to be safe havens for all residents, where they can freely assemble, study or seek help without fear of the U.S. Department of Homeland Security threatening their families and lives. We also strongly support efforts that protect immigrants from being detained and deported, particularly when interacting with other law enforcement offices on minor charges or for time already served. Immigrants need greater access to know your rights information and to legal and other services. We commend the council and the speaker for recognizing these needs and for working to create the infrastructure to ensure these are delivered with the cultural sensitivity and financial support to make these efforts meaningful.

For labor and our union, the bills signify peace of mind for our members and future members and sends a clear message to employers that intimidation tactics using a worker's immigration status will not be tolerated. These tactics are already commonly used in many of the low wage sectors we represent to deter workers from reporting discrimination and labor violations, and from

organizing. Over the last few months, it has been difficult to observe the elevated levels of stress and anxiety among our own members. Our union has responded with additional supports, more access to resources and know your rights information, as well as more staff time to help our members develop plans of emergency should they be detained.

We know that creating an environment of fear only helps unethical employers more ruthlessly exploit and abuse workers with impunity, as immigrant workers, regardless of immigration status, may be more reluctant to seek help. We have already observed that immigrants may not report being victims of a crime or domestic abuse; they may forgo reporting wage theft; they may opt to not seek medical help when injured on the job.

We welcome the City Council's efforts to formally create an open and welcoming city for immigrants in the city. The bills introduced today will go a long way to assuring the immigrant community and our union members that they will be protected from the temperamental political winds of Washington. We strongly support their passage.

Thank you for allowing RWDSU to submit testimony today.

ASH ACTION ON SMOKING & HEALTH

Global action for everyone's health.

Honorable Corey Johnson
Chair, Health Committee
New York City Council
City Hall
New York, NY 10007

April 25, 2017

Dear Mr. Johnson:

I am writing to support the proposed tobacco legislation that will be heard by the Health Committee on April 27. New York City has made extraordinary efforts to combat the death and disease caused by tobacco. Tobacco products and non-tobacco shisha are dangerous. Their use is a major public health concern that we cannot overlook. These bills will help take the next step towards ending the tobacco epidemic for good.

The World Health Organization's Framework Convention on Tobacco Control (FCTC)[1] is the world's first public health treaty. The treaty and its guidelines provide international best practices for tobacco control. While the U.S. has signed the treaty, it is not yet a Party. However, 179 countries and the European Union representing nearly 90% of the world's population are Parties to the FCTC[2]; a clear indication of the near global acceptance of these strategies. These bills incorporate several of these best practices. I mention just a few of the bills below, but Action on Smoking and Health finds all of the bills in this package worthwhile, and I believe that they will have a significant, positive impact on the health of New Yorkers.

Proposal Int 1544-2017- increased prices and tax

This bill raises the minimum price for tobacco products and imposes a new 10% local tax on other tobacco products. The international community has recognized price and tax increases as an effective way to reduce smoking rates, and therefore included it in Article 6 of the FCTC[3]. Domestically, the U.S. Surgeon General has called raising prices on cigarettes "one of the most effective tobacco control interventions." [4] In high-income countries, like the United States, a 10% increase in tobacco

[1] World Health Organization, Framework Convention on Tobacco Control, http://apps.who.int/iris/bitstream/10665/42811/1/9241591013.pdf?ua=1.

[2] WHO FCTC, Parties to the Framewok Convention on Tobacco Control, http://www.who.int/fctc/signatories_parties/en/.

[3] WHO FCTC, Article 6. http://apps.who.int/iris/bitstream/10665/42811/1/9241591013.pdf?ua=1.

[4] U.S. Department of Health and Human Services (HHS), The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General, Atlanta, GA: HHS, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. http://www.surgeongeneral.gov/library/reports/50-years-ofprogress/index.html

prices will reduce consumption by about 4% for adults.[5] Tobacco taxes are particularly effective in preventing or reducing tobacco use among young people. A 10% price increase decreases youth smoking by about 7%.[6]

Proposal Int 1131-2016- pharmacies

This bill prohibits pharmacies from selling tobacco products. Tobacco products are the number one cause of preventable death and disease[7], and selling them is antithetical to pharmacies' goals of improving people's health. Several cities, including San Francisco and Boston[8], have already taken this step to protect the health of their citizens, and New York should as well.

Int 1585-2017- disclosure of smoking policies

This bill requires owners of residential buildings to create a policy on smoking and disclose it to both current and prospective residents. Although this bill does not require a building to adopt a no smoking policy, it allows prospective tenants to make a fully informed decision about whether or not they want to live in a building. In 2011-2012, more than 1 in 3 (36.8%) nonsmokers who lived in rental housing were exposed to secondhand smoke.[9] This is no small problem; since 1964, approximately 2,500,000 nonsmokers have died from health problems caused by exposure to secondhand smoke.[10]

This bill allows potential tenants to decide whether or not living in a building that allows smoking is an acceptable level of risk to their health and that of their children. The disclosure that this bill requires is supported by Article 8 of the FCTC which calls for universal protection from exposure to tobacco smoke[11], and also Article 12[12], which encourages public education and awareness.

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[5] World Health Organization, Raise Taxes on Tobacco, http://www.who.int/tobacco/mpower/publications/en_tfi_mpower_brochure_r.pdf.

[6] Campaign for Tobacco Free Kids, RAISING CIGARETTE TAXES REDUCES SMOKING, ESPECIALLY AMONG KIDS, https://www.tobaccofreekids.org/research/factsheets/pdf/0146.pdf.

[7] Centers for Disease Control and Prevention (CDC), Smoking and Tobacco Use. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/.

[8] Americans for Non-Smokers Rights, Tobacco Free Pharmacies, http://no-smoke.org/learnmore.php?id=615.

[9] Centers for Disease Control and Prevention (CDC), Secondhand Smoke Facts. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/general_facts/.

[10] *Id*.

[11] WHO FCTC, Article 8. http://apps.who.int/iris/bitstream/10665/42811/1/9241591013.pdf?ua=1.

[12] WHO FCTC, Article 12. http://apps.who.int/iris/bitstream/10665/42811/1/9241591013.pdf?ua=1.

Conclusion

Unfortunately, tobacco use is still the leading cause of preventable death in the United States.[13] Every year, over 480,000 people in the United States[14] and over 28,000 New Yorkers[15] die from tobacco related diseases. New York City has taken a progressive role as a leader in the area of tobacco control. This legislation can continue that tradition and save many people from tobacco related death and disease. I urge the committee to pass these important policies.

Best Regards,

Laurent Huber
Executive Director, Action on Smoking & Health
Ambassador, Framework Convention Alliance on Tobacco Control

[13] *Supra* note 7.

[14]Centers for Disease Control and Prevention (CDC), Tobacco Related Mortality. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/tobacco_related_mortality.

[15] Campaign for Tobacco Free Kids, The Toll of Tobacco in New York. https://www.tobaccofreekids.org/facts_issues/toll_us/new_york.

April 27, 2017

Hookah Legislation

Note that while I am a member of Community Board 1, in Queens, I am not a member of the health committee and did not vote on any resolution brought by CB1. I am here as a private citizen and do not in any way represent Community Board 1 in Queens. I am speaking on behalf of Le Souk and Faluka in the west village.

The legislation reads that in order to qualify for a permit 50% of the gross sales must be Hookah related. . I feel this would be too restrictive and penalize many current businesses.

However, initially I read the summary from Councilman Gentile. It stated that the requirement for permit was 50% of the "Profit". This we are in favor of. (See attached). This is a much more accurate way of determining the importance of Hookah sales to a businesses survival.

50 % of the profit is fair: note that the profit margins in hookah are up to 80 %, so even if hookah is not as large % of the gross, it still may qualify. It is a fine line between supporting local business (especially those with a cultural legitimacy) and public health. It sounds like this bill works.

The other question I have is how the accounting is done. What accounting procedure is used in order to determine eligibility, whether a percentage of the gross sales or profit?

Permits cause vendors to be more responsible, a good thing.

The requirements for cleanliness, ventilation, and proper charcoal handling are a definite imperative.

And the requirement for 21 and older, as long as enforced, is very important. The hookah bars have been used by underage teens for years for illegal activities, like drinking, etc.

So in general I think this bill (Based on 50% of the profit, not gross revenue) allows for businesses that exist primarily from the sale of hookah to continue in business, while others that have other significant sources of revenue would cease, hopefully reducing the spread of hookah to populations that do not have a cultural history of use and positively effecting public health.

Richard Khuzami
2538 18th St, Astoria NY 11102
917 701 6023

April 27, 2017

Honorable Corey Johnson
Chair, Health Committee
New York City Council
City Hall
New York, NY 10007

Dear Councilmember Johnson,

Please see the attached testimony on behalf of NYPIRG. NYPIRG has long been involved in the effort to protect New Yorkers of all ages from the negative effects of smoking—from addressing tobacco marketing, to supporting smoke-free spaces. In 2013-14, NYPIRG worked with NYC Smoke-Free to create a mentorship program between high school students and college students at CUNY colleges. The program paired students together to educate their peers about the health effects of tobacco use and the industry's targeted marketing strategies.

The program was continued in 2015 and 2016. Each year, students participated in a community mapping survey of tobacco advertisements. The reports are neighborhood snapshots and collected anecdotal evidence, and therefore does not constitute a scientific report.

In total, areas surrounding 10 high schools in nine neighborhoods of the Bronx, Brooklyn, and Queens were surveyed. An alarming 906 tobacco advertisements and product displays were observed by surveyors. We invite you to review the full reports (attached). They are also available online:

Still At Risk, 2016: http://www.nypirg.org/pubs/NYPIRG_REPORT-STILL_AT_RISK_Sept_2016.pdf
Adverse Advert, 2015: http://www.nypirg.org/health/adverseadvertsreport.pdf
Overexposed, 2014: http://www.nypirg.org/health/overexposed/index.html

Thank you for the opportunity to present this information. Please do not hesitate to contact NYPIRG with questions or requests.

Sincerely,
Megan Ahearn
Program Director

OVEREXPOSED

Big Tobacco's Advertising Saturation Around New York City Schools

A survey of tobacco marketing in the NYC neighborhoods of Flatbush, Brooklyn, Tremont, Bronx and Flushing, Queens

NYPIRG

New York Public Interest Research Group/NYPIRG

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The Community Mapping Survey and pilot mentorship program were made possible by funding from the Centers for Disease Control and Prevention. For more information, contact Megan Ahearn at NYPIRG at mahearn@nypirg.org or visit www.nycsmokefree.org.

INTRODUCTION AND EXECUTIVE SUMMARY

Tobacco remains the number one leading cause of preventable death in the United States.[1] In New York City, tobacco use kills more people than AIDS, illegal drugs, homicide, and suicide combined.[2] In an attempt to distract the public from these staggering facts, the tobacco industry spends $213.5 million each year in New York to market their products. Because of legal restrictions, cigarette ads have left billboards and TV commercials and now bombard customers in local corner stores, pharmacies, and other stores that the tobacco industry knows young people visit frequently. What's more, out of the nearly ten thousand licensed tobacco retailers in the city, 75% are within 1,000 feet of a school.[3] It would seem that Big Tobacco is crowding in on the places that our children frequent.

The U.S. Centers for Disease Control and Prevention ("CDC") has found that reducing exposure to tobacco advertisements and products during adolescence and teenage years will dramatically decrease the number of addicted adult smokers in New York City.[4] The less tobacco marketing youth see, the less likely they are to smoke.

NYPIRG has a long and successful history protecting New Yorkers of all ages from the negative effects of smoking, from targeted marketing to smoke-free spaces. This year, NYPIRG is continuing our work with the NYC Coalition for a Smoke-Free City (hereafter "the Coalition"), a health advocacy group that works throughout the five boroughs to increase awareness of tobacco control issues among community members and stakeholders to reach the following goals: reduce youth exposure and access to tobacco products; limit the effects of tobacco advertising and promotion on youth; and expand community awareness of the health effects of secondhand smoke.

As part of NYPIRG's work with the Coalition, a pilot mentorship project was launched at Bronx Community College, Brooklyn College, and Queens College. The program paired college and high school students who are interested in the public health arena, community-based service, or community education campaigns. Students completed a local mapping survey which plotted tobacco advertisements and displays they observed within a three to six block radius around their high school. The survey collected anecdotal evidence and is not a scientific report.

The mentorship program educated participants about the health effects of tobacco use and the industry's marketing, exposed them to Big Tobacco's advertising strategy, and empowered them to act in their com-

[1]U.S. Department of Health and Human Services. How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General. Atlanta, GA: 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, 2010. Available at www.surgeongeneral.gov/library/tobaccosmoke/report/executivesummary.pdf.
[2]U.S. Department of Health and Human Services. _The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General_ Six Major Conclusions of the Surgeon General._ Office on Smoking and Health, 2006.
[3]Luke, Douglas A., PhD, et. al. "Family Smoking Prevention and Tobacco Control Act: Banning Outdoor Tobacco Advertising Near Schools and Playgrounds." (American Journal of Preventive Medicine; 40(3): 295-302), 2011.
[4]Supra note 1.

munities. The anecdotal survey results and mapping project serve as a reminder of the saturation of tobacco advertisements, product displays and other marketing (collectively referred to as "tobacco ads" or "ads" throughout this report) that youth are exposed to in their everyday lives. The Community Mapping Survey found the following:

NYPIRG staff and student volunteers surveyed 45 stores.

- 24 stores were in Flatbush (53%)
- 12 stores were in Tremont (27%)
- 9 stores were in Flushing (20%)

NYPIRG students and staff volunteers observed at least one tobacco ad in the following types of stores:

- 31 Corner Store/Bodegas
- 5 gas stations
- 3 pharmacies
- 3 grocery stores
- 2 smoke shops
- 1 non-food retail store

Surveyors observed 136 tobacco ads on the exteriors of store buildings.

- Of the 136 total exterior ads, 107 ads were observed in the Flatbush area, 15 ads were observed in the Tremont area, and 14 ads were observed in the Flushing area.

Surveyors observed 209 total tobacco ads on the interior of stores.

- Of the 209 total interior ads, 120 ads were observed in Flatbush, 46 ads were observed in Tremont, and 43 ads were observed in Flushing.

Surveyors observed a total of 345 interior and exterior tobacco advertisements within a small radius around the three high schools included in the project.

SURVEY HIGHLIGHTS

Survey Methodology

Photo: Megan Ahearn

Volunteers were trained by NYPIRG's Smoke-Free Project Coordinator to canvass neighborhoods and map tobacco advertisements, product displays, and other marketing observed on the exterior and interior of stores. Three neighborhoods, Flatbush in Brooklyn, Tremont in the Bronx, and Flushing in Queens, were surveyed between April and June 2013. In each neighborhood, between three and six main blocks were surveyed directly surrounding a high school. Small, residential streets that do not provide through-traffic to the main blocks were not always included. For instance, in Flatbush, the main thoroughfares of Nostrand Avenue, Bedford Avenue, and Flatbush Avenue were included, but the residential streets of East 21st Street through East 29th Street were not included.

Effort was taken to map an area of similar significance and size in each neighborhood. This always included the streets directly around the high school and contiguous streets with local bus and subways stops that serve the school. The survey results collected are anecdotal and unscientific.

Maps of each neighborhood are attached to this report. The areas surveyed include:

> Flatbush: Ditmas Avenue, Newkirk Avenue, Foster Avenue, Farragut Road, and Avenue I all between Ocean Avenue and Flatbush Avenue as well as Flatbush Avenue, Bedford Avenue, and Ocean Avenue between Ditmas Avenue and Avenue I and Nostrand Avenue between Glenwood Road and Avenue I.
>
> Tremont: East 180th Street, East 179th Street, East 178th Street, and East Tremont Avenue all between Washington Avenue and Hughes Avenue, as well as Washington Avenue, Bathgate Avenue, 3rd Avenue, Lafontaine Avenue, Arthur Avenue, and Hughes Avenue all between East 180th St and East Tremont Avenue, and Monterey Avenue between East 179th Street and East Tremont Avenue.
>
> Flushing: Horace Harding Expressway, Reeves Avenue, Melbourne Avenue, and Jewel Avenue all from Kissena Boulevard to Main Street, as well as Main Street and Kissena Boulevard both between Horace Harding Expressway and Jewel Avenue.

All stores in each neighborhood were canvassed; however, a store was only surveyed when at least one exterior ad, interior ad, tobacco product display or other tobacco company marketing was observed. For each completed survey, the type of business was identified. Surveyors were asked to classify each store by one of these categories:

- Corner Store/Bodega
- Non-Food Retail
- Restaurant
- Other:_____

Types of stores which were identified as "Other" include gas stations, pharmacies, smoke shops*, and grocery stores.

Types of Businesses Surveyed
A store was surveyed when at least one exterior ad, interior ad, tobacco product display or other tobacco marketing was observed. Traditional tobacco cigarettes, hookah, cigar, cigarillo, and electronic cigarette ads were all included in the survey. In total, our staff and student volunteers surveyed 45 stores.

- 24 stores were in Flatbush (53%)
- 12 stores were in Tremont (27%)
- 9 stores were in Flushing (20%)

In total, 31 Corner Store/Bodegas, 5 gas stations, 3 pharmacies, 3 grocery stores, 2 smoke shops, and 1 non-food retail store were surveyed. Corner Stores/Bodegas represent 69% of total stores surveyed, gas stations represent 11%, pharmacies and grocery stores represent 7% apiece, smoke shops represent 4%, and non-food retail represents 2%. Corner Store/Bodegas represented the most common location for tobacco ads in all boroughs.

- In Flatbush, 15 Corner Store/Bodegas, 3 grocery stores, 2 gas stations, 2 smoke-shops, 1 pharmacy, and 1 non-food retail store were surveyed. Flatbush had the most diverse type of stores included in the survey.

- In Tremont, only Corner Store/Bodegas were found to have tobacco advertisements. 12 Corner Store/ Bodegas were surveyed.

- In Flushing, 4 Corner Store/Bodegas, 3 gas stations, and 2 pharmacies were surveyed. Flushing represented the most even split between types of stores.

* Only the exteriors of the two smoke shops were surveyed since you must be 18 years or older to enter the stores. However, passersby of all ages are exposed to the store exteriors.

Exterior Advertisements

Surveyors observed 136 total tobacco advertisements on the exteriors of store buildings including the walls, windows, doors, and other property of the establishment. Of the 136 total exterior ads, 107 ads were observed in the Flatbush area, 15 were observed in the Tremont area, and 14 were observed in the Flushing area. Flatbush ads represent 79% of total exterior ads observed, Tremont ads represent 11%, and Flushing ads represent 10%.

Photo: Robert Noonan

Interior Advertisements

Surveyors observed 209 total tobacco advertisements on the interior of stores. The interior of the store includes in, on and around counters, shelves, registers, interior walls, ceilings, and other places easily visible from anywhere a customer might stand. Compared to the total number of interior ads observed, Flatbush represented 57%, Tremont represented 22% and Flushing represented 21%. Citywide, of the 209 total tobacco ads, 74 (or 35.4%) were visible from the doorway into the store. In Flatbush, surveyors observed 120 interior tobacco ads, 33 of which were visible from the door. In Tremont, surveyors observed 46 interior tobacco ads, 21 (nearly half) of which were visible from the door. In Flushing, surveyors observed 43 interior tobacco ads, 20 (nearly half) of which were visible from the door.

Health Warnings

There were only 11 health warnings about smoking observed at eight different stores. 4 warnings in 3 stores were observed in Flatbush, 6 warnings in 4 stores were observed in Tremont, and 1 warning in 1 store was observed in Flushing. These signs are posted voluntarily and possibly remnant of a New York City mandate for tobacco retailers to post graphic warnings that was ultimately overturned in the courts.

Brand Observations

Newport brand tobacco product advertisements were found most frequently on store exteriors, followed by Marlboro. However, Newport was only seen on the exterior of one store in Flushing, Queens. Inside of stores, Newport brand tobacco products were again found the most frequently, followed by Marlboro. However, it is worth noting that Newport advertisements were not observed in any store interiors in Flushing (see Brand Frequency List pg 13-15 for more information).

Conclusion

The large amount of advertising around schools, as shown by this survey, indicates an effort by tobacco companies to reach audiences that include youth. While youth are engaging one another on public health issues related to smoking and helping their peers make decisions in their own best interest, we can do more. This problem is one that the public is supportive of tackling head on. According to a 2011 public opinion survey, 65% of New Yorkers support limiting tobacco retailers near schools. For more information please visit www.nypirg.org/health or www.nycsmokefree.org.

ACKNOWLEGEMENTS AND CREDITS

Observations were carried out by NYPIRG staff as well as college and high school students working with NYPIRG. Surveyors include the following: Megan Ahearn, Tiffany Brown, Sebastian Bullock, Niara Carrenard, Armando Chapelliquen, Noah Jackson, Faiza Khan, Tamari Khornauli, Talia LeRay, Robert Noonan, and Brandon Robinson. The Community Mapping Survey and pilot mentorship program were made possible by funding from the Centers for Disease Control and Prevention. The program was also made possible through the support of the NYC Coalition for a Smoke-Free City. For more information, contact Megan Ahearn at NYPIRG at mahearn@nypirg.org or visit www.nycsmokefree.org.

Cover page photo: Tobacco Free NYS http://www.tobaccofreenys.org/Tobacco-Marketing-Works-NY.html.

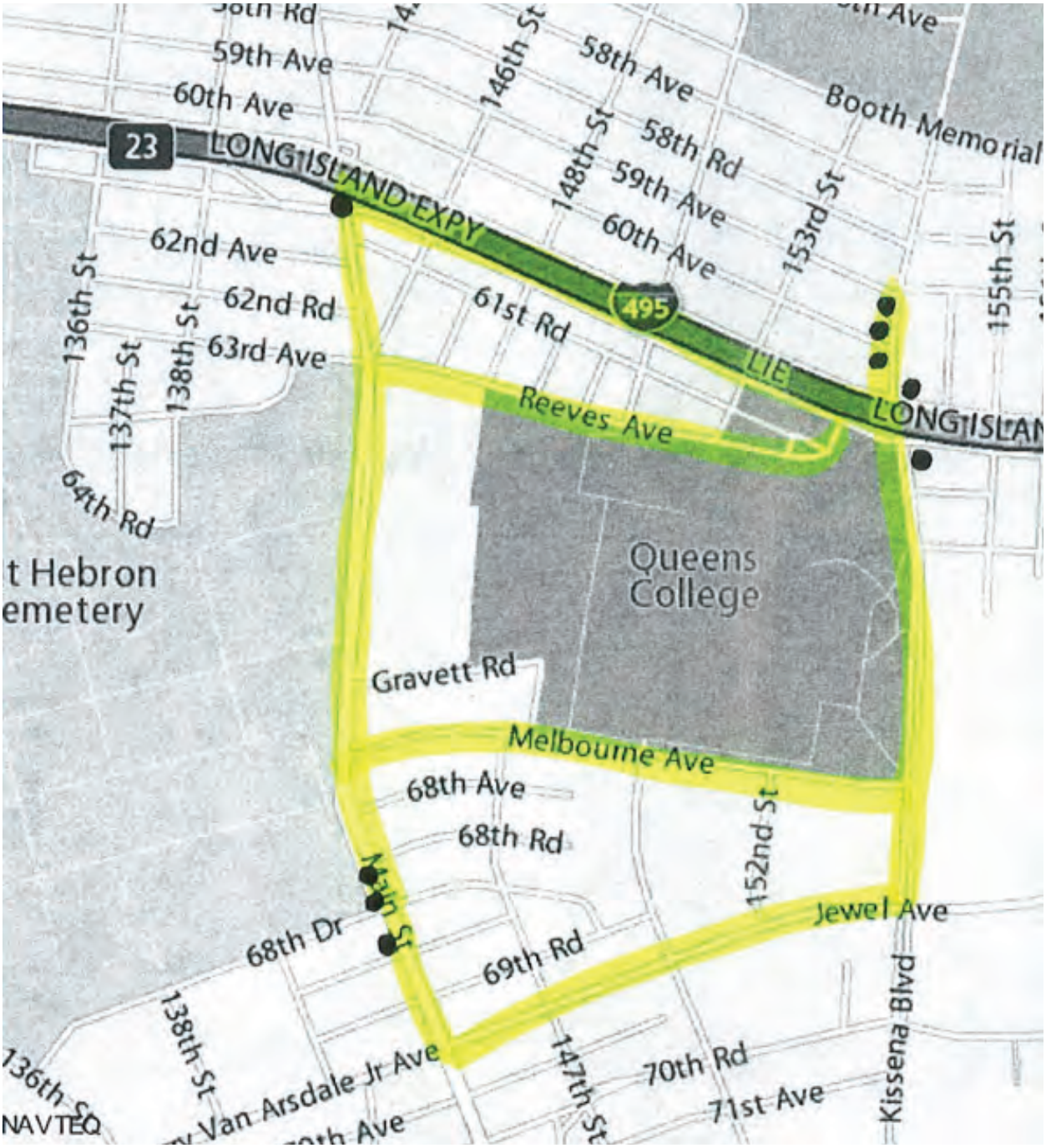
Flatbush Map*

* For all maps, highlighted blocks were canvassed and black marks indicate a store which was surveyed.

Tremont Map


Conrail
Park Ave
Washington Ave
E Tremont Ave
Bathgate Ave
3rd Ave
Monterey Ave
La Fontaine Ave
Arthur Ave
Hughes Ave
Belmont Ave
E 172th St
E 178th St
E 179th St
E 180th St
E 181st St
Post Office-Tremont
Ms 118
Ps 3
Public School 59 Annex

Flushing Map



BRAND FREQUENCY LISTS

CITYWIDE

Exterior, [Brand] at [number of stores]	Interior, [Brand] at [number of stores]
Newport, 23	Newport, 22
Marlboro, 8	Marlboro, 18
Blu e-Cigarette, 7	Maverick, 15
Eonsmoke, 6	Black and Mild, 10
Maverick, 5	Blu e-Cigarette, 10
Camel, 5	Parliament, 9
Njoy, 3	Pall Mall, 5
Parliament, 3	Camel, 5
Spirit, 3	Salem, 4
Backwoods, 2	Eonsmoke, 4
USA Gold, 2	Backwoods, 4
Fortuna, 2	American Spirits, 2
Phillies, 2	USA Gold, 2
Black and Mild, 1	Logic, 1
American Spirit, 1	NJoy, 1
Mild Seven, 1	Bugler, 1
Logic, 1	Spirit, 1
Hookah, 1	Hookah, 1
Capone, 1	Imperial, 1
White Owl, 1	Palma, 1
Remington, 1	Capri, 1
Leaf cigars, 1	Kool, 1
Cheyenne, 1	D'ville, cigars 1
Premium cigars, 1	Drum, 1
E-Z wider, 1	Skoal, 1
	Zig Zag, 1
	Entourage, 1
	Swisher Sweets cigars, 1
	Phillies, 1
	Blue Crush, 1

FLATBUSH, BROOKLYN

Exterior, [Brand] at [number of stores]	**Interior, [Brand] at [number of stores]**
Newport, 17	Newport, 13
Marlboro, 8	Marlboro, 8
Blu e-Cigarette, 5	Maverick, 7
Maverick, 4	Black and Mild, 7
Parliament, 3	Blu e-Cigarette, 5
Camel, 2	Parliament, 4
NJoy, 2	Pall Mall, 3
Phillies, 2	Camel, 2
Backwoods, 2	Salem, 2
Eonsmoke, 1	Eonsmoke, 2
Hookah, 1	Logic, 1
Leaf cigars, 1	Phillies, 1
Logic, 1	D'ville cigars, 1
Mild Seven, 1	Backwoods, 1
Cheyenne, 1	Drum, 1
Remington, 1	Bugler, 1
Black and Mild, 1	Spirit, 1
USA Gold, 1	Hookah, 1
Capone, 1	Imperial, 1
White Owl, 1	Palma, 1
Spirit, 1	Capri, 1
	Kool, 1

TREMONT, THE BRONX

Exterior, [Brand] at [number of stores]	Interior, [Brand] at [number of stores]
Newport, 5	Newport, 9
Eonsmoke, 3	Maverick, 8
Spirit, 2	Blu e-Cigarette, 4
Maverick, 1	Black and Mild, 3
Blu e-Cigarette, 1	Parliament, 2
	Marlboro, 2
	Salem, 2
	Eonsmoke, 1

FLUSHING, QUEENS

Exterior, [Brand] at [number of stores]	Interior, [Brand] at [number of stores]
Camel, 3	Marlboro, 8
Fortuna, 2	Parliament, 3
Newport, 1	Camel, 3
Blu e-Cigarette, 1	Backwoods, 3
NJoy, 1	Pall Mall, 2
Eonsmoke, 1	USA Gold, 2
USA Gold, 1	American Spirits, 2
Premium cigars, 1	Blue Crush, 1
American Spirit, 1	Blu e-Cigarette, 1
E-Z wider, 1	Eonsmoke, 1
	NJoy, 1
	Skoal, 1
	Zig Zag, 1
	Entourage, 1
	Swisher Sweets cigars, 1

Survey Copy- Page 1
Surveyor Name: _____
School: _____
Phone #: _____
Date: _____

Instructions:
Thank you for taking part in this community mapping survey! To complete this survey, you will need a pen, this paper survey, a camera and a tape measure. Fill out the answers to the below questions when you observe any sort of tobacco or anti-tobacco advertisements (ads) on the exterior or interior of stores within the designated number of blocks from your high school, college campus and/or home addresses. Advertisements include pricing and promotion announcements, traditional advertisements, tobacco brand labels, the cigarettes themselves, health announcements, etc. If you are unsure, take a picture of the advertisement and fill out the survey in full. Use a different survey form for each store that you observe tobacco and/or anti-tobacco ads on or in. Please take a picture that can be emailed at a later time of all tobacco or anti-tobacco ads and signs. Please be as specific as possible in your answers.

Business Name:		Borough:
Street Address:		Zip-Code:
Type of Business:	❑ Corner Store/Bodega ❑ Non-Food Retail	
	❑ Restaurant ❑ Other: _____	

1. EXTERIOR TOBACCO ADVERTISEMENTS

o How many tobacco ads are on the exterior of the store?: _____
o List the tobacco brands that are advertised on the store's exterior?:
_____
o For each ad, where is it placed (near door, on window, at eye level/near ground/above head, etc.)?
- Ad 1: _____
- Ad 2: _____
- Ad 3: _____
- Ad 4: _____
- Additional ads: _____

2. INTERIOR TOBACCO ADVERTISEMENTS

o When you first enter, how many tobacco ads are visible from the doorway?: _____
o Do you see any tobacco ads inside the store?:(circle one) YES or NO
- If YES, how many?: _____

o What tobacco brands are advertised in the store?: _____
_____
o For each ad, where is it placed (on counter, in front of register, behind register/counter, on window, hanging from ceiling, on store shelves, on wall at eye level/near ground/above head, etc.)?
- Ad 1: _____
- Ad 2: _____
- Ad 3: _____
- Ad 4: _____
- Additional ads: _____

o For each ad, how large is the largest text (use tape measure)?
- Ad 1: _____
- Ad 2: _____
- Ad 3: _____
- Ad 4: _____
- Additional ads: _____

o For each ad, what colors are used (please be specific and include whether they are bright, dull, etc)?

- Ad 1: _____
- Ad 2: _____
- Ad 3: _____
- Ad 4: _____
- Additional ads: _____

3. INTERIOR TOBACCO PRODUCT DISPLAYS

o Do you see cigarette packs OR cartons displayed anywhere in the store?: (circle one) YES or NO

o Do you see other tobacco products (e.g., smokeless products, cigars, pipes, papers, loose tobacco, etc.) displayed anywhere in the store?: (circle one) YES or NO

o Do you see cigarette packs, cartons or other tobacco products displayed behind the cash register?: (circle one) YES or NO

o Please describe each tobacco product display. Measure shelf space by counting the number of "pack facings" on the front row of shelves and displays. Count the number of packs across and down and multiply. Cartons stacked with the longest side facing front count as five packs; cartons stacked with the shorter side facing front count as two. One pack facing equals seven square inches.

- DISPLAY 1:
- Location of display: _____
- Size of display (total pack facings/horizontal x vertical): _____
  (size in sq. inches or pack facings x 7): _____
- DISPLAY 2:
- Location of display: _____
- Size of display (total pack facings/horizontal x vertical): _____
  (size in sq. inches or pack facings x 7): _____

4. ANTI-TOBACCO HEALTH-WARNING ADVERTISMENTS/SIGNS

o Are there any anti-tobacco health warning ads on or in the store?: (circle one) YES or NO

- If YES, how many are there?: _____

o For each health-warning ad, where is it placed (on counter, in front of register, behind register/counter, on window, hanging from ceiling, on store shelves, on wall at eye level/near ground/above head, etc.)?

- Ad 1: _____
- Ad 2: _____
- Ad 3: _____
- Ad 4: _____
- Additional ads: _____

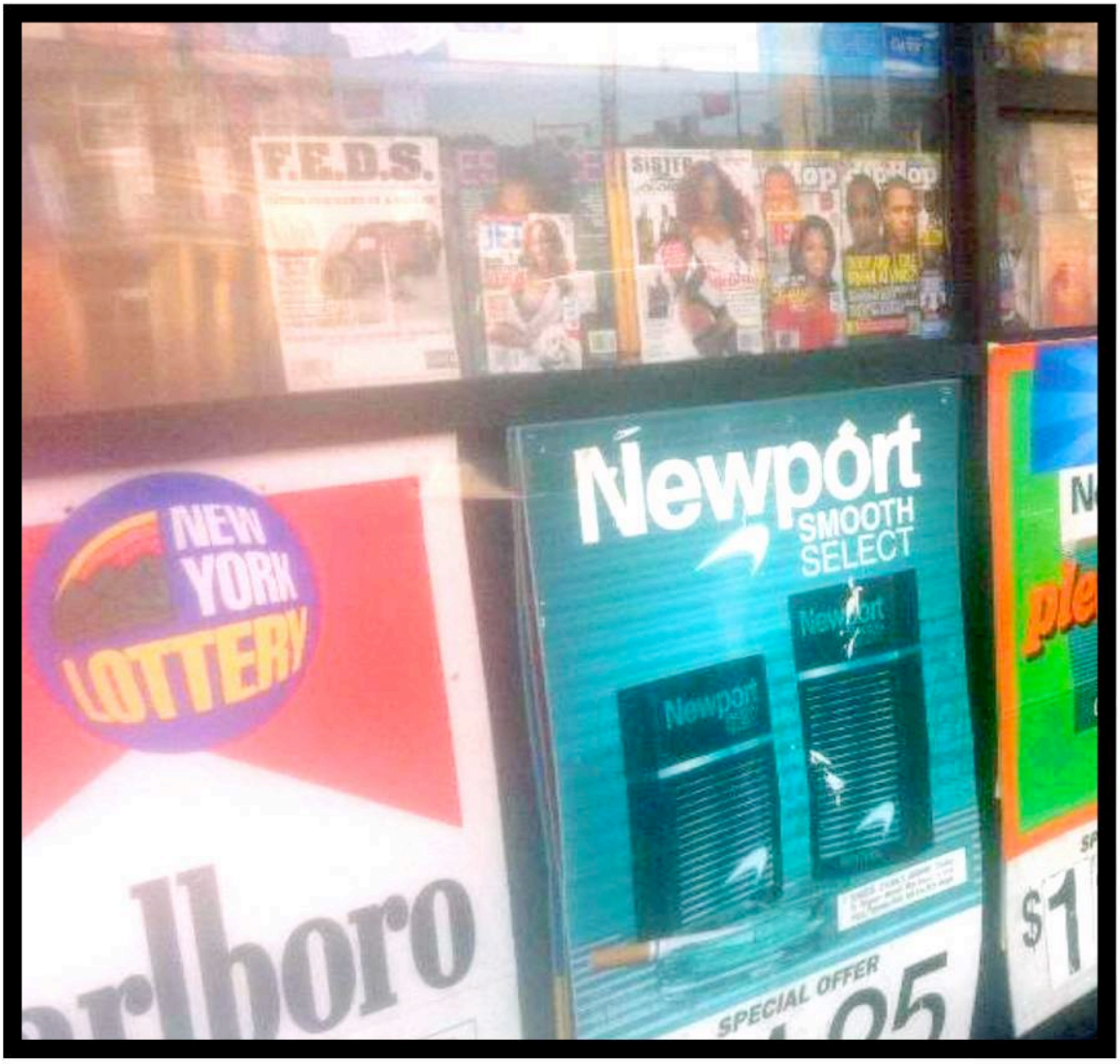
o For each health-warning ad, how large is the largest text (use tape measure)?

- Ad 1: _____
- Ad 2: _____
- Ad 3: _____
- Ad 4: _____
- Additional ads: _____

o For each health-warning ad, what colors are used (please be specific, include whether bright, dull, etc)?

- Ad 1: _____
- Ad 2: _____
- Ad 3: _____
- Ad 4: _____
- Additional ads: _____

5. What grabbed your attention most as you went through the store?:



ADVERSE ADVERTS:

Mapping Tobacco Marketing in Three Brooklyn Neighborhoods

A snapshot of tobacco marketing in
Bay Ridge, Boerum Hill, and Bushwick

NYPIRG

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For more information, contact author Megan Ahearn at NYPIRG at mahearn@nypirg.org or visit www.nypirg.org/health.

INTRODUCTION AND EXECUTIVE SUMMARY

Tobacco remains the number one cause of preventable death in the United States.[1] Tobacco use has prematurely killed ten times more United States citizens than in all the wars fought by the U.S. throughout its history.[2] Tobacco marketing is an especially significant issue when it comes to youth. Currently, 19,000 New York City public high school students under the age of 18 smoke, and nearly 30,000 others tried smoking for the first time.[3] Nationally, one out of every thirteen current smokers will die prematurely from smoking-related illnesses.[4]

The largest cigarette companies are investing big money to reach new smokers, spending over $9 billion nationally—and $213.5 million in New York—to market their products each year.[5] Due to legal restrictions, cigarette advertisements have left billboards and TV commercials. Now, they bombard customers in local corner stores and bodegas, pharmacies, and other stores. Unfortunately, these also happen to be places that young people visit frequently. The U.S. Surgeon General has found that the more tobacco advertising and marketing youth see, the more likely they are to smoke.[6] There are over 9,000 licensed tobacco retailers in New York City and 75% of them have been found to be within 1,000 feet of a school.[7]

NYPIRG has a long and successful history protecting New Yorkers of all ages from the negative effects of smoking—from addressing tobacco marketing targeting youth to supporting smoke-free spaces. In 2013-14, NYPIRG worked with NYC Smoke-Free, formerly the NYC Coalition for a Smoke-Free City, to create a mentorship program between high school students and college students at four CUNY colleges. The program paired students together to educate their peers and the public about the health effects of tobacco use and the industry's targeted marketing strategies. It culminated in a community mapping survey of tobacco advertisements, *Overexposed,* which can be viewed at www.nypirg.org/health/overexposed.

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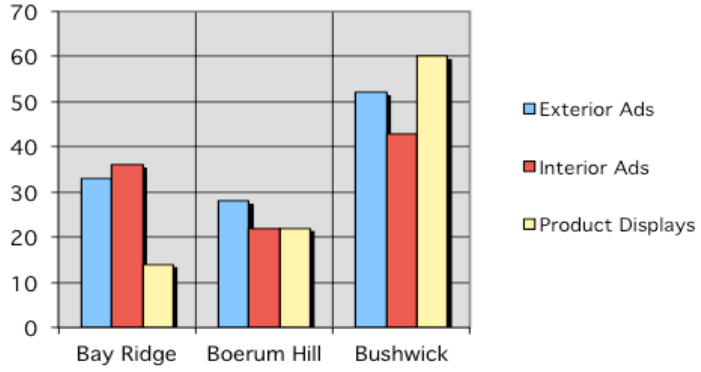
[1] U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
[2] *Supra note 1.*
[3] Stalvey L, Grimshaw V, Johns M, Coady MH. Promotion of Tobacco Products in Retailers in New York City. NYC Vital Signs 2013; 12(1):1-4.
[4] *Supra note 1.*
[5] U.S. Federal Trade Commission (FTC), Cigarette Report for 2012, Issued March 27, 2015. https://www.ftc.gov/system/files/documents/reports/federal-trade-commission-cigarette-report-2012/150327-2012cigaretterpt.pdf; and Campaign for Tobacco Free Kids, estimated tobacco industry marketing in NYS prorated based on cigarette pack sales in the state. http://www.tobaccofreekids.org/facts_issues/toll_us/sources/.
[6] U.S. Department of Health and Human Services. Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General. Atlanta, GA: 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.
[7] Luke, Douglas A., PhD, et. al. "Family Smoking Prevention and Tobacco Control Act: Banning Outdoor Tobacco Advertising Near Schools and Playgrounds." (American Journal of Preventive Medicine; 40(3): 295-302), 2011.

In 2015, NYPIRG embarked on an exploration to address community-based tobacco control issues within New York City, and more specifically, youth exposure to tobacco products and tobacco advertising. Students and NYPIRG staff worked together to survey and map tobacco advertisements and displays they observed within a one to seven block area surrounding high schools in three Brooklyn neighborhoods: the High School of Telecommunications, Arts and Technology in Bay Ridge; Coy L. Cox School (PS 369) in Boerum Hill; and two high schools across the street from one another in Bushwick—Bushwick Leaders High School for Academic Excellence and EBC High School for Public Service (K 545). These locations provided a snapshot of tobacco marketing in three geographically and socio-economically diverse neighborhoods.

The neighborhood snapshot collected anecdotal evidence, and therefore does not constitute a scientific report. The results spotlight the tobacco advertisements, product displays and other marketing (collectively referred to as "tobacco ads" or "ads" throughout this report) that youth may be exposed to in their everyday lives. NYPIRG staff and student volunteers surveyed 41 stores: 34 corner stores/bodegas; 2 discount chains; 2 gas stations; 2 smoke shops/hookah bars; and 1 grocery store.

The Tobacco Marketing Neighborhood Snapshot found the following:

- Surveyors observed 113 tobacco ads on the exteriors of store buildings.
    - Of the 113 total exterior ads, 52 ads were observed surrounding the two Bushwick high schools, 33 ads were observed surrounding the Bay Ridge high school, and 28 ads were observed surrounding the Boerum Hill high school.
- Surveyors observed 101 total tobacco ads on the interior of stores.
    - Of the 101 total interior ads, 43 ads were observed surrounding the two Bushwick high schools, 36 ads were observed surrounding the Bay Ridge high school, and 22 ads were observed surrounding the Boerum Hill high school.
- Surveyors observed 96 total tobacco product displays on the interior of stores.
    - Of the 96 total tobacco product displays, 60 displays were observed surrounding the two Bushwick high schools, 22 displays were observed surrounding the Boerum Hill high school, and 14 displays were observed surrounding the Bay Ridge high school.



Surveyors observed a total of 310 tobacco advertisements and product displays within one to seven blocks surrounding the high schools in the three neighborhoods included in the project.

NEIGHBORHOOD SNAPSHOT HIGHLIGHTS

Methodology

Volunteers were trained by NYPIRG's Organizing Director to canvass neighborhoods and map tobacco advertisements, product displays, promotional product pricing, and other marketing observed on the exterior and interior of stores. Three neighborhoods in Brooklyn, NY—Bay Ridge, Boerum Hill, and Bushwick—were surveyed between August and September 2015.

These locations provided a snapshot of tobacco marketing in three geographically and socio-economically diverse neighborhoods. In each neighborhood, between one and seven blocks directly surrounding a high school were surveyed.

Effort was taken to map an area of similar significance and size in each neighborhood. This always included the streets directly around the high school and contiguous streets with local bus and subways stops that serve the school. Maps of the neighborhood snapshot area in each neighborhood are attached to this report.

All stores in each defined survey area of each neighborhood were canvassed; however, a store was only surveyed when at least one exterior ad, interior ad, or tobacco product display was observed. For each completed survey, the type of business was identified. Surveyors were asked to classify each store by one of these six categories:

- Corner Store/Bodega
- Grocery Store
- Non-Food Retail
- Gas Station
- Restaurant
- Other: _____

> Types of stores which were identified as "Other" include smoke shops, bars, and discount chains. Note: only the exteriors of smoke shops and bars were surveyed since you must be 18 years or older to enter. However, passersby of all ages are exposed to the store exteriors.

Types of Businesses Surveyed

A store was surveyed when at least one exterior ad, interior ad, tobacco product display or other tobacco marketing was observed. Traditional tobacco cigarettes, loose tobacco, hookah, cigar, cigarillo, and electronic cigarette ads were all included in the results. In total, our staff and student volunteers surveyed 41 stores.

- 21 stores were in Bushwick (51%)
- 10 stores were in Bay Ridge (24%)
- 10 stores were in Boerum Hill (24%)

In total, 34 corner stores/bodegas, two discount chains, two gas stations, two smoke shops/bars, and one grocery store were surveyed. Corner stores/bodegas represented 83% of total stores surveyed, discount stores, gas stations, and smoke shops/bars represented 5% a piece, and the grocery store represented 2% of total businesses surveyed. Corner stores/bodegas represented the most common location for tobacco ads and displays survey-wide and in all boroughs.

- In Bushwick, 17 corner stores/bodegas, two discount chains, one gas station, and one grocery store were surveyed. Bushwick had the most diverse types of stores included in the neighborhood snapshot.
- In Bay Ridge, eight corner stores/bodegas, one gas station, and one hookah bar were surveyed.
- In Boerum Hill, nine corner stores/bodegas, and one smoke shop were surveyed.

Exterior Advertisements

Exterior advertisements subject shoppers and passersby to tobacco marketing whether they are tobacco users or not. Scores more people than the store's shoppers may see exterior advertisements in high traffic areas, such as mass transit hubs. Surveyors observed 113 total tobacco advertisements on the exteriors of store buildings including the walls, windows, doors, and other property of the establishment. Of the 113 total exterior ads, 52 ads were observed in the Bushwick area, 33 were observed in the Bay Ridge area, and 28 were observed in the Boerum Hill area. Bushwick ads represented 46% of total exterior ads observed, Bay Ridge ads represented 29%, and Boerum Hill ads represented 25%.

Photo credit: Tassia Rosa, 2015

The higher number of exterior ads found in Bushwick mirrors results in the New York City Department of Health and Mental Hygiene's (DOHMH) in report, *NYC Vital Signs*.[8] They found that tobacco retailers with exterior advertisements were more common in high-risk neighborhoods—Bushwick is one of ten such neighborhoods.

[8] Stalvey L, Grimshaw V, Johns M, Coady MH. Promotion of Tobacco Products in Retailers in New York City. NYC Vital Signs 2013, Volume 12, No. 1; 1-4.

In this NYPIRG survey, a total of 80 ads (or 71%) were placed on exteriors at an adult's eye-level, 17 (15%) were placed above the head, and 16 (14%) were near the ground or at a child's eye-level.

What's more, in ten locations (five in Boerum Hill, three in Bushwick, and two in Bay Ridge), large—often times floor to ceiling—interior displays of tobacco products or paraphernalia, such as hookah pipes and e-cigarette cartridges and vaporizers, were visible to passersby on the exterior.

Interior Advertisements

Surveyors observed 101 total tobacco advertisements on the interior of stores. The interior of the store includes in, on and around counters, shelves, registers, interior walls, ceilings, and other places easily visible from anywhere a customer might stand. In total, 43 interior ads were observed in Bushwick, 36 were observed in Bay Ridge, and 22 were observed in Boerum Hill. Compared to the total number of interior ads observed, Bushwick represented 43%, Bay Ridge represented 36% and Boerum Hill represented 22%.

Tobacco Display Observations

Surveyors observed 96 separate tobacco product displays. Product displays are any tobacco product or paraphernalia that was visible for purchase. Tobacco products included traditional cigarettes, e-cigarette cartridges and liquids, loose tobacco and rolling papers, cigars, cigarillos, pipes, and hookahs. In total, 60 tobacco product displays were observed in Bushwick, 22 displays were observed in Boerum Hill, and 14 displays were observed in Bay Ridge.

Although the same amount of stores were surveyed in Boerum Hill and Bay Ridge, and more exterior and interior ads were observed in Bay Ridge, there were 57% more tobacco product displays observed in Boerum Hill than Bay Ridge.

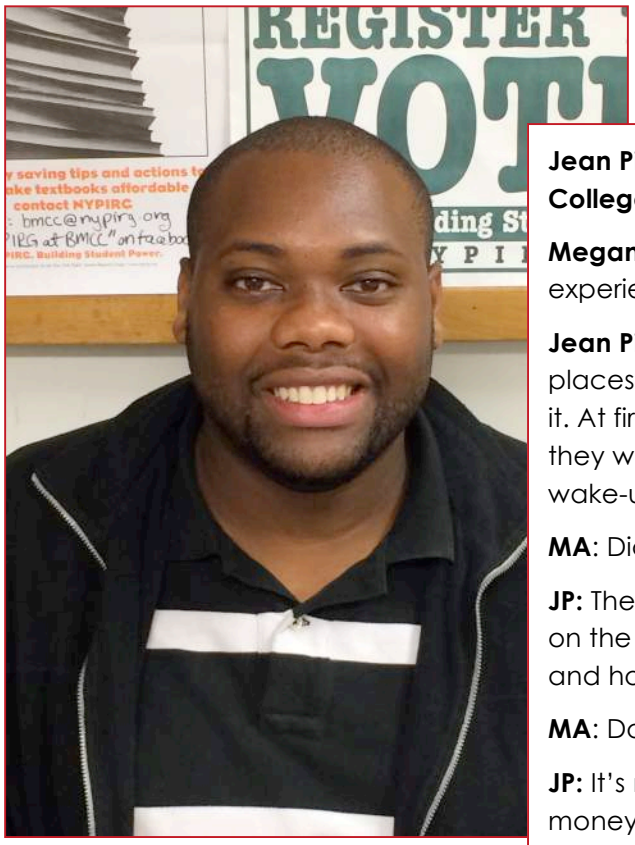
Photo Credit: NYC Smoke-Free: http://nycsmokefree.org/tobacco-retail-marketing, Accessed in 2015

Brand Observations

Newport brand tobacco product advertisements were found most frequently on store exteriors and interiors. The second most frequently observed brand was Blu E-cig on both store exteriors and interiors. However, there was only one Blu E-Cig ad observed in Boerum Hill.

It is worth noting that traditional tobacco cigarette and e-cigarette brand ads were observed in nearly identical numbers (45 to 44 ads, respectively) on the exterior of stores, while traditional tobacco cigarette brand ads were seen 183% more frequently than e-cigarette brand ads on the interior of stores (see Brand Frequency List pgs. 14-16 for more information). The prevalence of exterior e-cigarette ads is noteworthy as the 2014 National Youth Tobacco Survey found that, in just one year, e-cigarette use tripled among high school students, even while traditional cigarette use declined.[9]

NEIGHBORHOOD SNAPSHOT PARTICIPANT OBSERVATIONS



Jean Pierre Felder, Borough of Manhattan Community College student and survey participant

Megan Ahearn: What are your overall thoughts from the experience?

Jean Pierre: I learned a lot. I learned that there are a lot of places that are subtly targeting kids without people realizing it. At first I didn't notice the advertisements, but when I did, they were everywhere. It was crazy—it was definitely a wake-up call.

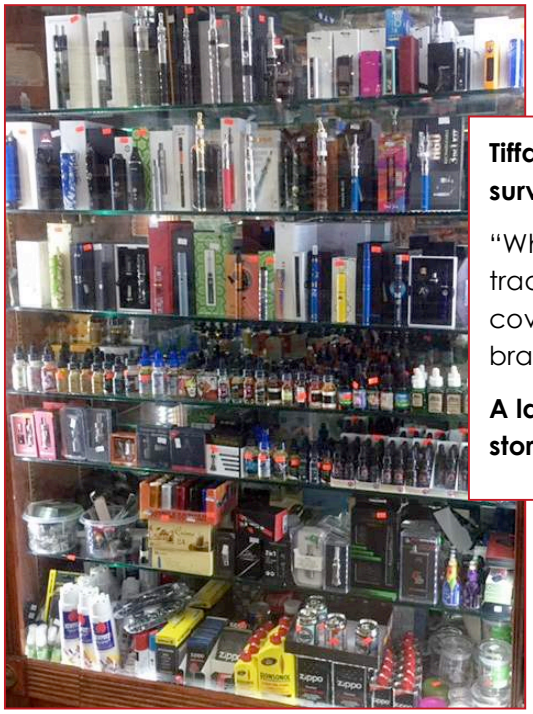
MA: Did anything stand out to you in particular?

JP: There were a lot of advertisements on store banners and on the outside of the stores. There were a lot of e-cigarettes and hookahs visible, it was so obvious.

MA: Do you have any advice for younger people?

JP: It's not worth it to smoke. And realistically, you'll save money! A lot of young people have an immortality mentality—that they can quit at any time—but that's just not the case. Smoking is costly to your health and your pocket.

[9] Centers for Disease Control and Prevention and the U.S. Food and Drug Administration's Center for Tobacco Products, 2014 National Youth Tobacco Survey, http://www.cdc.gov/media/releases/2015/p0416-e-cigarette-use.html.



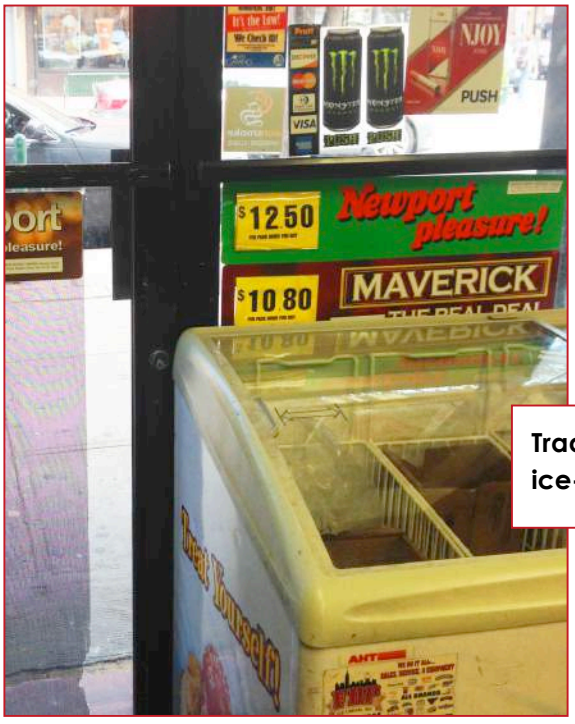
Tiffany Brown, Queens College NYPIRG Project Coordinator and survey participant

"While surveying, I was really surprised at the amount of non-traditional tobacco products I saw. Many of the walls were covered with e-cigarette brands and flavors, as well as multiple brands of rolling papers and loose tobacco."

A large display of tobacco products is visible from within this store in Bushwick, Brooklyn.

Farouk Abdallah, NYPIRG Deputy Director, Bay Ridge resident, father of two young children, and survey participant

"Wow, I saw lots of tobacco products that were placed at a child's eye level. It was like a wall of tobacco that hits you in the face."



Traditional tobacco advertisements are observed near an ice-cream freezer in Bay Ridge, Brooklyn.

Pipes and other paraphernalia are displayed in a case visible from both the exterior and interior of this Bushwick store.

CONCLUSION

While this neighborhood snapshot educated participants and the public about Big Tobacco's advertising strategies, there's more we can do to tackle this issue head on. Retailers can help by reducing tobacco marketing in and on their stores. They might also elect not to place tobacco products or advertisements near children's products such as toys or candy, or sell or advertise tobacco products around schools. New Yorkers can help to draw attention to tobacco marketing in their own communities and encourage tobacco control protections for youth.

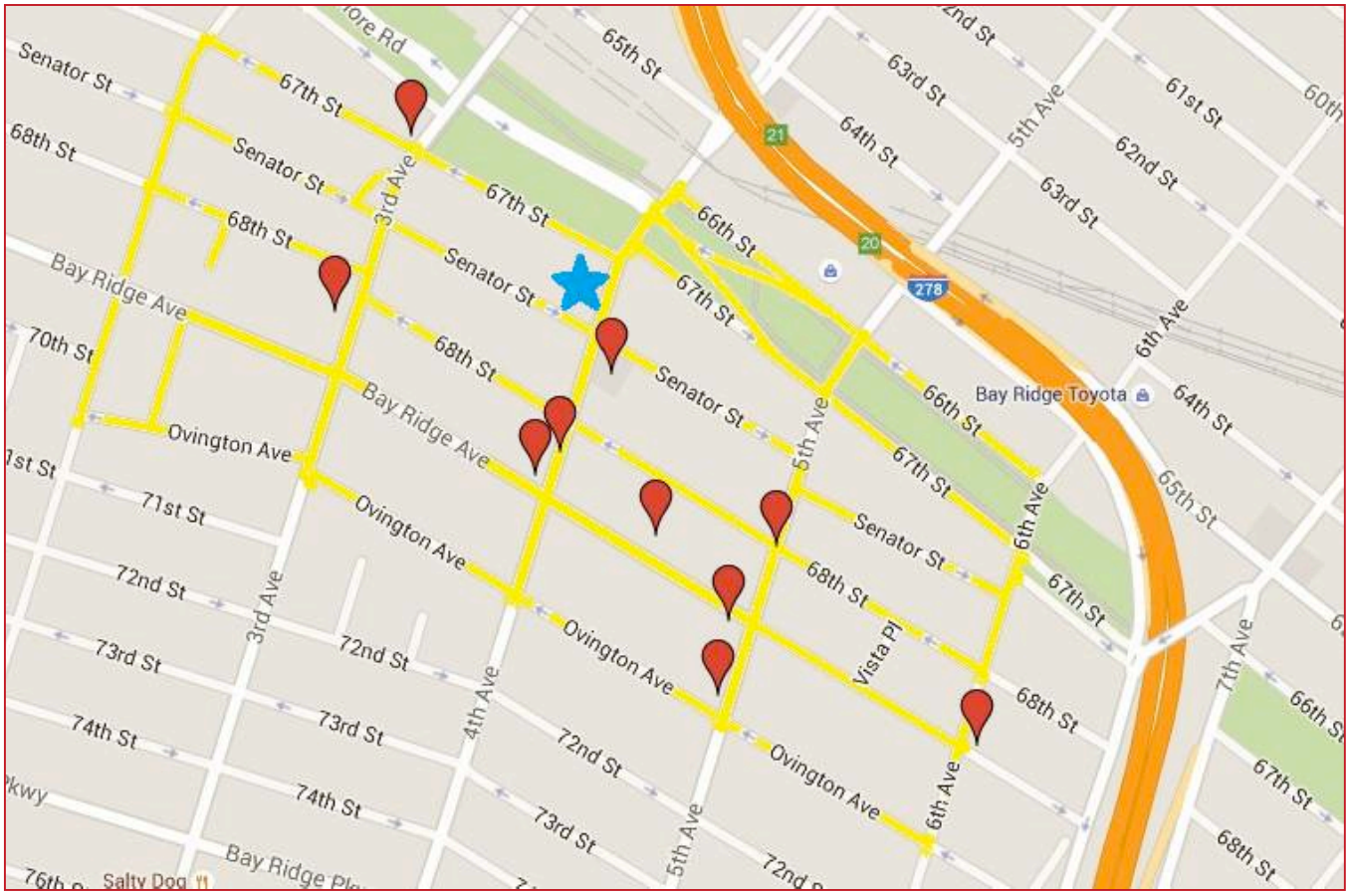
ACKNOWLEGMENTS AND CREDITS

Observations were carried out by NYPIRG staff and college students working with NYPIRG in August and September of 2015. Surveyors included the following people: Farouk Abdallah, Megan Ahearn, Tiffany Brown, Kevin Dugan, Jean Pierre Felder, Patrick Krug, Jasmine Quinones, Tassia Rosa, Emily Skydel, and Daniel Zhou. The survey authors would also like to thank Blair Horner, Diana Fryda, Laena Orkin, and Rebecca J. Weber for their assistance and contributions. This publication was made possible with funding from the Centers for Disease Control and Prevention. For more information, contact Megan Ahearn at NYPIRG at mahearn@nypirg.org or visit www.nypirg.org/health. Cover page photo credit: Robert Noonan, 2013.

ATTACHMENTS

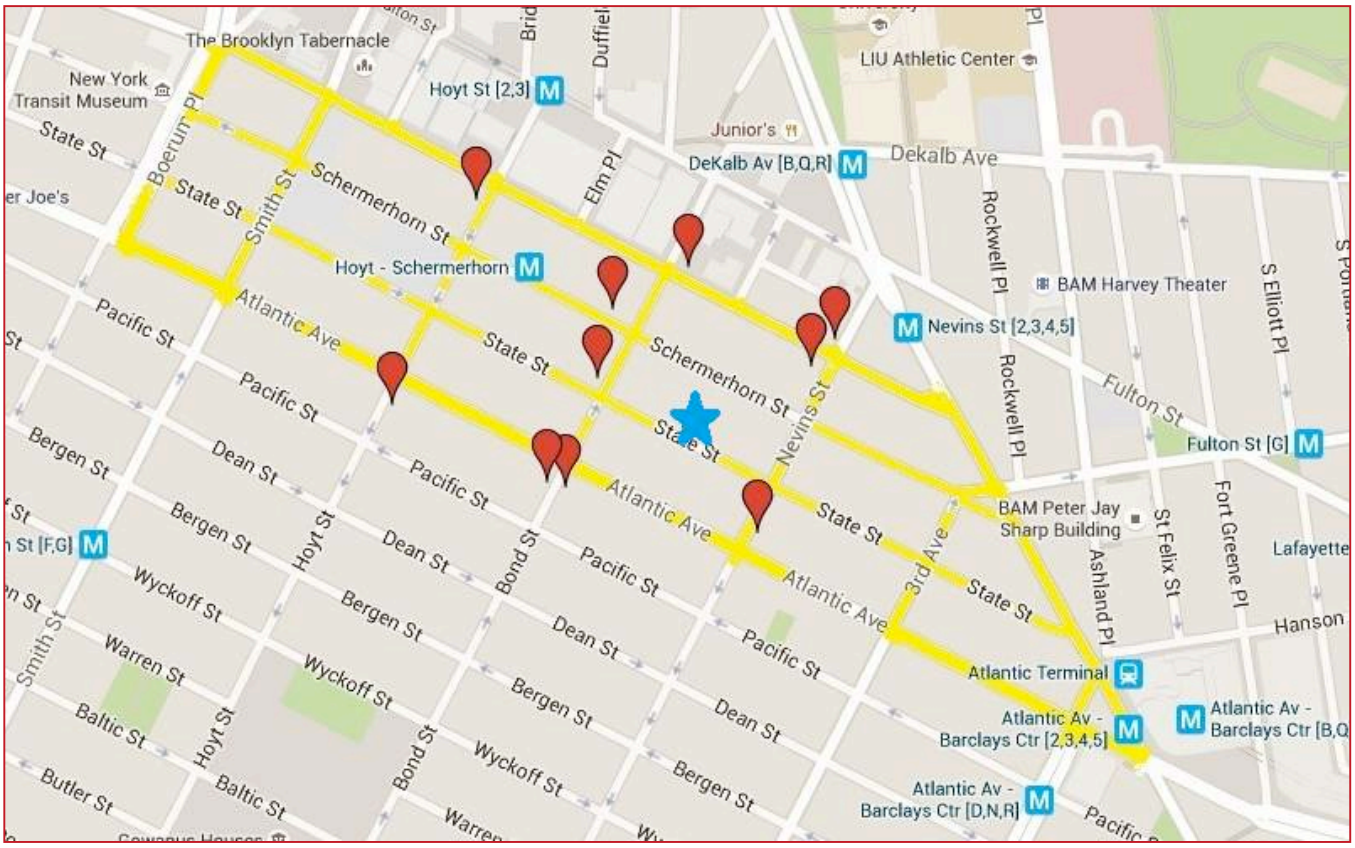
Bay Ridge Map

Highlighted areas indicate the blocks surveyed. Pins indicate locations were tobacco advertisements or tobacco product displays were observed. The star indicates the high school.



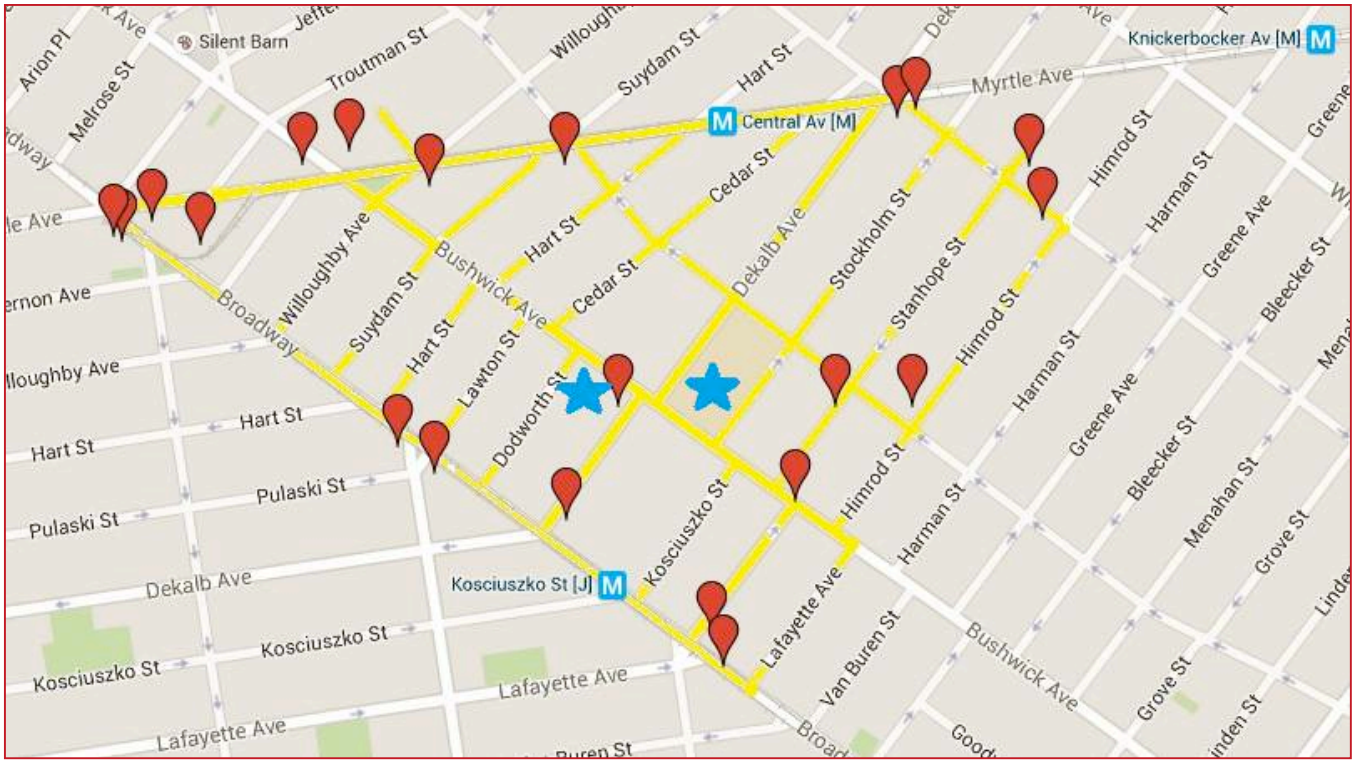
Boerum Hill Map

Highlighted areas indicate the blocks surveyed. Pins indicate locations were tobacco advertisements or tobacco product displays were observed. The star indicates the high school.



Bushwick Map

Highlighted areas indicate the blocks surveyed. Pins indicate locations were tobacco advertisements or tobacco product displays were observed. The stars indicate the high schools.



Brand Frequency Lists

SURVEY-WIDE	Exterior Ad Brands	Number of Occasions Observed	Interior Ad Brands	Number of Occasions Observed
	Newport	29	Newport	40
	Blu E-Cig	23	Blu E-Cig	16
	Eon Smoke	14	Maverick	13
	Maverick	9	Eon Smoke	4
	Camel Snus	8	Marlboro	4
	Marlboro	3	American Spirits	3
	V2 E-cig	3	Camel	2
	Game Natural Leaf	2	Camel Snus	2
	Longhorn	2	N Joy	2
	Raw Hemp	2	Pall Mall	2
	Starbuzz	2	Parliament	2
	American Spirit	1	Game Natural Leaf	1
	Cheap cigarettes	1	Grizzly	1
	Eagle 20	1	Krave E-cig	1
	Export A	1	Longhorn	1
	Flix E-Cig	1	Pyramid	1
	Kamry	1	Red Man	1
	Logic	1	Swisher	1
	N Joy	1	White Owl	1
	Pax	1	Winston	1
	Pyramid	1	Wolf	1
	Red Man	1	Xtra E-cig	1
	Rock n Roll Cigarillo	1		
	Smoking filters	1		
	Spirit	1		
	White Owl	1		
	Zig-Zag	1		

BAY RIDGE	Exterior Ad Brands	Number of Occasions Observed	Interior Ad Brands	Number of Occasions Observed
	Newport	12	Newport	16
	Blu E-Cig	7	Maverick	6
	Eon Smoke	5	Blu E-cig	5
	Maverick	4	Eon Smoke	1
	Game Natural Leaf	1	Game Natural Leaf	1
	Longhorn	1	Longhorn	1
	N Joy	1	Marlboro	1
	Red Man	1	N Joy	1
	Camel Snus	1	Parliament	1
			White Owl	1
			Wolf	1
			Xtra E-cig	1

BOERUM HILL	Exterior Ad Brands	Number of Occasions Observed	Interior Ad Brands	Number of Occasions Observed
	Camel Snus	7	Newport	5
	Eon Smoke	5	Eon Smoke	3
	Newport	4	Camel	2
	Raw Hemp	2	Camel Snus	2
	V2 E-Liquid	2	Pall Mall	2
	American Spirit	1	American Spirits	1
	Blu E-Cig	1	Grizzly	1
	Export A	1	Marlboro	1
	Game Natural Leaf	1	Maverick	1
	Kamry	1	N-Joy	1
	Longhorn	1	Parliament	1
	Maverick	1	Red Man	1
	Smoking filters	1	Winston	1

BUSHWICK	Exterior Ad Brands	Number of Occasions Observed	Interior Ad Brands	Number of Occasions Observed
	Blu E-Cig	15	Newport	19
	Newport	13	Blu E-Cig	11
	Eon Smoke	4	Maverick	6
	Maverick	4	American Spirits	2
	Marlboro	3	Marlboro	2
	Starbuzz	2	Krave E-cig	1
	Cheap cigarettes	1		
	Eagle 20	1	Pyramid	1
	Flix E-Cig	1	Swisher	1
	Logic	1		
	Pax	1		
	Pyramid	1		
	Rock n Roll Cigarillo	1		
	Spirit	1		
	V2 E-cig	1		
	White Owl	1		
	Zig-Zag	1		

Survey Copy

Surveyor Name: _____

School: _____

Phone #: _____

Date: _____

Instructions:

Thank you for taking part in this community mapping survey! To complete this survey, you will need a pen, this paper survey, and a camera. Fill out the answers to the below questions when you observe any sort of tobacco advertisements (ads) on the exterior or interior of stores within the designated survey area. Advertisements include pricing and promotion announcements, traditional advertisements, tobacco brand labels, the cigarettes themselves, branded display cases, etc. If you are unsure, take a picture of the advertisement and include it in your survey. Use a different survey form for each store that you observe tobacco and/or anti-tobacco ads on or in. Please take a picture of at least 5 tobacco ads that can be emailed at a later time. Please be as specific as possible in your answers.

Business Name:	
Street Address:	Cross Streets:
Type of Business: ☐ Corner Store/Bodega ☐ Grocery Store ☐ Non-Food Retail ☐ Gas Station ☐ Restaurant ☐ Other: _____	

1. EXTERIOR TOBACCO ADVERTISEMENTS

- How many tobacco ads do you see on the exterior of the store?: _____
- For each ad, list the brand and where it is placed in comparison to your eye-level:
  - Brand: _____Placed (circle one): at eye-level[i] near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
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  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head

2. INTERIOR TOBACCO PRODUCT DISPLAYS

- Do you see cigarette packs OR cartons displayed anywhere in the store? (circle one): YES or NO
- Do you see other tobacco products (e.g., smokeless products, e-cigarettes, cigars, pipes, papers, loose tobacco, etc.) displayed anywhere in the store? (circle one): YES or NO
- Please describe each tobacco product display. Measure shelf space by counting the number of "pack facings" on the front row of shelves and displays. Count the number of packs across and down. Cartons stacked with the longest side facing front count as five packs; cartons stacked with the shorter side facing front count as two.
- DISPLAY 1:
  - Location of display: _____
  - Size of display (total pack facings horizontal x vertical): _____ x _____
- DISPLAY 2:
  - Location of display: _____
  - Size of display (total pack facings horizontal x vertical): _____ x _____

(continued on back)

3. INTERIOR TOBACCO ADVERTISEMENTS

- How many tobacco ads do you see on the inside of the store? : _____
- For each ad, what is the brand and where is it placed in comparison to your eye-level:
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
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  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head

Additional Notes: _____

_____

4. Testimonial: Please describe one thing you are taking away with you from this survey experience:

_____

_____

_____

_____

_____

_____

_____

_____

_____

5. Other concluding comments:

_____

_____

_____

_____

_____

_____

Please attach photos you took of ads and send to mahearn@nypirg.org when you hand in this survey. Thank you!

_____

[i] Surveyors were trained to judge the height of an ad based on average adult heights of 5'5 -5'10.

STILL AT RISK:

A Snapshot of Tobacco Marketing in Bedford-Stuyvesant, Park Slope, and Williamsburg, Brooklyn

New York Public Interest Research Group Fund/NYPIRG | September 2016

TABLE OF CONTENTS

For more information, contact Megan Ahearn (mahearn@nypirg.org) or Diana Fryda (dfryda@nypirg.org) at NYPIRG or visit www.nypirg.org/health.

INTRODUCTION AND EXECUTIVE SUMMARY

Tobacco remains the number one cause of preventable death in the United States.[1] Tobacco use has prematurely killed ten times more United States citizens than in all the wars fought by the U.S. throughout its history.[2] Tobacco marketing is an especially significant issue when it comes to youth.

According to a 2015 Youth Risk Survey Assessment of New York City High School students, 22% of survey participants stated that they had tried smoking cigarettes, and 5.8% of survey participants stated that they had tried a cigarette within the past 30 days.[3]

Nationally, one out of every thirteen current smokers will die prematurely from smoking-related illnesses.[4]

The largest cigarette companies are investing big money to reach new smokers, spending over $9 billion nationally—and $213.5 million in New York—to market their products each year.[5] Due to legal restrictions, cigarette advertisements have left billboards and TV commercials. Now, they bombard customers in local corner stores and bodegas, pharmacies, and other stores. Unfortunately, these also happen to be places that young people visit frequently. The U.S. Surgeon General has found that the more tobacco advertising and marketing youth see, the more likely they are to smoke.[6] There are over 9,000 licensed tobacco retailers in New York City and 75% of them have been found to be within 1,000 feet of a school.[7]

NYPIRG has long been involved in the effort to protect New Yorkers of all ages from the negative effects of smoking—from addressing tobacco marketing and youth to supporting smoke-free spaces. In 2013-14, NYPIRG worked with NYC Smoke-Free, formerly the NYC Coalition for a Smoke-Free City, to create a mentorship program

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[1] U.S. Department of Health and Human Services. 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, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

[2] *Supra note 1.*

[3] Centers for Disease Control and Prevention (CDC). 1991-2015 High School Youth Risk Behavior Survey Data. Available at http://nccd.cdc.gov/youthonline/. Accessed on September 24, 2016.

[4] *Supra note 1.*

[5] U.S. Federal Trade Commission (FTC), Cigarette Report for 2012, Issued March 27, 2015. https://www.ftc.gov/system/files/documents/reports/federal-trade-commission-cigarette-report-2012/150327-2012cigaretterpt.pdf; and Campaign for Tobacco Free Kids, estimated tobacco industry marketing in NYS prorated based on cigarette pack sales in the state. http://www.tobaccofreekids.org/reports/settlements/toll.php?StateID=NY.

[6] U.S. Department of Health and Human Services. Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General. Atlanta, GA: 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.

[7] Luke, Douglas A., PhD, et. al. "Family Smoking Prevention and Tobacco Control Act: Banning Outdoor Tobacco Advertising Near Schools and Playgrounds." (American Journal of Preventive Medicine; 40(3): 295-302), 2011.

between high school students and college students at four CUNY colleges. The program paired students together to educate their peers and the public about the health effects of tobacco use and the industry's targeted marketing strategies. It culminated in a community mapping survey of tobacco advertisements, *Overexposed,* which can be viewed at www.nypirg.org/health/overexposed.

In 2015, NYPIRG embarked on an exploration to address community-based tobacco control issues within New York City, and more specifically, youth exposure to tobacco products and tobacco advertising. Students and NYPIRG staff worked together to survey and map tobacco advertisements and displays they observed within a one to seven block area surrounding high schools in three Brooklyn neighborhoods: the High School of Telecommunications, Arts and Technology in Bay Ridge; Coy L. Cox School (PS 369) in Boerum Hill; and two high schools across the street from one another in Bushwick—Bushwick Leaders High School for Academic Excellence and EBC High School for Public Service (K 545). The results were published in a report Adverse Adverts, which can be viewed at www.nypirg.org/health/advserseadverts.

In 2016, NYPIRG continued its exploration of tobacco-based marketing surrounding Brooklyn high schools to highlight youth exposure to tobacco-based marketing. This year, student volunteers and NYPIRG staff mapped tobacco advertisements and displays they observed within a one to seven block area surrounding high schools in three more Brooklyn neighborhoods: Brooklyn Community Arts and Media High School in Bedford-Stuyvesant; Brooklyn Millennium High School in Park Slope; and Williamsburg Prep High School in Williamsburg. These locations provided a snapshot of tobacco marketing in three geographically and socio-economically diverse neighborhoods.

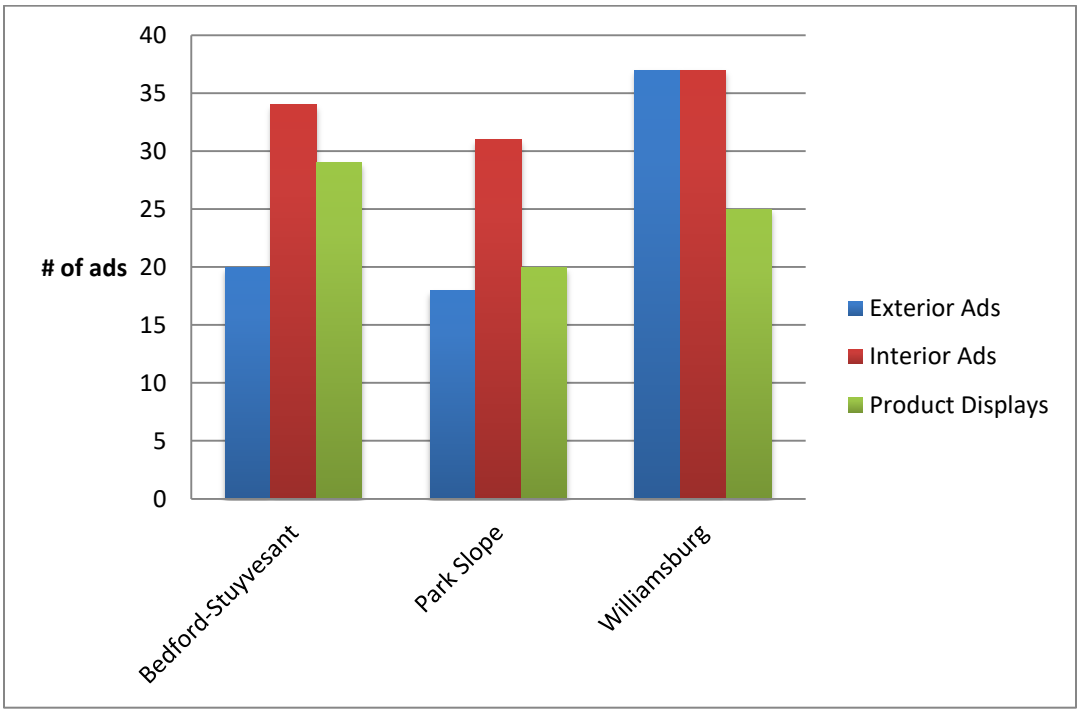
The neighborhood snapshot collected anecdotal evidence, and therefore does not constitute a scientific report. The results spotlight the tobacco advertisements, product displays and other marketing (collectively referred to as "tobacco ads" or "ads" throughout this report) that youth may be exposed to in their everyday lives. NYPIRG staff and student volunteers surveyed 37 stores: 25 corner stores/bodegas; three smoke shops/hookah bars; three grocery stores; two delis; two gas stations; and two non-food retail stores.

The Tobacco Marketing Neighborhood Snapshot found the following:

- Surveyors observed 75 tobacco ads on the exteriors of store buildings.
    - Of the 75 total exterior ads, 20 ads were observed surrounding the Bedford-Stuyvesant high school, 18 ads were observed surrounding the Park Slope

high school, and 37 ads were observed surrounding the Williamsburg high school.

- Surveyors observed 102 total tobacco ads on the interior of stores.
    - Of the 102 total interior ads, 34 ads were observed surrounding the Bedford-Stuyvesant high school, 31 ads were observed surrounding the Park Slope high school, and 37 ads were observed surrounding the Williamsburg high school.
- Surveyors observed 74 total tobacco product displays on the interior of stores.
    - Of the 74 total tobacco product displays, 29 displays were observed surrounding the Bedford-Stuyvesant high school, 20 displays were observed surrounding the Park Slope high school, and 25 displays were observed surrounding the Williamsburg high school.



Surveyors observed a total of 251 tobacco advertisements and product displays within one to seven blocks surrounding the high schools in the three neighborhoods included in the project.

NEIGHBORHOOD SNAPSHOT HIGHLIGHTS

Methodology

Volunteers were trained by NYPIRG's Program Director to canvass neighborhoods and map tobacco advertisements, product displays, promotional product pricing, and other marketing observed on the exterior and interior of stores. Three neighborhoods in Brooklyn, NY—Bedford-Stuyvesant, Park Slope, and Williamsburg—were surveyed between March and May of 2016.

These locations provided a snapshot of tobacco marketing in three geographically and socio-economically diverse neighborhoods. In each neighborhood, between one and seven blocks directly surrounding a high school were surveyed.

Effort was taken to map an area of similar significance and size in each neighborhood. This always included the streets directly around the high school and contiguous streets with local bus and subways stops that serve the school. Maps of each neighborhood are attached to this report.

All stores in each defined area were canvassed; however, a store was only surveyed when at least one exterior ad, interior ad, or tobacco product display was observed. For each completed survey, the type of business was identified. Surveyors were asked to classify each store by one of these six categories:

- Corner Store/Bodega
- Grocery Store
- Non-Food Retail
- Gas Station
- Restaurant
- Other: _____

  Types of stores which were identified as "Other" include smoke shops, bars, and discount chains. (Note: only the exteriors of smoke shops and bars were surveyed since you must be 18 years or older to enter. However, passersby of all ages are exposed to the store exteriors.)

Types of Businesses Surveyed

A store was surveyed when at least one exterior ad, interior ad, tobacco product display or other tobacco marketing was observed. Traditional tobacco cigarettes,

loose tobacco, hookah, cigar, cigarillo, and electronic cigarette ads were all included. In total, our staff and student volunteers surveyed 37 stores.

- 17 stores were in Bedford-Stuyvesant
- 6 stores were in Park Slope
- 14 stores were in Williamsburg

In total, 25 corner stores/bodegas, three smoke shops/bars, three grocery stores, two delis, two gas stations, and two non-food retail stores were surveyed. Corner stores/bodegas represented the most common location for tobacco ads and displays survey-wide and in all three locations.

- In Bedford-Stuyvesant, 12 corner stores/bodegas, two gas stations, two grocery stores, and one smoke shop were surveyed.
- In Park Slope, four corner stores/bodegas, one smoke shop, and one non-food retail were surveyed.
- In Williamsburg, nine corner stores/bodegas, two delis, one grocery store, one smoke shop, and one non-food retail store were surveyed.

There were 251 ads observed in the 37 stores, which is an average of 6.8 ads or product displays per store.

Exterior Advertisements

Exterior advertisements subject shoppers and passersby to tobacco marketing whether they are tobacco users or not. Scores more people than the store's shoppers may see exterior advertisements in high traffic areas, such as mass transit hubs. Surveyors observed 75 total tobacco advertisements on the exteriors of store buildings including the walls, windows, doors, and other property of the establishment. Of the 75 total exterior ads, 20 ads were observed in the Bedford-Stuyvesant area, 18 were observed in the Park Slope area, and 37 were observed in the Williamsburg area. Bedford-Stuyvesant ads represented 27% of total exterior ads observed, Park Slope ads represented 24%, and Williamsburg ads represented 49%.

Photo Credit: Diana Fryda

In this survey, a total of 37 ads (or 49%) were placed on exteriors at an adult's eye-level (five to six feet above the ground), 15 (20%) were placed above the head, and 23 (31%) were near the ground.

It is worth noting that, in six locations (three in Bedford Stuyvesant and three in Williamsburg), large—often times floor to ceiling—interior displays of tobacco products or paraphernalia, such as hookah pipes and e-cigarette cartridges and vaporizers, were visible to passersby on the exterior. In Bedford-Stuyvesant, the majority of external ads were for hookah paraphernalia and alternate tobacco products rather than traditional tobacco brands.

Interior Advertisements

Surveyors observed 102 total tobacco advertisements on the interior of stores. The interior of the store includes in, on and around counters, shelves, registers, interior walls, ceilings, and other places easily visible from anywhere a customer might stand. In total, 34 interior ads were observed in Bedford Stuyvesant, 31 were observed in Park Slope, and 37 were observed in Williamsburg. Compared to the total number of interior ads observed, Bedford-Stuyvesant represented 33%, Park Slope represented 30% and Williamsburg represented 36%.

Tobacco Display Observations

Surveyors observed 74 separate tobacco product displays. Product displays are any tobacco product or paraphernalia that was visible for purchase. Tobacco products included traditional cigarettes, e-cigarette cartridges and liquids, loose tobacco and rolling papers, cigars, cigarillos, pipes, and hookahs. In total, 29 tobacco product displays were observed in Bedford-Stuyvesant, 20 displays were observed in Park Slope, and 25 displays were observed in Williamsburg.

Photo Credit: NYC Smoke-Free: http://nycsmokefree.org/tobacco-retail-marketing Accessed in 2015

Surveyors noted at least three instances where interior tobacco ads or product displays were placed adjacent to candy and ice cream displays.

Brand Observations

Newport brand tobacco product advertisements were found most frequently on both store exteriors and interiors. The second most frequently observed brand was American Spirit on store exteriors and Marlboro on store interiors. (see Brand Frequency List pgs. 17-19 for more information).

While exterior ads had a wide variety of traditional and alternate tobacco product ads (such as e-cigarettes, chewing tobacco and hookah), from a variety of traditional and new brands (such as Blu or Snus), the interior ads and product displays in all three neighborhoods had were mostly traditional product brands (such as Newport, Marlboro, American Spirit, and Camel).

It is worth noting that e-cigarette brand ads accounted for 20 of the 36 brands observed on the exterior of stores The prevalence of exterior e-cigarette ads is noteworthy as the 2014 National Youth Tobacco Survey found that, in just one year, e-cigarette use tripled among high school students, even while traditional cigarette use declined.[8] According to the Center for Disease Control, "In 2015, e-cigarettes were the most commonly used tobacco product among middle (5.3%) and high (16.0%) school students."[9]

[8] Centers for Disease Control and Prevention and the U.S. Food and Drug Administration's Center for Tobacco Products, 2014 National Youth Tobacco Survey, http://www.cdc.gov/media/releases/2015/p0416-e-cigarette-use.html.
[9] Singh T, Arrazola RA, Corey CG, et al. Tobacco Use Among Middle and High School Students—Unites States, 2011–2015. MMWR Morb Mortal Wkly Rep 2016; 65:361–367. DOI: http://dx.doi.org/10.15585/mmwr.mm6514a1.

NEIGHBORHOOD SNAPSHOT PARTICIPANT OBSERVATIONS

"My advice to younger people is don't use tobacco, it's bad for your health." – *Ucheyahweh Nwabuoku, New York City College of Technology student and survey participant*

"This was a very informative experience. I realized how many tobacco ads there are, both inside and next to candy and outside the store too." – *Nidah Sheikh, Brooklyn College student and survey participant*

Photo Credit: Jenna Lamb

"At one location, there was a General Snus advertisement near the ice cream freezer. That really stood out to me." - *Jennifer Ramos, New York City College of Technology student and survey participant*

Photo Credit: Megan Ahearn

"The amount of tobacco brands out there really stood out to me. I was not aware that there were so many tobacco brands being advertised…There were three shelves of hookahs and other electronic smokes in the display window – I was surprised at the amount! I was also astonished at the four shelves of cigarettes near the candy…They are placed in the stores strategically to look enticing." – *Renella Thomas, Brooklyn College student and survey participant*

"I noticed a huge prevalence of e-cigarette ads – I was surprised at how many there were. They look like high-tech toy ads, very cool and sleek." – *Emily Skydel, NYPIRG Project Coordinator and survey participant*

Photo Credit: Neil Button

TOBACCO ADVERTISEMENTS AND TOBACCO PRODUCTS ON DISPLAY

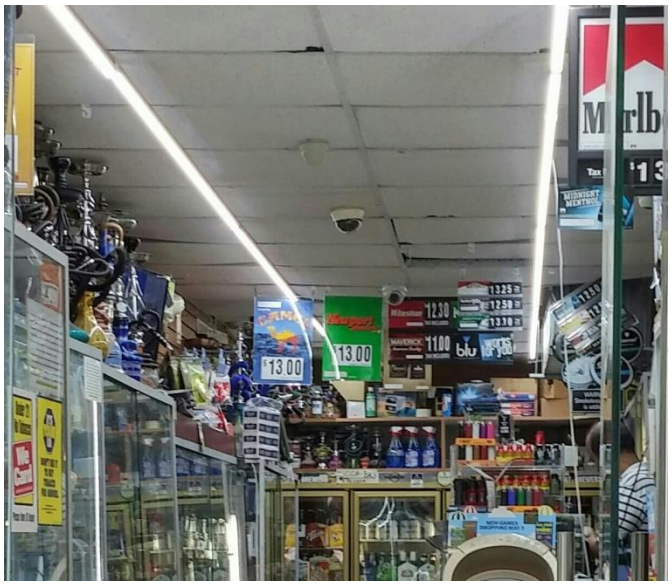


Photo Credits: Diana Fryda

Conclusion

While this neighborhood snapshot educated participants and the public about Big Tobacco's advertising strategies, there's more we can do to tackle this issue head on. Retailers can help by reducing tobacco marketing in and on their stores. They might also elect not to place tobacco products or advertisements near children's products such as toys or candy, or sell or advertise tobacco products around schools. New Yorkers can help to draw attention to tobacco marketing in their own communities and encourage tobacco control protections for youth.

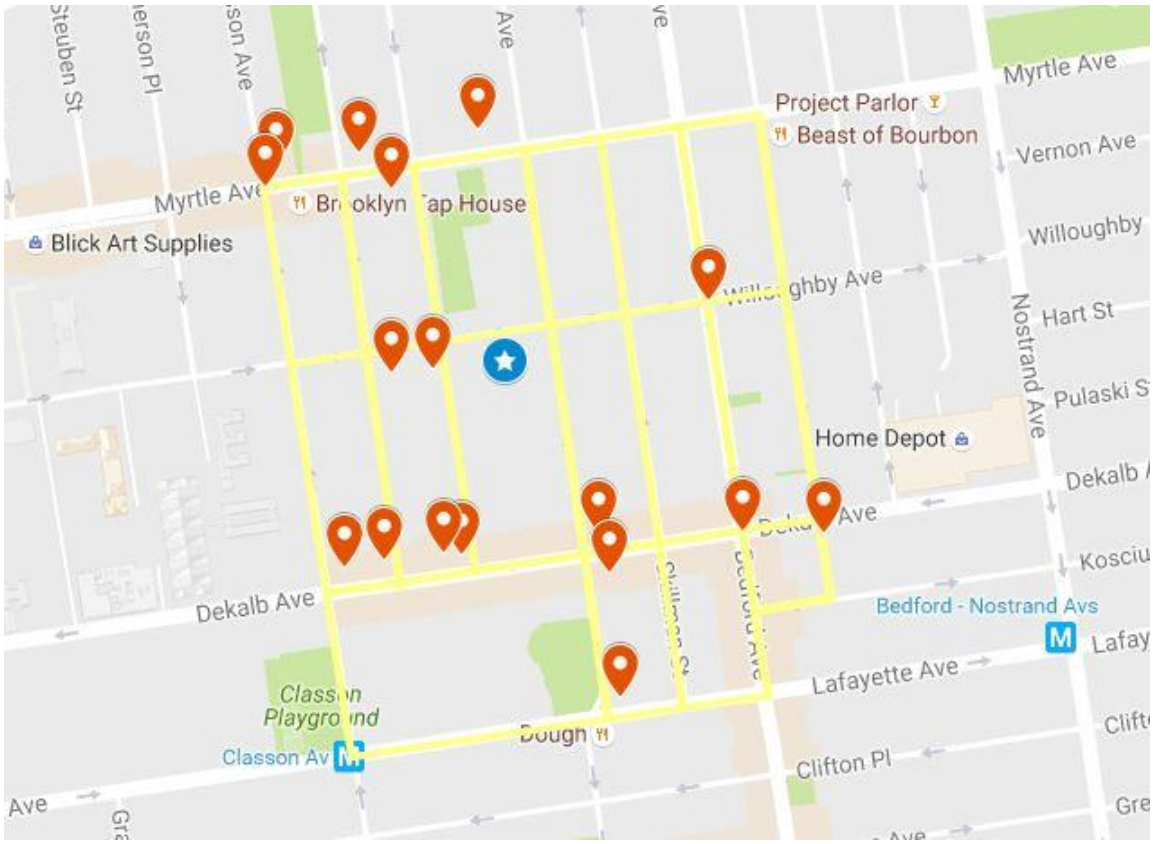
ACKNOWLEGMENTS AND CREDITS

Observations were carried out by NYPIRG staff and college students working with NYPIRG in March, April, and May of 2016. Surveyors included the following people: Megan Ahearn, Kevin Flores, Diana Fryda, Diana Lee, Ucheyahweh Nwabuoku, Jennifer Ramos, Nidah Sheikh, Emily Skydel, Renella Thomas, and Eli Todd. The survey authors would also like to thank Blair Horner and Laena Orkin for their assistance and contributions. This publication was made possible with funding from the Centers for Disease Control and Prevention. For more information, contact Megan Ahearn (mahearn@nypirg.org) or Diana Fryda (dfryda@nypirg.org) at NYPIRG or visit www.nypirg.org/health. *Cover page photo credit: Diana Fryda*

ATTACHMENTS

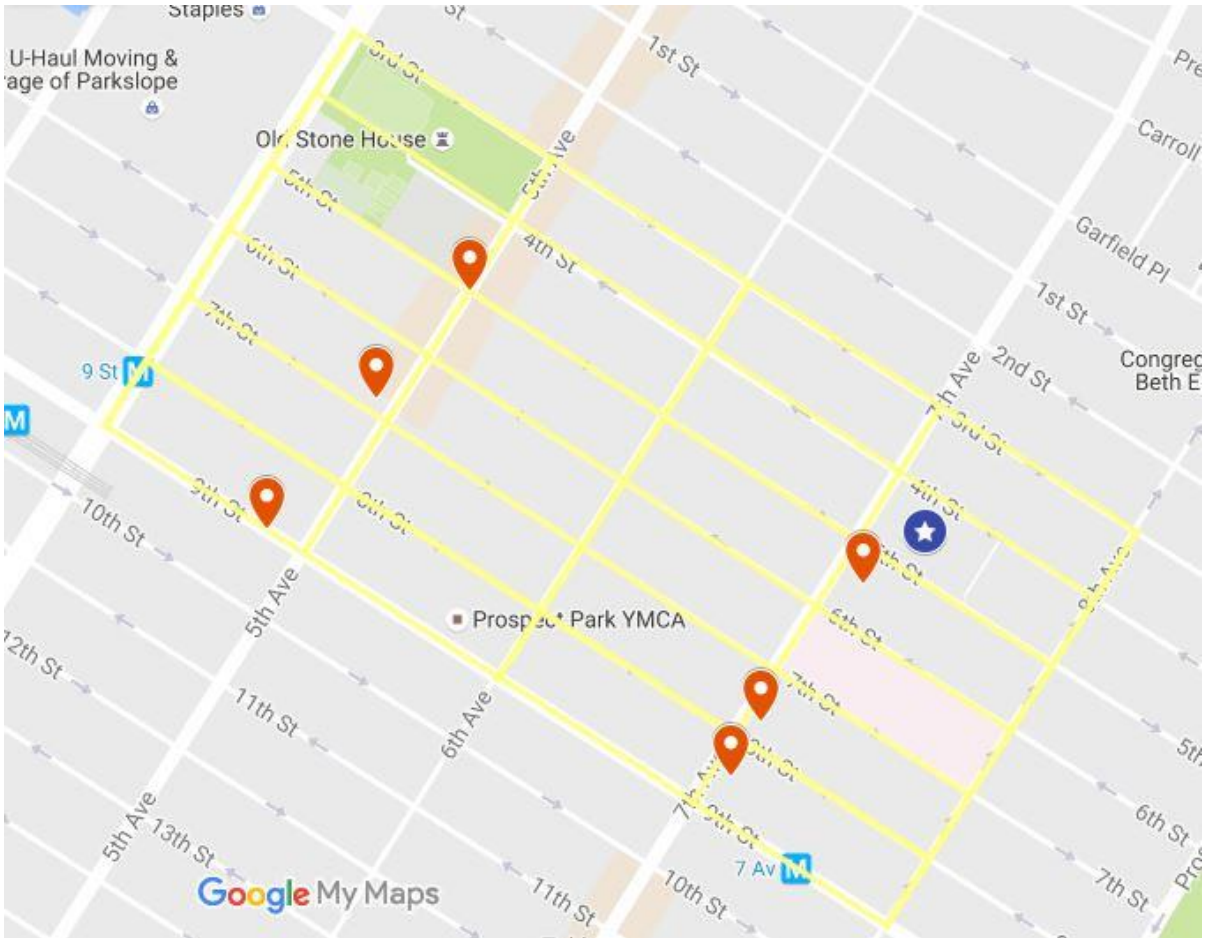
Bedford-Stuyvesant Map

Highlighted areas indicate the blocks surveyed. Pins indicate locations were tobacco advertisements or tobacco product displays were observed. The star indicates the high school.



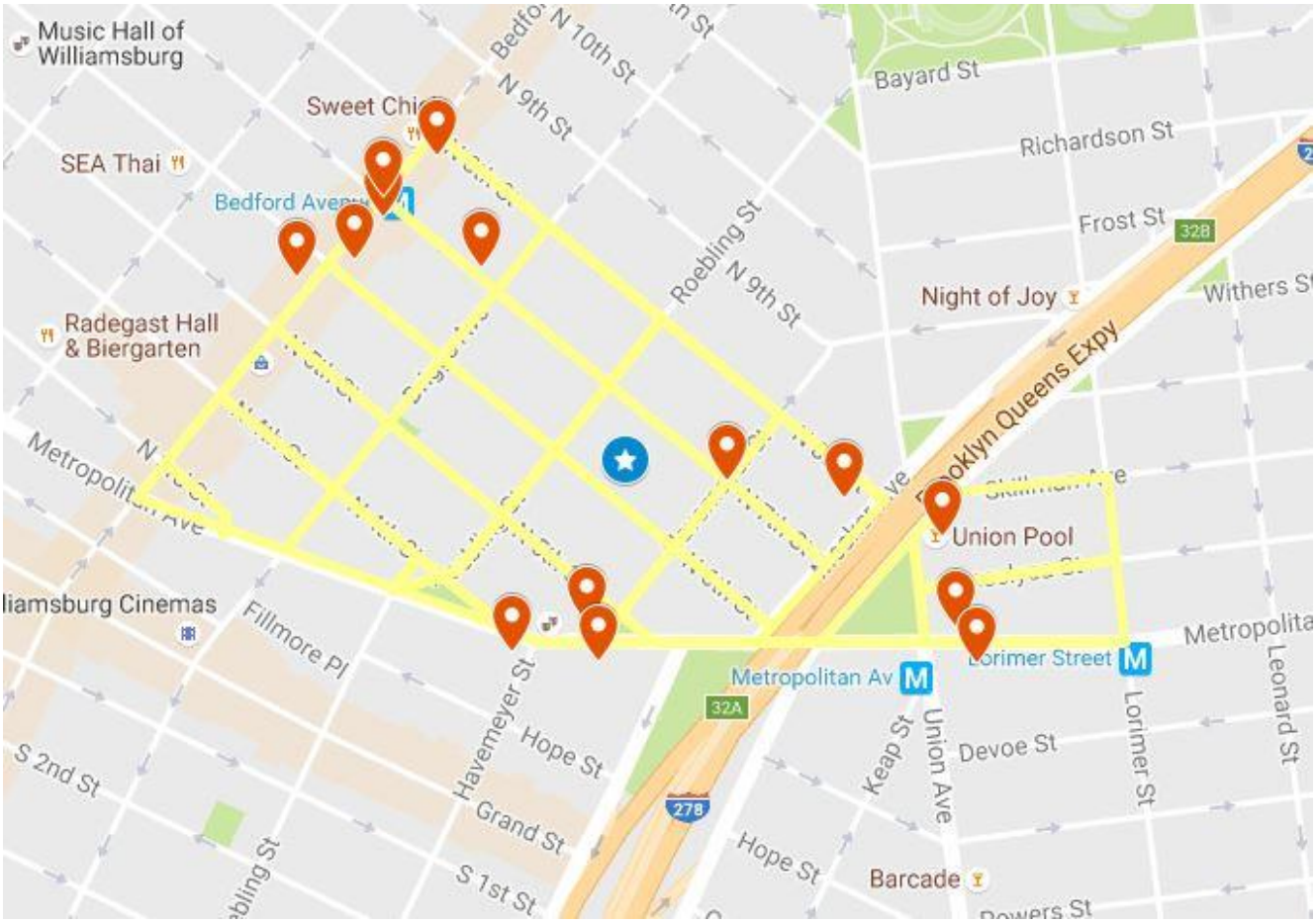
Park Slope Map

Highlighted areas indicate the blocks surveyed. Pins indicate locations were tobacco advertisements or tobacco product displays were observed. The star indicates the high school.



Williamsburg Map

Highlighted areas indicate the blocks surveyed. Pins indicate locations were tobacco advertisements or tobacco product displays were observed. The star indicates the high school.



Brand Frequency Lists

Survey Wide	Exterior Ad Brands	Exterior, [Number of Occasions Observed]	Interior Ad Brands	Interior, [Number of Occasions Observed]
	Newport	8	Newport	23
	American Spirit	7	Marlboro	19
	Hookah pipes	6	Camel	13
	General Snus	6	American Spirit	11
	E-cigarette paraphenalia	3	Pall Mall	8
	Eon Smoke	3	Parliament	4
	Pax	3	E-on Smoke	3
	Blu E-cig	2	Game Cigars	3
	Camel	2	Logic Pro	3
	Cigars	2	Blu E-cig	2
	Grizzly	2	Nat Sherman	2
	Logic	2	Crush Experience	1
	Nat Sherman	2	Export A	1
	NJoy	2	General Snus	1
	Push	2	Grizzly	1
	Raw	2	Kool	1
	Vuse	2	Maverick	1
	Al Capone Cigar	1	Palmolive	1
	Ascent	1	Phillies	1
	Big Flavor Tobacco	1	Red Sun	1
	Craft	1	Vuse	1
	Eagle	1	Winston	1
	Firefly	1		
	G	1		
	Hype	1		
	Longhorn pouches	1		
	Marlboro	1		
	Maverick	1		
	Natural Leaf	1		
	Play e-cigs	1		
	Redman	1		
	Show	1		
	Space Vapor	1		
	Top & Bulger	1		
	Torch	1		
	Wolf pouches	1		

Bedford Stuyvesant	Exterior Ad Brands	Exterior, [Number of Occasions Observed]	Interior Ad Brands	Interior, [Number of Occasions Observed]
	Hookah pipes	4	Newport	11
	Eon Smoke	3	Marlboro	6
	Newport	3	Camel	3
	American Spirit	1	E-on Smoke	3
	General Snus	1	American Spirit	2
	Grizzly	1	Game Cigars	2
	Hype	1	Pall Mall	2
	Logic	1	General Snus	1
	Marlboro	1	Grizzly	1
	Raw	1	Parliament	1
	Show	1	Red Sun	1
	Top & Bulger	1	Vuse	1
	Vuse	1		

Park Slope	Exterior Ad Brands	Exterior, [Number of Occasions Observed]	Interior Ad Brands	Interior, [Number of Occasions Observed]
	Newport	4	Newport	8
	NJoy	2	Marlboro	7
	Blu E-cig	1	American Spirit	4
	Camel	1	Camel	4
	Cigars	1	Logic	3
	General Snus	1	Parliament	2
	Logic	1	Crush Experience	1
	Longhorn pouches	1	Nat Sherman	1
	Maverick	1	Pall Mall	1
	Natural Leaf	1		
	Play e-cigs	1		
	Redman	1		
	Space Vapor	1		
	Wolf pouches	1		

Williamsburg	Exterior Ad Brands	Exterior, [Number of Occasions Observed]	Interior Ad Brands	Interior, [Number of Occasions Observed]
	American Spirit	6	Camel	6
	General Snus	4	Marlboro	6
	E-cigarette paraphernalia	3	American Spirit	5
	Pax	3	Pall Mall	5
	Hookah pipes	2	Newport	4
	Nat Sherman	2	Blu E-cig	2
	Push	2	Cigars	1
	Al Capone Cigar	1	Export A	1
	Ascent	1	Kool	1
	Big Flavor Tobacco	1	Maverick	1
	Blu E-cig	1	Nat Sherman	1
	Camel	1	Palmolive	1
	Cigars	1	Parliament	1
	Craft	1	Phillies	1
	Eagle	1	Winston	1
	Firefly	1		
	G	1		
	Grizzly	1		
	Newport	1		
	Raw	1		
	Torch	1		
	Vuse	1		

Surveyor Name: _____

School: _____

Phone #: _____

Email: _____

Instructions:
Thank you for taking part in this community mapping survey! To complete this survey, you will need a pen, this paper survey, and a camera. Fill out the answers to the below questions when you observe any sort of tobacco advertisements (ads) on the exterior or interior of stores within the designated survey area. Advertisements include pricing and promotion announcements, traditional advertisements, tobacco brand labels, the cigarettes themselves, branded display cases, etc. If you are unsure, take a picture of the advertisement and include it in your survey. Use a different survey form for each store that you observe tobacco and/or anti-tobacco ads on or in. Please take a picture of at least 5 tobacco ads that can be emailed at a later time. Please be as specific as possible in your answers.

Business Name:	
Street Address:	Cross Streets:
Type of Business: ☐ Corner Store/Bodega ☐ Grocery Store ☐ Non-Food Retail ☐ Gas Station ☐ Restaurant ☐ Other: _____	

1. EXTERIOR TOBACCO ADVERTISEMENTS

- How many tobacco ads do you see on the exterior of the store?: _____
- For each ad, list the brand and where it is placed in comparison to your eye-level:
  - Brand: _____Placed (circle one): at eye-level[10] near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head

2. INTERIOR TOBACCO PRODUCT DISPLAYS

- Do you see cigarette packs OR cartons displayed anywhere in the store? (circle one): YES or NO
- Do you see other tobacco products (e.g., smokeless products, e-cigarettes, cigars, pipes, papers, loose tobacco, etc.) displayed anywhere in the store? (circle one): YES or NO
- Please describe each tobacco product display. Measure shelf space by counting the number of "pack facings" on the front row of shelves and displays. Count the number of packs across and

[10] Five to six feet above the ground.

down. Cartons stacked with the longest side facing front count as five packs; cartons stacked with the shorter side facing front count as two.

- DISPLAY 1:
  - Location of display: _____
  - Size of display (total pack facings horizontal x vertical): _____x_____
- DISPLAY 2:
  - Location of display: _____
  - Size of display (total pack facings horizontal x vertical): _____x_____
- DISPLAY 3:
  - Location of display: _____
  - Size of display (total pack facings horizontal x vertical): _____x_____

3. INTERIOR TOBACCO ADVERTISEMENTS

- How many tobacco ads do you see on the inside of the store? :

  _____

- For each ad, what is the brand and where is it placed in comparison to your eye-level:
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
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  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Brand: _____Placed (circle one): at eye-level near ground above head
  - Additional Notes: _____

_____

_____

_____

_____

4. **Other Notes:**

_____

_____

_____

_____

_____

_____

5. **Interview Questions:**

What are your overall thoughts from the experience?: _____

_____

_____

Did anything stand out to you in particular?: _____

_____

_____

Do you have any advice for younger people?: _____

_____

_____

Please attach photos you took of ads and a headshot and send to mahearn@nypirg.org when you hand in this survey. Thank you!

NYU Langone Medical Center

Honorable Corey Johnson
Chair, Health Committee
New York City Council
City Hall
New York, NY 10007

April 25, 2017

Honorable Mr. Johnson,

I am an Associate Professor of Medicine and Population Health at the New York University (NYU) School of Medicine. I have been conducting research for over 15 years that aims to reduce health disparities related to tobacco use. In addition, I lead a smoking cessation service at the NYU Perlmutter Cancer Center which provides me with firsthand knowledge of the challenges smokers face in trying to quit which are exacerbated by a retail environment that creates "cues" to smoke on every corner in NYC.

I am writing in strong support of the four bills that have been proposed to strengthen NYC's tobacco control policies. NYC has been a national and international leader in combating the tobacco epidemic. These bills represent NYC's continued commitment to find innovative solutions to reduce the tremendous population health burden of tobacco use.

Individually, each of these bills represents an effective method for addressing gaps in current policies that encourage youth uptake of tobacco products and electronic cigarettes, and create barriers to cessation among current smokers. However, implemented together they represent a powerful, comprehensive and synergistic approach to addressing multiple aspects of the retail environment that undermine tax policy and create environmental triggers that further undercut youth prevention and cessation programs and policies.

There is strong evidence for the proposed bills. First, the widespread availability of tobacco products in retails outlets, along with extensive marketing at the retail point-of-sale, is designed to attract new tobacco users, discourage quitting and create a normative environment that makes tobacco use acceptable and even desirable. Several studies have found that a higher density of tobacco outlets in residential neighborhoods is associated with recent initiation of tobacco use among young adults.[1] Similarly, smokers living near a high density of tobacco retail outlets are less likely to quit.[2] Thus the tobacco outlet environment is a critical factor in promoting youth tobacco use initiation and creating obstacles to cessation. **The bill to limit new licenses by setting caps in community districts promises to reduce the density of retailers over time** and responds to the strong evidence of the harm high density retail environments pose, particularly in low income neighborhoods.

The bill prohibiting pharmacies or retail stores that contain pharmacies from selling cigarettes and electronic cigarettes will act synergistically with the previous bill to reduce retail density even further. Backed by high levels of public support, other cities have already taken this step and demonstrated the link between these bans and reduced retail density in communities.[3,4]

Establishing price floors and increasing taxes for other tobacco products, again, will fill an important policy gap. Tobacco taxes are one of the most effective tobacco control strategies. However, tobacco industry behavior undermines tax policy with cigarette coupons and other promotions. Creating a floor price for cigarette packages, other tobacco products and nontobacco shisha, and evening the playing field between cigarettes and other products in terms of price, will reduce opportunities for smokers to minimize cigarette expenditures by switching to cheaper products and create a tax and price environment that will reduce youth initiation and promote cessation.

Unfortunately, the tobacco epidemic is not static. New products are introduced at an alarming rate, the tobacco industry continues to look for loop holes to circumvent tobacco policies, and sometimes policies have unintended consequence that need to be remedied. To continue to achieve our prevention and cessation goals we must be proactive and keep pace with this changing environment by introducing new laws to fill gaps in current policies, particularly when the evidence points us in the right direction. This evidence-based policy package represents a tremendous step forward in achieving NYC's prevention and cessation goals and represents an enormous advance in NYC's efforts to meet the National Healthy People 2020 goal of 12% smoking prevalence.

Sincerely,

Donna Shelley, MD MPH

1. Cantrell J, Pearson JL, Anesetti-Rothermel A, Xiao H, Kirchner TR, Vallone D. Tobacco Retail Outlet Density and Young Adult Tobacco Initiation. Nicotine Tob Res. 2016 Feb;18(2):130-7.
2. Cantrell J, Anesetti-Rothermel A, Pearson JL, Xiao H, Vallone D, Kirchner TR. The impact of the tobacco retail outlet environment on adult cessation and differences by neighborhood poverty. Addiction. 2015 Jan;110(1):152-61.
3. Jin Y, Lu B, Klein EG, Berman M, Foraker RE, Ferketich AK. Tobacco-Free Pharmacy Laws and Trends in Tobacco Retailer Density in California and Massachusetts. Am J Public Health. 2016 Apr;106(4):679-85.
4. Kroon LA[1], Corelli RL, Roth AP, Hudmon KS. Public perceptions of the ban on tobacco sales in San Francisco pharmacies.Tob Control. 2013 Nov;22(6):369-71.

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April 25, 2017

Honorable Corey D. Johnson
Chair, Health Committee
New York City Council
City Hall
New York, NY 10007

Dear Chairman Johnson,

My name is Dr. Kurt Ribisl, and I am a Professor and researcher who studies tobacco control policy and tobacco product regulation. I wrote and edited portions of both the 2012 and 2016 Surgeon General Reports on Tobacco products. I am writing with my colleague, Shelley Golden, also a faculty member and tobacco control policy expert. Between us, we have have published nearly 60 articles in the area of tobacco control, including several focused specifically on tobacco retailer licensing, reducing tobacco retailer density, and minimum price laws, and we lead four grants to research effective tobacco control policies, funded by the National Cancer Institute and other agencies. We are writing to comment on the recently proposed New York City laws to expand and cap licenses for tobacco retailers (Int. 1547) and electronic cigarette retailers (Int. 1532), and establish or increase a minimum price for various tobacco products (Int. 1544).

Tobacco products are the most lethal consumer product ever introduced into commerce, killing nearly half of all regular users. New York City has been a pioneering leader in developing ground-breaking tobacco control polices, but there is still more to be done. More than 930,000 city residents smoke, including 15,000 youth. Moreover, New York City has nearly 10,000 tobacco product retailers and a recent report highlighted how the city is oversaturated with tobacco retailers.

Minimum Price Laws

Raising the price of tobacco products is considered one of the most effective, evidence-based strategies for reducing consumption.[1,2] Despite strong pricing policies, many tobacco products are still priced too cheaply in New York City. A pack of cigarettes costs the same as a trip through the Lincoln Tunnel, and a single cigar is cheaper than a Starbucks latte.

Most jurisdictions, including New York City, raise prices through excise taxes that are designed to raise the price of all products by the same amount. But the tobacco industry can choose how to absorb a new tax by manipulating the prices of their products.[3] A study by tobacco researchers in Great Britain found that when faced with higher cigarette taxes, the industry raises prices by even more than the tax on premium tobacco products, and by *less than the tax* on discount brands.[4] In this way, they can keep cheap products on the market, even if sold at a loss, because the loss is offset by profits on the more expensive products. Consumers can also avoid the brunt of a cigarette tax increase by switching to

cheaper brands; a recent study by Monica Cornelius and colleagues documented a large uptick in discount brand cigarette purchases after the federal government raised the federal excise tax in 2009.[5]

Minimum price laws (MPLs) have one advantage over excise taxes because they have the potential to prevent the sale of products with very cheap prices, which are popular with youth and other vulnerable populations. By setting a minimum price below which products cannot be sold, very cheap products should no longer be legally available. Evidence suggests the tobacco industry has targeted low income smokers with coupons and low price brands.[3,6,7] Buying discount brands is more common among lower socioeconomic status smokers, and a national study Dr. Golden conducted found that lower income smokers report paying $0.30 less per pack of cigarettes than those with higher incomes.[8] Moreover, the same pack of cigarettes, on average, is sold at a lower price in a low income neighborhoods than in a high income neighborhood. Given their abiliy to increase prices of the cheapest brands, MPLs may reduce socioeconomic disparities in tobacco use as well.[9]

Of course, implementing an MPL requires choosing a specific floor price. Several recent studies have attempted to estimate the likely effects of MPLs set at different minimum prices. Researchers at Ohio State University concluded that a strong federal minimum price would result in 10 million fewer smokers nationwide.[10]

In a recent study,[11] we estimated the impact of various minimum price levels tied to the prices that consumers reported paying in their own state. We found that setting the price floor above the state average was critical to reducing use and disparities. We projected that setting the floor price to the average local price would produce a 4% decline cigarette consumption, but when that price was set at 50% above the average price, a nearly 16% consumption decline would result. Our models also suggested that minimums set at 25% above the average price or higher eliminated disparities in the number of cigarettes smoked between low- and high-income groups. This is important from a public health perspective because low income New Yorkers die of tobacco-related illnesses at a significantly higher rate than high income New Yorkers. Finally, we also found that MPLs would reduce both overall cigarette consumption, and socioeconomic disparities in smoking, even more than a comparable tax increase. In summary, we anticipate that if New York City increases the minimum price for tobacco products, we would see a decrease in tobacco use and this reduction in tobacco use would be even greater among low income tobacco users.

Although we are unaware of research specifically analyzing actual or potential impacts of minimum price laws for non-cigarette tobacco products (e.g., cigars, smokeless), research does provide a general rationale for setting minimum pricing for cigars, smokeless tobacco and shisha prices. As with cigarettes, higher prices for other tobacco products are associated with lower levels of consumption.[12] Other tobacco products are generally less regulated than cigarettes, are available in a variety of candy and fruit flavors, and are sold in smaller packages (i.e., a 4-pack of cigars vs 20 cigarettes in a pack). Little cigars and cigarillos are nearly as popular among youth as cigarettes, and cigar use, in particular, is nearly twice as prevalent among African Americans as among other groups. A recent study from RTI, International found that when cigarette prices go up, sales of little cigars increased.[13] Therefore, *setting price standards for cigarettes and other tobacco products simultaneously* limits incentives for consumers to change products to avoid higher cigarette prices.

Our final point on MPLs is that this regulation would be relatively easy to enforce, because it is clear and easy to understand. We have published several studies of mark-up cigarette price policies, which require a specified percent mark-up on the wholesale or retail price (e.g, the retailer must mark up the price by a minimum of 12% over what they paid the wholesaler), and found that this style of law typically does not raise prices.[14,15] This may be due to difficulties with enforcement, since mark-up laws result in different legally allowable minimums for every brand or price tier, which is hard to track and enforce given the thousands of brand style combinations on the market. Our team recently calculated legally allowable minimums for two brands of cigarettes in 37 different states; the process took months and required long discussions with pricing and policy experts in each place. Retailers and enforcement officials would likely face the same challenges. A set minimum price, however, is clear, and easy for consumers, retailers and enforcement officials to understand.

Tobacco retailer density

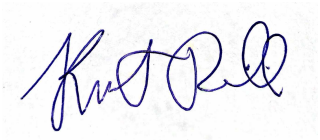
There are 25 times as many tobacco retailers in the United States as there are McDonalds restaurants, making tobacco an extraordinarily accessible consumer product.[16] Furthermore, tobacco retailers are densely concentrated in areas with greater proportions of African Americans, Hispanics, same-sex couples and low income residents. Policies to reduce the number and density of tobacco retailers will help address the unequal burden of tobacco product retailers in New York City neighborhoods.

Studies of retailer density, often expressed as the number of tobacco retailers within 800 meters of a school or per 1,000 people, find that greater tobacco retailer density has been linked to higher smoking rates. For example, schools with more tobacco retailers within walking distance (800m) have been observed to have higher prevalence of current smoking.[17] Living near tobacco retailers is related to youth smoking,[18,19] and a lower likelihood of smoking cessation,[20] and may undermine the effects of tobacco prevention interventions.[21] A study in Scotland documented positive associations between tobacco retailer density and adult smoking,[22] and in Finland, proximity to a tobacco outlet was negatively associated with smoking cessation.[23] There are several reasons that could explain why greater tobacco retailer density is related to higher smoking rates: (1) stores have approximately 30 tobacco ads[24] and exposure to store-based tobacco marketing increases the odds of smoking initiation for adolescents and stimulates craving among adults, (2) more tobacco retailers sets an expectation that smoking is popular and normative, thereby influencing consumption, and (3) greater density means that cigarettes are more readily available meaning that travel costs and search costs are much lower, and lower costs are linked to more smoking.[6]

Several communities have already implemented policies to reduce retailer density. In 2014, the San Francisco Board of Supervisors adopted a policy that caps the number of tobacco sale permits in each of the City's 11 Supervisorial Districts to 45 (some had >125), and forbids licensing stores within 500 feet of a school or another tobacco retailer. In December of 2016, Philadelphia adopted a similar regulation that will increase tobacco licensing fees, limit available permits by district and restrict retailers from operating near schools.[25] Based on the evidence linking density and smoking, we believe that reducing tobacco retailer density in New York City will reduce tobacco product use and improve public health.

In sum, these policies will help ensure some fairness by providing reasonable balance to company tactics that continue to selectively market deadly products to young and poor people. New York City now has a chance to pass landmark policies that will reduce smoking rates, particularly among children and the poor.

Sincerely,



Kurt M. Ribisl, Ph.D.
Professor, Department of Health Behavior
Director, Cancer Prevention and Control,
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Shelley Golden, PhD, MPH
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UNDERSTAND PREVENT & CURE CANCER

April 26, 2017

Honorable Corey Johnson
Chair, Health Committee
New York City Council
City Hall
New York, NY 10007

Dear Council Member Johnson,

Attached please find Roswell Park Cancer Institute's written statement in support of the proposed policies to reduce smoking rates in New York City.

Andrew Hyland, PhD
Chair, Department of Health Behavior
Roswell Park Cancer Institute

Comprehensive Tobacco Policies Are Necessary to Reduce Tobacco Use and Improve Health

Testimony before the New York City Council Health Committee

Presented by

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April 27, 2017

I am Chair of the Department of Health Behavior at Roswell Park Cancer Institute in Buffalo, New York. I have been actively involved in tobacco control policy research for 22 years and have over 250 peer review publications and numerous grants and contracts from government sources. I am the Director of the New York State Smokers' Quitline and have helped evaluate the New York State Tobacco Control Program for the last ten years. Understanding the role that tobacco policies have on consumer behavior has been a priority area of research for my group. The purpose of this testimony is to share with the NYC Council Health Committee the highlights of our research to help inform their deliberations as they consider a series of bills intended to reduce smoking rates in New York City.

Smoking is the number one preventable cause of death in America. Over 480,000 people die each year in the United States. At least 8.6 million people suffer from a serious chronic disease like emphysema caused by smoking. Being the largest city in the country, New York City experiences a huge share of this national burden.

Higher prices for tobacco are perhaps the most effective strategy to reduce tobacco use, particularly among children, and to save lives. A pricing policy that requires tobacco products to be uniformly expensive is most effective in reducing tobacco use. This proposal raises the price floor for cigarettes and cigarillos from $10.50 a pack to $13 and also raises the price floor for other products such as cigars, smokeless tobacco, loose tobacco, and shisha. The bill also imposes a tax of 10 percent on other tobacco products for the first time. These higher prices will reduce tobacco consumption, prevent kids from starting and save lives.

An aspect of the current tax policy is that cigars are taxed at a much lower rate than cigarettes. The historical distinguishing feature between cigars, little cigars, and cigarettes is that cigars are wrapped in tobacco leaf, and cigarettes are wrapped in paper. For many products on

the market today it is difficult to tell the two apart, yet one product experiences significantly lower taxes than the other. Consumption of these little cigars has increased in times when cigarette taxes have increased, thus serving as a less expensive substitute product for cigarettes.

The impact of this situation is that the strong tobacco tax policy New York City has on paper is comparatively weak in practice, and tobacco in New York City is more affordable than it would be otherwise, which leads to fewer people quitting and more young people starting. Our research shows that the availability of cheaper tobacco products results in 20% less success quitting, even after controlling for other factors like how much people smoke and their educational level. These are people for whom the high price would have been a major incentive for them to quit; however, the availability of these cheaper products gives them a mechanism to afford continued smoking.

Our rough calculations indicate that efforts to require cigars and cigarettes to be comparably priced at a high minimum price will result in thousands of additional quitters under conservative assumptions, and perhaps much higher, per year in New York City. The public health benefits to the City will be tremendous

The proposed legislation also seeks to prohibit pharmacies and retail outlets with pharmacies from selling tobacco products. Pharmacies play an important role in protecting and promoting the health of their patients and patrons, and more people are utilizing the outlets for preventive care and health counseling. There is an inherent contradiction in consumers patronizing pharmacies that are also in the business of marketing the very product that causes many illnesses to begin with. Selling tobacco products and e-cigarettes in pharmacies alongside medicines and health products perpetuates misconceptions about their popularity and acceptability.

Many people accept the notion that tobacco and pharmacies are an unhealthy mix. A Centers for Disease Control and Prevention study published last year in the American Journal of Preventive Medicine, showed that 66 percent of Americans don't think tobacco products should be sold in pharmacies. The study showed that even half of smokers believe that.

Prohibiting the sale of tobacco products on pharmacies has been successfully undertaken in San Francisco, over 130 municipalities in the state of Massachusetts and all of Canada. In 2014, CVS Health became the first national retail pharmacy chain to stop selling tobacco products. After implementing the new policy, CVS Health reported that annual revenues increased in 2014 and 2015.

Requiring a license for the sale of tobacco and electronic cigarettes is a common sense measure. First and foremost a list of retailers is needed to ensure compliance with the minimum age sales law. Without a list of licensed retailers compliance checks cannot be performed. Secondly, a list of licensed retailers is needed to help the City to set limits on the number, location, and types of tobacco retailers in its jurisdiction. Fourteen states and the District of Columbia have passed laws requiring e-cigarette retailers and vape shops to obtain either a license or a permit to do business.

Research shows that tobacco outlets are disproportionately located in neighborhoods with more racial/ethnic minorities and that limits on the concentration of tobacco outlets reduces smoking prevalence, particularly by youth. Using tobacco retail licensing as a tobacco control tool is gaining traction. In fact, the Institute of Medicine (IOM) recommends licensing to regulate the sale of tobacco products. The cities of Philadelphia and San Francisco among others have already implemented similar licensing restrictions.

As a health professional who works in a cancer hospital, I see the toll tobacco use places on our society every day. Strategies to make these products more expensive and less accessible will reduce their appeal and use in both youth and adults. Based on my scientific expertise, the measures proposed in this bill will result in significant health improvements to NYC residents.

City and County of San Francisco
Department of Public Health
Community Health Equity & Promotion Branch
Tobacco Free Project

April 18, 2017

Dear Mr. Schroth-

I am writing you regarding the San Francisco experience with a few tobacco control policies that parallel proposals recently introduced in New York City. I'd like to share briefly our experience with these policies related to tobacco sales in pharmacies, tobacco retailer density caps, and e-cigarette licensing. San Francisco does not currently have legislation related to pack size, minimum price or delivery, though these are very compelling approaches to keeping youth safe from tobacco addiction.

San Francisco has long worked to limit the harmful impacts of tobacco use and as such we have worked to limit the exposure to tobacco products in the retail environment. In 2004 San Francisco adopted a tobacco retailer licensing ordinance, which over time has cut in half the rate of illegal sales to minors from over 24% in 2005 to less than 12% in 2012. That licensing ordinance has been added to as the above issues became clear priorities in the community.

In 2009, San Francisco introduced an ordinance that disallows a retailer from holding both a state pharmacy license and simultaneously a local tobacco retailer license. The ordinance was aimed at removing tobacco from health care delivery sites such as pharmacies/drug stores. The result was instantly 62 fewer retailer locations, as supermarkets and drug stores with pharmacy services no longer were able to sell tobacco products in San Francisco, instead serving as health partners in the community. Many independent specialty pharmacies in San Francisco never sold tobacco products and continue to serve as health providers without the confusion of tobacco sales on site.

In 2013, San Francisco addressed the emerging issue of e-cigarettes by engaging in data collection and work with youth agencies to ascertain the breadth of local e-cigarette retail access. In 2013 and 2014 we did phone sampling and saw an exponential increase in the availability of e-cigarettes at local retailers. Noting that youth use was clearly increasing, San Francisco adopted an ordinance pulling e-cigarette devices into our local tobacco retailer license while also defining them as tobacco products for our indoor air laws. Since 2014 all vape shops and e-cigarette vendors are required to hold the same license as other tobacco retailers. San Francisco launched an educational campaign in 2015 to inform parents and non-vapers about where these products are allowed to be used.

Starting in 2009, San Francisco Department of Public Health engaged with local youth-serving community agencies to investigate tobacco retail sales with a social justice lens. Youth data collectors quickly realized that neighborhoods that were lower income and had a larger proportion of people of color were dramatically overburdened with tobacco retail locations. Equally populated districts showed drastic differences in the number of tobacco permits, with one district that has an approximate $37,000 per household income noting 180 tobacco retailers while another community with over $94,000 household income had only 37 licenses.

To address this deep health inequity, youth engaged in a 6-year effort to reduce the tobacco retailer density burden by adopting a cap for each district that would disallow the issuance of new permits until the district had a more equitably low number of permits. The policy was shaped by leadership from our local youth and in partnership with our local small business association.

The health equity focused tobacco retail density ordinance was implemented in early 2015. That ordinance set a future cap of 45 licenses in each district of approximately 75,000 people. It also implemented several requirements, such as no new permits near schools or other permitted establishments. In the two years since implementation, through a natural attrition process and with limitations on overly burdened neighborhoods, San Francisco has seen a reduction from 970 total citywide permits to 852 total as of January 2017. This reduction includes no removal of

licenses from active stores and has led to a 12% reduction in the number of tobacco sales locations in San Francisco. The good news is that reductions are most pronounced in overly burdened neighborhoods, like San Francisco's Tenderloin which has seen a 19.4% reduction in the overall number of permitted sales sites.

I hope this information will be of help to New York City as your team aims to protect your citizens from the many harms faced by communities that are oversaturated with tobacco retail locations. We have learned that retail-based approaches are among the top strategies to keep our kids safe from ever commencing smoking, denormalizing the purchase and use of tobacco products for the whole community, and ensuring that people who have successfully quit are not inundated with triggers that encourage the purchase of tobacco products. I wish you good luck and offer any data support we can provide. You may find our case studies on the above issues on our website as well as greater detail about our local density ordinance:

http://sanfranciscotobaccofreeproject.org/case-studies/
http://sanfranciscotobaccofreeproject.org/density/

With my best regards,

Derek R. Smith, MSW, MPH
Director - Tobacco Free Project
Community Health Equity & Promotion Branch
San Francisco Department of Public Health
628.206.7640
derek.smith@sfdph.org

NYU School of Medicine
NYU LANGONE MEDICAL CENTER

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Department of Population Health

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April 24, 2017

Honorable Corey Johnson
Chair, Health Committee
New York City Council
City Hall
New York, NY 10007

Dear Mr. Johnson,

I am writing in strong support of the upcoming bills before the City Council regarding smoking and tobacco use in New York City. I am an Associate Professor of Population Health, Medicine and Psychiatry at NYU School of Medicine and an Associate Professor at the New York University College of Global Public Health. My career and work for the last 25 years has been focused on helping people to quit smoking, something of the utmost importance since tobacco use remains the leading preventable cause of death in the United States. In particular, I have been conducting research with the Veterans Health Administration and NYC Health and Hospitals, looking at ways to increase the delivery of effective tobacco use cessation treatment in order to help people quit smoking. My research has been funded by the National Institutes of Health, Veterans Health Administration and California Tobacco-Related Diseases Research Program.

The bills being considered by the City Council are outstanding additions to current regulations, and are part of why New York City has been a leader in helping promote the health of all New York City residents. They will further the current excellent measures protecting public health, such as taxes on cigarettes and the clean indoor air laws.

The legislation to have a minimum price for tobacco will have a profound impact. Among available tobacco control measures, price increases have unequivocally been the most effective measure for reducing the initiation of smoking and helping current smokers to quit. Price increases have their biggest effect on young adults, so they particularly help prevent initiation and promote cessation at a time when people are forming lifelong habits.

New York City has already demonstrated that reducing the availability of places to smoke gets many tobacco users to quit. Two of the measures under consideration – putting a cap on the number of tobacco retailers in each district and banning tobacco sales in pharmacies – should have the same beneficial effect by decreasing the availability of cigarettes. Note that this does ***not*** impinge on anyone's freedom. The New York City Smoke Free Air Act and the New York State Clean Indoor Air Act do not prohibit anyone from smoking, but they do place limits on where people can smoke. Similarly, these proposed restrictions do not prohibit anyone over age 21 from buying tobacco, but they do place limits on where they can buy it.

I would expect each of the measures proposed will substantively contribute to decreasing the prevalence of smoking in New York City, as well as decreasing tobacco-related morbidity and

mortality among residents. As a package, they represent a formidable addition to New York City's current tobacco control regulations. New York City is already recognized globally as a leader in reducing the impact of tobacco on the health of its population, and these measures are a logical next step in our tobacco control efforts. I strongly encourage the City Council to endorse and pass these regulations.

Sincerely,

Scott E. Sherman, MD, MPH
Co-Chief, Section on Tobacco, Alcohol and Drug Use
Associate Professor of Population Health, Medicine and Psychiatry
212-686-7500 x3018 (O) / 212-951-3269 (F)

Tobacco-Free Staten Island
REALITY CHECK

Jewish Community Center of Staten Island

Honorable Corey Johnson
Chair, Health Committee
New York City Council
City Hall
New York, NY 10007

April 25, 2017

Honorable Mr. Johnson,

New York City has been the leader in combating the tobacco control epidemic and protecting its residents for over a decade. However, annually tobacco use kills an estimated 12,000 individuals in New York City and we must continue to work harder to protect our city.

While we have made great strides in combating the tobacco epidemic, more work still needs to be done to reduce the significantly higher smoking rates among disparate populations in our region and throughout the state. According to the U.S. Surgeon General, advertising and promotional activities by tobacco companies have been shown to cause the onset and continuation of smoking among adolescents and young adults. Studies show that reducing the amount of tobacco retailers in a community makes youth less likely to be influenced by cigarette advertising and less likely to initiate tobacco use. Additionally, the Surgeon General has called raising prices on cigarettes "one of the most effective tobacco control interventions". [i]

A number of municipalities across the nation have taken such steps as raising the minimum prices for all tobacco products and reducing the number of tobacco retailers in order to decrease smoking among youth and limiting exposure of tobacco marketing, which studies show contribute to youth initiation.

The sale of tobacco in pharmacies poses as an ethical dilemma and contradicts what a pharmacy is intended for. February 2014 was a significant movement in the retail environment when CVS announced its decision to stop selling tobacco products, becoming the first retail pharmacy chain in the U.S. to take such action. Subsequent to the chain's removal of tobacco products from its stores, total cigarette purchases in states where CVS holds significant market share declined by 1%, and smokers who had previously purchased their cigarettes exclusively at CVS were up to twice as likely to stop buying cigarettes entirely.[ii]

Advancements like those described here have contributed to healthier communities and have lowered the staggering death toll caused by tobacco use.

Respectfully,

Ashley F. Zanatta

Tobacco-Free Staten Island

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[i] U.S. Department of Health and Human Services. *Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General.* Atlanta, GA: 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

[ii] Jennifer M. Polinski, Benjamin Howell, Michael A. Gagnon, Steven M. Kymes, Troyen A. Brennan, and William H. Shrank. Impact of CVS Pharmacy's Discontinuance of Tobacco Sales on Cigarette Purchasing (2012–2014) American Journal of Public Health April 2017: Vol. 107, No. 4, pp. 556-562

Center for Public Health Systems Science

GEORGE WARREN BROWN SCHOOL OF SOCIAL WORK

April 25, 2017

Honorable Corey D. Johnson
Chair, Health Committee
New York City Council
City Hall
New York, NY 10007

Dear Chairman Johnson:

My name is Douglas Luke, and I am Professor and Director of the Center for Public Health Systems Science (CPHSS) at the Brown School at Washington University in St. Louis. The research I direct at CPHSS focuses on public health policy and tobacco control. I am writing to express my support for two recently-introduced bills that will be heard before your council on April 27, 2017: **Limiting Tobacco Retail Licenses** *(Intro 1547, Lander)*, which will reduce the number of stores that can sell tobacco products by capping the tobacco retail dealer licenses in each community district at 50 percent of the current number of licenses, and **Pharmacy Sales Restriction** *(Intro 1131-A, Lander)* which will prohibit pharmacies, or retail stores that contain pharmacies, from selling tobacco products, including cigarettes.

Tobacco use remains the leading preventable cause of death in the US and around the world. Much of the work I direct at our Center has focused on tobacco control, specifically how states and communities can design, implement, and evaluate evidence-based tobacco control policies. This work has been published in top public health journals as well as in important policy documents such as CDC's *Best Practices for Comprehensive Tobacco Control.* I currently lead (along with Kurt Ribisl of the University of North Carolina and Lisa Henriksen of Stanford University) a 5-year, NCI funded study (*Maximizing state & local policies to restrict tobacco marketing at point of sale*) that is developing the first ever national surveillance system of tobacco retail policies. I have published several tobacco control science articles in top public health journals and was a member of the panel that produced the recent Institute of Medicine Report, *Assessing the use of agent-based models for tobacco regulation*, which provided the FDA and other public health scientists with guidance on how best to use agent-based computational models to inform tobacco control regulation and policy.

Our Center's work has influenced the tobacco control policy environment. Early CPHSS research helped to counter the tobacco industry's assertions that it did not engage in targeted marketing of tobacco products to minorities and other at risk groups.[1] Our more recent work has focused on the dissemination and implementation of effective tobacco control policies, especially at retailer settings.[2] We have been active disseminators of this work; for example, a number of our studies have been entered as public comments in support of FDA's tobacco regulatory efforts.[3] More notably, the Office of Smoking and Health (OSH) at the Centers for Disease Control and Prevention (CDC) have incorporated results of our research and evaluation into their latest evidence-based guideline *Best Practices for Comprehensive Tobacco Control Programs,* as well as their latest funding RFA for state tobacco control programs.[4]

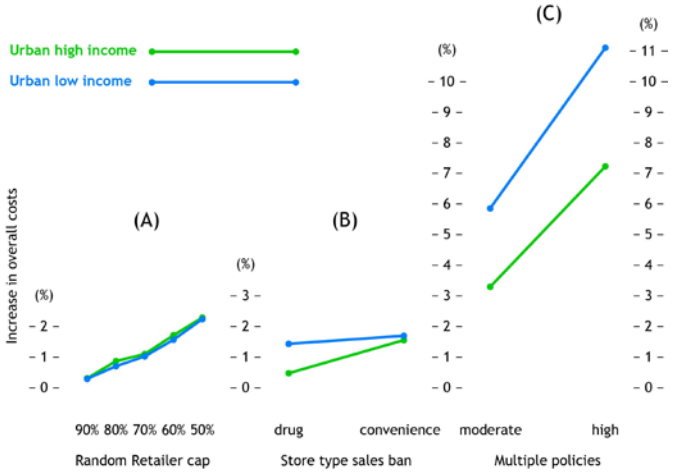
Marketing in the retail environment for tobacco remains largely unregulated relative to other promotional mediums. Since tobacco companies cannot promote sales through most conventional advertisements due to the Master Settlement Agreement,[5] the majority of tobacco marketing spending in the past few decades has occurred in the retail environment. Over 90 percent of the top five tobacco companies' marketing expenditures in 2014 – totaling over $9.1 billion – were spent in retail settings.[6] The impact of this targeted spending is greater in poor and racially diverse neighborhoods, where tobacco retailers are more numerous relative to population.[7,8] Additionally, this $9.1 billion – or over $1 million per hour[9] – reflects only spending on marketing cigarettes and smokeless tobacco; it does not include marketing strategies and dollars spent on flavored cigarillos or e-cigarettes.

High retailer density in neighborhoods of low socioeconomic status creates more opportunities for exposure to product promotion and marketing tactics that are intended to encourage initiation and discourage cessation.[10-12] Retailer density refers the number of businesses in a given area (*e.g.,* neighborhood, zip code, or district) that sell tobacco products, and can be calculated in terms of population (*e.g.*, retailers per 1,000 people) or area (*e.g.*, retailers per square mile). Studies have shown that areas with lower tobacco retailer density have lower smoking prevalence among youth,[13] lower exposure to tobacco advertisements and promotions,[14] and lower rates of cessation relapse.[15] Policies that reduce tobacco retailer density – like *Intros 1547* & *1131-A* – stand not only to reduce the effects of high product exposure on smoking cessation and initiation, but could also attenuate the effects of brand exposure, product promotion, and tobacco advertising pervasive in the retail environment.

Pharmacies – which provide an increasing number of health care services – sell cigarettes cheaper and offer more discounts on tobacco than other types of tobacco retailers.[16,17] Removing tobacco from pharmacies is a novel tobacco control policy approach that began in San Francisco with a 2008 ordinance.[18] That grass-roots initiative led to a precedent for communities to adopt pharmacy bans as local policy and since then, more than 150 municipalities across the country have adopted similar laws.[19] In addition, many pharmacies have voluntarily opted to remove tobacco products from their stores in response to growing support from communities. One of the largest was CVS in 2014. Results from a study comparing the effects of the nationwide removal of tobacco products from CVS pharmacies show a decrease in smoking among customers who purchased tobacco products from CVS pharmacies.[20] The diffusion of this policy across US localities exemplifies the community-level drive to limit access to tobacco products and, more largely, helps to change social norms around the acceptance of tobacco.

Our recent research supports the importance of strategies like *Intros 1547* & *1131-A*. "Tobacco Town: Computational Modeling of Policy Options to Reduce Tobacco Retailer Density," published in the *American Journal of Public Health* in 2017, uses a simulation model to compare the potential impact of various tobacco retailer density reduction strategies.[21] We estimated the increase in cost of cigarette acquisition (travel plus purchase price cost) of three main policies: retailer licensing caps, store type sales restrictions, and distance buffers between retailers and schools or other retailers. We also tested combinations of these policies and compared results to those for the individually implemented ones. Based on real, empirical US data, we ran the simulations in four virtual communities representing high- and low-income urban and suburban environments. Figure 1 below shows selected results from our simulations for the high- and low-income urban community prototypes (for complete results please see attached article). Three takeaways from this study are relevant to *Intros 1547* & *1131-A*.

1. **Strong policies – like *Intro 1547* – may have the most dramatic effects.** While it may seem straightforward that stronger policies have larger impact than weaker ones, our model suggests that these differences are not linear. As shown in Figure 1a, the impact on the overall (travel plus purchase) cost per pack of cigarettes for a 50 percent retailer reduction is greater than five times a 10 percent reduction within each community type.



2. **Restricting sales in pharmacies – as *Intro 1131-A* will do – can have a larger impact than a random reduction of the same percentage of retailers.** As stated above, pharmacies tend to have cheaper cigarette prices than other retailers like convenience stores and bodegas, grocery stores, and tobacco specialty shops. In our model, pharmacies represent up to 10 percent of all retailers (depending on community type), though as shown in Figures 1a & 1b, the impact on costs are greater for a pharmacy sales restriction than those of a random 10 percent reduction. This is due to the cheaper purchase prices of cigarettes at pharmacies relative to other retailers.

3. **Multiple policies – like the suite of tobacco control policies proposed along with *Intros 1547* & *1131-A* – may have multiplicative effects larger than the sum of their parts.** Results from our model suggest that layering multiple policies might be more effective and have greater impact than 1) any of those policies alone and 2) the simple sum of the effects of the constituent policies. Figure 1c shows the increases in overall costs for layered policies (retailer caps and store type sales restrictions along with distance buffers). The results suggest that a suite of moderate policies may have impacts larger than any single policy at its highest intensity.

In closing, I want to recognize the importance of these innovative and strong tobacco control policies for New York City. They have the potential to save and improve the lives of many of the residents of NYC. Also, as strong as the policies are in each of the five bills being considered, taken as a package their effects are likely to be much greater than the sum of their individual parts.

Sincerely,

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Tobacco Town: Computational Modeling of Policy Options to Reduce Tobacco Retailer Density

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Objectives. To identify the behavioral mechanisms and effects of tobacco control policies designed to reduce tobacco retailer density.

Methods. We developed the Tobacco Town agent-based simulation model to examine 4 types of retailer reduction policies: (1) random retailer reduction, (2) restriction by type of retailer, (3) limiting proximity of retailers to schools, and (4) limiting proximity of retailers to each other. The model examined the effects of these policies alone and in combination across 4 different types of towns, defined by 2 levels of population density (urban vs suburban) and 2 levels of income (higher vs lower).

Results. Model results indicated that reduction of retailer density has the potential to decrease accessibility of tobacco products by driving up search and purchase costs. Policy effects varied by town type: proximity policies worked better in dense, urban towns whereas retailer type and random retailer reduction worked better in less-dense, suburban settings.

Conclusions. Comprehensive retailer density reduction policies have excellent potential to reduce the public health burden of tobacco use in communities. (*Am J Public Health.* 2017;107:740–746. doi:10.2105/AJPH.2017.303685)

Local, state, and federal policy change has great potential to ameliorate the major risk factors for chronic disease and cancer, although much of this potential is unrealized.[1] Policy proposals to create healthier communities increasingly attempt to alter the retail availability of unhealthy and healthy products.[2] Tobacco control policy and research are increasingly focused on the retail environment because it is the dominant channel for tobacco marketing in the United States. After the Master Settlement Agreement eliminated billboard and transit advertising and curtailed industry-sponsored events, annual spending at retail increased from $4.7 billion in 1998 to $8.6 billion in 2013.[3] Retail-focused policy is arguably the most important frontier in tobacco control and can be seen as a new fifth core strategy of state and national tobacco control programs. The traditional strategies have been to (1) raise cigarette excise taxes, (2) implement comprehensive smoke-free air laws, (3) offer cessation services, and (4) launch hard-hitting countermarketing campaigns.

Tobacco companies have contested nearly all provisions of the Family Smoking Prevention and Tobacco Control Act that would have the greatest impact on the retail environment.[4,5] Given the inevitable delays during court battles, one of the most legally sound means to counteract the impact of retail marketing on tobacco use is for state and local governments to restrict the quantity and location of tobacco retailers, which can reduce both the availability of the product and the marketing associated with it.[6,7] Such retailer reduction strategies have been effective to reduce alcohol consumption[8] and there is considerable interest in adapting this paradigm to tobacco control.[2,9]

Approximately 40% of US adolescents (aged 13–16 years) live within walking distance of a tobacco retailer,[10] and nearly half visit these stores at least weekly.[11] Living in neighborhoods with higher tobacco retailer density predicts a higher incidence of current smoking among adolescents[12] and more frequent smoking by adults.[13] Despite these associations, little is known about how policies can most effectively reduce retail density, and whether those reductions can have notable public health benefits.

The foundational policy for monitoring and reducing density is retailer licensing.[6] In the absence of a national requirement to license tobacco retailers, 39 states; Washington, DC; and growing numbers of localities currently regulate how and where tobacco products can be sold through licensing.[14] Retail licensing also paves the way for more innovative policy strategies, such as capping the number of licenses, maximizing distances between retailers, and prohibiting sales near youth-oriented locales (e.g., schools and parks) and at certain store types (most often pharmacies). For example, in 2014, San Francisco, California, amended its licensing ordinance to include a cap that aims to equalize the number of retailers in its 11 administrative districts, and to establish a 500-foot buffer zone between retailers as well as between schools and retailers. In the first year after the amendment, the city saw an 8% decrease in retailers.[15] Almost 70% of Massachusetts residents live in municipalities that mandate tobacco-free pharmacies, and

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cities in Minnesota are currently working to reduce availability of flavored tobacco products (including menthol) by restricting their sale to tobacco specialty stores.[16]

Computational systems modeling is a powerful research tool for public health policies, especially when traditional experimental and observational studies of retail policies are not possible or practical.[17] Although computational modeling has been used in tobacco control, most of these studies have used system dynamics to model population-level characteristics such as smoking prevalence.[18,19] Agent-based modeling is a type of dynamic modeling that uses computer simulations to examine how elements of a system (agents) behave as a function of their interactions with each other and their environment.[20] Agent-based modeling is at the forefront of modern infectious disease research,[21] but is increasingly being used in chronic disease and health policy studies.[22–24] Although some modeling studies have examined retail policy effects, they have relied on econometric modeling techniques (such as life-table forecasting) that cannot examine individual behavior–environment interactions.[25,26] The focus of agent-based modeling on agent interaction allows detailed examination of how public health policies may affect individual behavior, as well as how the local physical and social environment influences behavioral dynamics. Use of agent-based models to study policy mechanisms and effects has recently been recommended as an important tool in tobacco control policy and regulation.[27]

This article presents the results from an agent-based model and virtual policy laboratory that we named Tobacco Town, which we developed with state-of-the-art complex systems modeling procedures, and based on existing epidemiological, tobacco retailer, and Census data. We used Tobacco Town to explore the potential effects of 4 types of retailer reduction policies: (1) random retailer reduction (similar to how cap-and-winnow strategies based on licensing and zoning laws would work), (2) restriction by type of retailer (e.g., pharmacy bans), (3) limiting proximity of retailers to schools, and (4) limiting proximity of retailers to each other. The model examined the potential effects of these policies alone and in combination across 4 different types of towns, defined by 2 levels of population density (urban vs suburban) and 2 levels of income (higher vs lower).

METHODS

The Tobacco Town agent-based model focuses on patterns in the purchase behavior of smokers. During each simulated run of the model, agents (smokers) commute between home and work and make decisions about whether to purchase cigarettes, where to purchase them, and how many cigarette packs or cartons to purchase. Because agents in this model utilize stylized but consistent decision-making approaches, we can glean important insight into the joint effect of environment and policy on tobacco retailer density and the total cost of acquiring cigarettes.

We designed this agent-based model by following current computational simulation best practices.[28] These begin with formulating a clear question (e.g., What impact do retailer density dynamics exert over cost?), and include grounding assumptions in research and theory and collaboration with substantive experts, iteratively building in model complexity, thorough calibration and sensitivity analyses, and, finally, thoughtful translation, visualization, and communication of results. It was written in Java (version 1.7.0_51/1.8.0_51, Oracle Corporation, Redwood City, CA) within the Repast Simphony framework (version 2.1/2.3.1).[29] In addition to the summary provided in this section, we direct interested readers to a more detailed technical description of the model in Appendix A (available as a supplement to the online version of this article at http://www.ajph.org) and to previous work by the authors that discusses the rationale and development of the features that were included in this model.

Environment and Agents

From previous studies[1,10,30] and experience in tobacco control policy, we appreciate that policy effects differ across diverse environments. Therefore, our model consists of 4 archetypal and abstract town types that we derived from data from California cities and a national sample of retailers. We refer to the town types as urban rich, urban poor, suburban rich, and suburban poor. Based on the California cities data, we constructed the 4 town types by using retailer, school, workplace, and population densities; commute times; and proportions of transport mode use (vehicle, bicycle, or walking; Appendix A, available as a supplement to the online version of this article at http://www.ajph.org). Data available from a national sample of retailers provide average prices for different store types that include convenience, pharmacy, liquor, grocery, warehouse, and tobacconist stores. We represented each town in an abstract 10-square-mile lattice grid of roads and blocks wherein retailers, homes, and workplaces are situated. Table 1 contains selected baseline statistics for the 4 town types.

Agents in the Tobacco Town model represented adult smokers and each had 6 time-invariant, or constant, attributes: smoking rate, mode of transport, wage, home and work locations, and a route between the 2 locations; we based distributions of these attributes on the environment in which a simulation takes place. During the course of a simulated run of the model, each agent's cigarette inventory and current location were dynamically updated based on their actions.

Agent Actions and Decision-Making

Each simulated day in Tobacco Town consisted of 2 periods, morning and evening. Each evening, agents smoked a number of cigarettes based on their smoking rate, depleting their inventory. Each morning, agents assessed their cigarette inventory and decided to procure cigarettes if their current inventory was less than their daily smoking rate.

As a simplifying assumption and consistent with standard economic theory, agents have perfect information about both direct and indirect costs: they know the price of cigarettes at each retailer in the environment, and the travel costs associated with deviating from their commute path to purchase cigarettes. On the basis of this knowledge, they made decisions about where to purchase and how many packs or cartons to purchase that resulted in the lowest possible total per-cigarette cost. The primary outcome observed in the model was an abstract total travel plus price cost that combined both the time required to travel to a tobacco retailer and the

TABLE 1—Comparison of Baseline Town Type Characteristics in the Tobacco Town Agent-Based Model

Town type	Price, $	Income, $	Retailers, No.	Population, No.	Transport, %		
					Car	Bike	Walk
Urban rich	5.68	92 198	8.84	7 811	78.5	12.7	3.6
Urban poor	5.01	39 798	12.03	9 565	88.0	7.3	1.2
Suburban rich	5.56	91 548	2.34	3 147	87.0	4.1	1.3
Suburban poor	4.88	30 176	4.23	4 159	93.1	3.8	1.3

Note. Prices are average pack prices; income is median household income; retailers and population are densities (per square mile); transport is the percentage of the population using each mode.

dollar cost of cigarettes (see Equation 2 in Appendix A, available as a supplement to the online version of this article at http://www.ajph.org).

Model Usage and Policy Tests

Each simulated run of the Tobacco Town model consisted of 30 "days" (morning and evening periods). During these runs, we collected data on the environment, agents, and their purchase decisions; our model stored aggregated and individual-level data on cigarette purchases. These data included the cost, distance, and time for travel to the selected retailer, purchase price and quantity, and type of retailer. The 30 days was both conceptually tidy (reflecting a simulated month) and, coupled with 40 runs conducted under every parameter set, ensured that stable agent behavior patterns could be identified from the stochastic model.[31]

Tobacco Town evaluated tobacco retailer reduction policies being tested in US communities and stronger versions of these policies to see their potential effects. We tested 4 types of policies individually and in combination: (1) a retailer cap compared effects of capping the density of retailers to 90%, 80%, 70%, 60%, and, finally, 50% of initial levels; (2) a school-proximity buffer compared prohibiting retailers within 500, 1000, or 1500 feet of schools; (3) a retailer-proximity buffer compared requiring a minimum distance between retailers of 500, 1000, or 1500 feet; and (4) a retailer type restriction tested the equivalent of a tobacco sales ban, by removing either all pharmacies or all convenience stores (with and without gasoline). Finally, we ran 2 sets of tests that combined all 4 individual policy types; a moderate-strength combination (75% cap, 1000-foot school and retailer buffers, pharmacy ban) and a high-strength combination (50% cap, 1500-foot school and retailer buffers, convenience store ban).

RESULTS

Table 2 presents the results of all model runs, including the changes in retailer density (retailers per square mile) and the subsequent increase in overall cost of obtaining cigarettes for the different types of policy interventions across the 4 town types.

Retailer Density Reduction

In the baseline runs (before policy tests), retailer density varied from 2.34 retailers per square mile (for the suburban rich town type) to 12.09 retailers per square mile (urban poor). As expected, higher levels of the interventions were associated with greater reductions in density. For example, a 500-foot school buffer decreased density in the urban poor town type from 12.03 to 11.27, while the much larger 1500-foot buffer reduced density to 3.23 retailers per square mile.

Figure 1 shows the relationship between density and overall cost across all model runs: in general, as density decreased, cost increased. The figure illustrates 2 other important findings. First, there appeared to be a nonlinear relationship between density and cost, with the possibility of a threshold effect around 3 retailers per square mile. Second, the relationship between density and cost varied by town type. In particular, the urban town types were less likely to see large increases in costs, as they started out with much higher retailer densities.

Effects on Cost of Retailer Reduction Policy Interventions

In addition to the specific average per-pack total travel plus price cost presented in Table 2, Figure 2 highlights the impacts on total cigarette travel plus price cost per pack in each town type as a result of each policy strategy. Each line plot shows the percentage increase in cost observed relative to the baseline costs. In general, stronger policies resulted in higher costs, although the pattern varied by town type.

Retailer caps and retailer type sales bans. For density, retailer cap strategies operated in a straightforward and uniform manner (i.e., capping the number of licenses at 50% of the current total cuts retailer density in half across town types). For town types other than suburban rich, cost increases were modest (< 4%), even at the highest intensity of halving the number of retailers per square mile. However, for suburban rich communities, a 50% retailer density reduction resulted in a 7% increase. This indicates that the average baseline cost of $5.56 would rise more than 35 cents to $5.94.

Pharmacies represented a small portion of tobacco retailers: 5% to 11% of all stores in the 4 town types here. However, because pharmacies sell cigarettes more cheaply than other retailers on average,[32] removing tobacco sales from pharmacies affected overall costs more than a random 10% retailer reduction (Table 2). Restricting sales for convenience stores, which comprised a much larger portion of tobacco retailers, predicted different impacts on density and cost. Here the policy effects for density reduction were more pronounced, and cost increases further illuminated differences between urban and suburban environments. Because suburban areas had fewer retailers at the baseline, removing convenience store tobacco sales effectively halved retailer density and, as stated previously and seen in Figure 1, more marked cost increases were predicted. In suburban poor town types, for example, implementing this policy reduced retailers from more than 4 to less than 2 per square mile, and the associated cost increases were about 7%.

TABLE 2—Density Reduction and Cost Increase Results From Tobacco Town Agent-Based Model Runs

	Urban Poor			Urban Rich			Suburban Poor			Suburban Rich		
Variable	Retailer Density	Cost, $	% Increase	Retailer Density	Cost, $	% Increase	Retailer Density	Cost, $	% Increase	Retailer Density	Cost, $	% Increase
Baseline	12.03	5.01	. . .	8.84	5.68	. . .	4.23	4.88	. . .	2.34	5.56	. . .
Retailer cap												
90%	10.83	5.03	0.27	7.97	5.69	0.29	3.81	4.90	0.27	2.11	5.59	0.62
80%	9.62	5.05	0.68	7.08	5.73	0.85	3.38	4.94	1.15	1.88	5.61	1.05
70%	8.42	5.06	1.00	6.19	5.74	1.08	2.96	4.98	1.85	1.64	5.68	2.28
60%	7.21	5.09	1.55	5.30	5.77	1.69	2.53	4.99	2.26	1.41	5.81	4.55
50%	6.03	5.12	2.22	4.45	5.81	2.27	2.14	5.05	3.44	1.20	5.94	6.99
School buffer												
500 ft	11.27	5.03	0.31	8.38	5.68	0.11	4.13	4.89	0.12	2.31	5.58	0.46
1000 ft	6.75	5.10	1.76	6.05	5.73	1.00	3.48	4.93	0.90	2.02	5.61	0.89
1500 ft	3.23	5.26	4.99	3.60	5.86	3.14	2.73	4.99	2.15	1.72	5.67	2.09
Retailer proximity												
500 ft	11.06	5.02	0.23	8.24	5.69	0.18	4.10	4.89	0.03	2.30	5.56	0.15
1000 ft	6.36	5.12	2.25	5.38	5.76	1.50	3.23	4.94	1.14	1.99	5.67	2.13
1500 ft	3.55	5.25	4.80	3.29	5.87	3.42	2.46	5.02	2.75	1.67	5.73	3.10
Store type sales ban												
Pharmacies	10.65	5.08	1.41	7.92	5.70	0.45	3.81	4.91	0.55	2.07	5.64	1.47
Convenience	5.60	5.10	1.68	4.02	5.76	1.53	1.97	5.24	7.25	1.08	6.06	8.99
Multiple policies												
Moderate[a]	3.81	5.30	5.84	3.74	5.86	3.27	2.40	4.96	1.59	1.52	5.86	5.53
High[b]	1.11	5.57	11.08	1.15	6.09	7.21	1.01	5.41	10.67	0.72	6.49	16.79

Notes. Each row represents the average result of 40 model runs. Density is number of retailers per square mile; cost values are scaled as average per-pack costs including purchase price and time and travel costs.

[a]Moderate intensity = 75% cap, 1000-foot school and retailer buffers, pharmacy sales ban.

[b]High intensity = 50% cap, 1500-foot school and retailer buffers, convenience store sales ban.

School and retailer proximity buffers. For 500-, 1000-, and 1500-foot restrictions, both types of proximity buffer policies exhibited largely the same impacts for density for each town type. We saw the most dramatic density and cost effects in urban poor environments, which were the most densely populated—by both people and tobacco retailers. For urban poor communities, a 1500-foot-from-schools tobacco sales restriction resulted in a projected 5% increase in costs whereas the same policy in urban rich areas predicted a 3% increase. Conversely, in diffusely populated suburban environments, proximity buffers would see smaller projected impacts on costs.

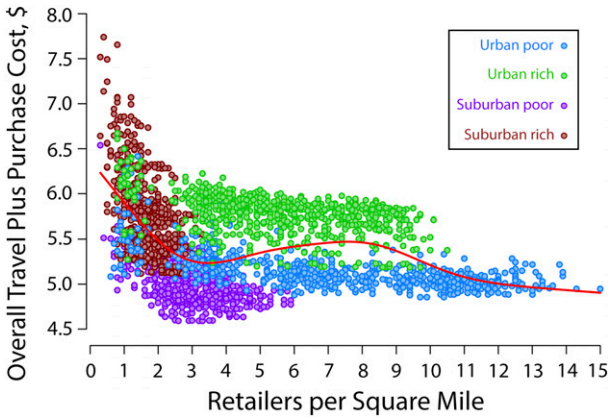

FIGURE 1—Relationship of Retailer Density and Overall Travel Plus Purchase Cost, With Smoothing Spline: Tobacco Town Agent-Based Simulation Model

Multiple policies. Implementation of multiple or multifaceted policies in the model resulted in the largest density reductions and the largest overall cost increases. Interestingly, a set of multiple policies at moderate intensities topped out at about a 6% increase in costs for suburban rich and urban poor communities. The moderate set of policies cut the density "disparity" across town types in half, from about 5 to 1 to about 2.5 to 1. The combined set of high-intensity policies could leave an average of only 1 retailer (or less than 1 in the suburban rich town type) per

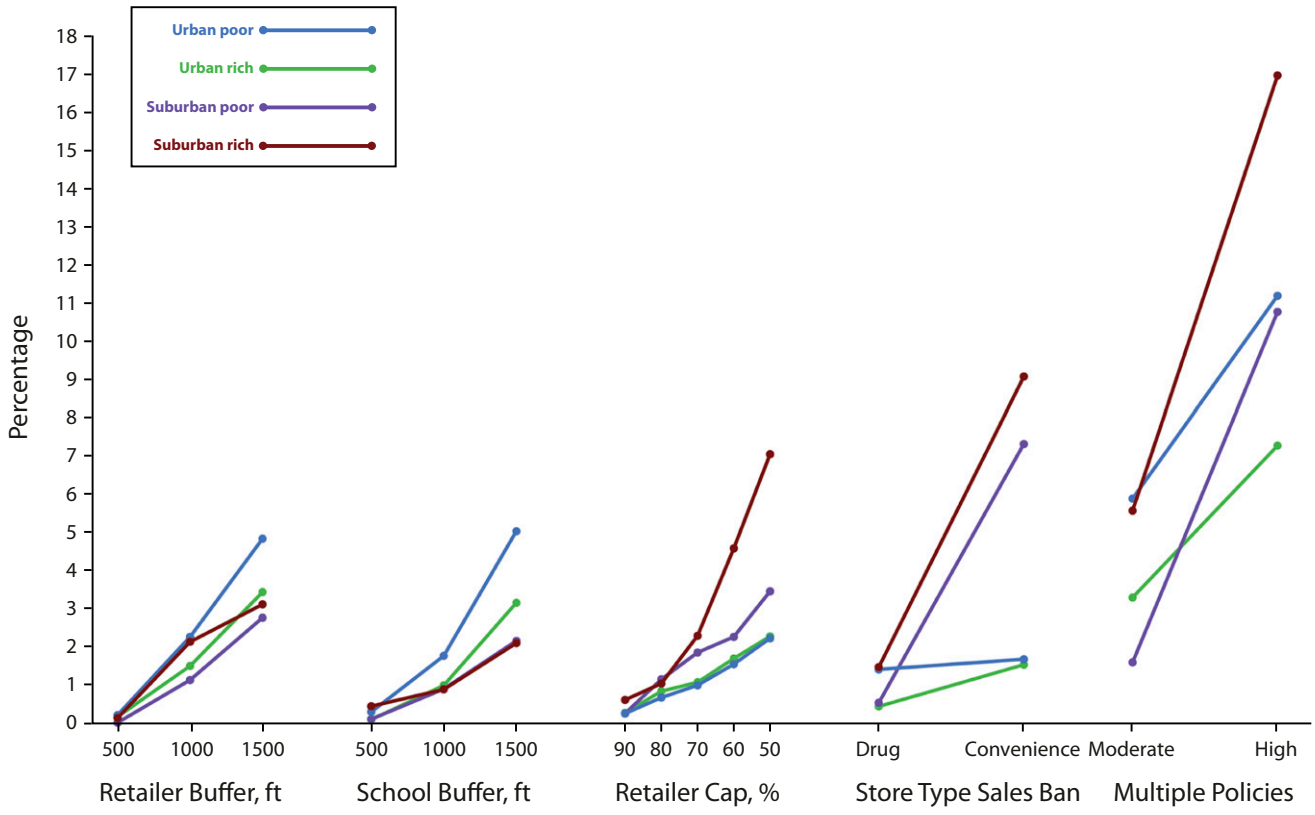

FIGURE 2—Relative Overall Travel Plus Purchase Cost Increases by Type of Policy and by Town Type: Tobacco Town Agent-Based Simulation Model

square mile. For all types except urban rich communities, the set of high-intensity policies predicted cost increases of more than 10%, and the expected cost increase for suburban rich communities was 17%.

We conducted an additional set of model runs by using a more realistic "2-phase" decision rule,[33] in which agents decided from which retailer to purchase tobacco products after ruling out some retailers on the basis of maximum acceptable price, maximum acceptable distance, or type of retailer. Both density reduction and cost increase results showed very similar patterns to the main model runs (see Table B-1 and Figure B-1 in Appendix B, available as a supplement to the online version of this article at http://www.ajph.org).

DISCUSSION

Communities around the United States are implementing a variety of policies to reduce the retail availability of tobacco products.[34] Despite these efforts, we still know little about how the underlying mechanisms of these policies drive down density, increase search costs, and affect price. In this study we used the Tobacco Town agent-based model to reveal important differences in potential policy impacts, both between policies and across town types. In a context in which real-time reduction can take years to evaluate, research informed by agent-based modeling is especially important to identify the most potent policies and to defend against increasing tobacco industry opposition to any and all forms of retailer reduction policies.

Contextual Policy Effects

The relationship between retailer density and cost is less straightforward than one might assume. Retailer density reduction exhibits a threshold effect on total cost of acquiring cigarettes; as retailer density decreases, the overall travel plus purchase costs increase modestly up to a point (around 3 retailers per square mile) and then begin to increase more dramatically as the concentration of retailers continues to diminish. That is, retailer densities must be reduced dramatically before large cost effects are seen. This suggests that the impacts of retailer reduction policies are likely to vary on the basis of the retailer density starting points.

For example, in New York City, where retailer density is 31 retailers per square mile,[35] it would take a dramatic 87% reduction in tobacco retailers to reduce retailers to fewer than 4 per square mile. Conversely, in the city of St Louis, Missouri, it would require only a 35% reduction to reach the same goal.[36] More densely populated areas tend to have more tobacco retailers, and similar relative reductions in density (e.g., 20%) may not have an impact on total costs as markedly as the same reduction in a less populated area. In addition, existing income differentials

between similarly populated and urbanized communities (e.g., suburban rich vs suburban poor) result in distinct impacts from the same policy.

Strength of Individual and Combined Policy Effects

As one might expect, a policy that caps the number of tobacco retailers at 50% of the existing total exhibits larger impacts (on retailer density and cost) than one that caps the number only at 90% of the status quo. However, implementation of multiple policies—even at lower, more politically palatable intensities—can decrease tobacco retailer density and increase costs more than a single policy at a higher, or its highest feasible intensity.

Public Health Implications

The Tobacco Town agent-based model suggests that, especially for dense, urban environments, modest reductions in tobacco retailer density may simply not lead to "noticeable" environmental changes that translate into public health benefits. More dramatic reductions in density may be required before consumers would either have to search longer for tobacco products or be willing to pay more for tobacco.[26] This has implications for communities that are considering many different policy options. For example, in our model, a 500-foot buffer around schools only resulted in a density reduction of 1% to 2% for suburban settings, and essentially no increased search costs. Even in urban settings, the modest 500-foot buffer only reduced density by around 5% to 8%. In other words, these policies may only remove half a dozen retailers out of every 100. Although stronger policies, or multiple policies in combination, are needed for density reduction, maximizing the distance from tobacco retailers to schools serves other public health priorities, such as limiting young people's exposure to retail tobacco marketing.

Our findings also suggest that there is not a "one size fits all" retailer reduction policy. These effects of different mechanisms (e.g., buffers vs store type restrictions) vary according to town type. This has important health disparities implications: places that need retailer reduction policies the most (i.e., lower-income urban communities) would benefit from policies that are specifically tailored to eliminate those inequities. For example, San Francisco's policy established a cap at the lowest number of retailers across all administrative districts, explicitly aiming to eliminate existing density disparities. Other simulations suggest that implementing bans on retailers near schools may reduce disparities across diverse communities.[37,38] Finally, our results are consistent with the Centers for Disease Control and Prevention's decades-long push for comprehensive policy approaches to tobacco control.[39] Communities are far more likely to see public health benefits if they combine multiple retailer reduction strategies with strong traditional tobacco control efforts, rather than relying on 1 policy to do everything.

It is useful to keep in mind a number of important limitations of this study. As with any agent-based model, it is based on a set of abstractions (e.g., 4 town types, average commute times) that make it important to avoid overgeneralizing to real towns, real behavior, and real policies.[40] However, that abstraction allows us to focus on a smaller set of agent behaviors and agent–environment interactions that help to reveal underlying policy mechanisms and behavioral dynamics that themselves have important policy implications.[41]

For similar reasons, it is important not to interpret the Tobacco Town cost outcome variable as being indicative of real-world costs. Rather, the cost outcome is a metric that captures both search and purchase costs, and is sensitive to policy and environmental changes in a way that allows us to connect the model results to our interpretations of what a successful retailer density reduction policy is meant to accomplish (i.e., make it less convenient and more expensive to obtain tobacco products). By focusing on search and acquisition costs, the modeling did not take into account other ancillary benefits of retailer reduction, such as decreasing exposure to retail tobacco marketing and denormalizing tobacco use. Indeed, the initial version of the Tobacco Town model presented here is just the first phase in a planned program of study using computational modeling to explore the benefits of policy solutions to chronic disease challenges.

Communities may implement model policies to reduce tobacco retailer density, but their effects will always play out differently. Such policies will change individual neighborhoods, making tobacco products less convenient and more costly to obtain for the people who live and work in those neighborhoods. Tobacco Town suggests to us that these policies may reduce the burden of tobacco in individual communities, but these benefits are more likely to be seen if the policies start out strong, are implemented in conjunction with other effective retailer policies, and are designed to take into account the specific characteristics of those communities. AJPH

CONTRIBUTORS

D. A. Luke originated and supervised the study. R. A. Hammond conceptualized and supervised the modeling. T. Combs supervised data collection and analysis. A. Sorg conducted data analysis. M. Kasman designed and programmed the model. A. Mack-Crane did model programming. K. M. Ribisl and L. Henriksen provided policy data and article feedback. All authors contributed to article development.

ACKNOWLEDGMENTS

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Note. The funders had no involvement in the study design, collection, analysis, writing, or interpretation. K. M. Ribisl is the chair of the board of directors of Counter Tools (http://countertools.org), a nonprofit from which he receives compensation. Counter Tools provides technical assistance on point-of-sale tobacco control issues and distributes store mapping and store audit tools. K. M. Ribisl also has a royalty interest in a store mapping and audit system owned by the University of North Carolina at Chapel Hill, but these systems were not used in this study.

HUMAN PARTICIPANT PROTECTION

This research included no human participants. We received exempt status from the Washington University Human Research Protection Office.

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April 27, 2017

Honorable Corey Johnson
Chair, Health Committee
New York City Council
City Hall
New York, NY 10007

Testimony of Asian American Tobacco Free Community Partnership to the New York City Council, Committee on Health
April 27, 2017 • New York, NY

Re: Statement in Support of legislative proposals Int. No. 1547, 1544, 1532, and 1131-2016 (Lander, Johnson, Cabrera, Lander) to reduce smoking and tobacco usage in New York City.

Good morning/afternoon Chairperson Johnson and members of the New York City Council Committee on Health. Thank you for the opportunity to testify today on Intros 1547, 1544, 1532, and 1131-2016, bills that increase the minimum prices for all tobacco products and reducing the number of licensed retailers that will decrease the number of smokers in New York City.

My name is Regina Lee and I represent the Asian American Tobacco Free Community Partnership which is a community-led partnership to address the burden of tobacco use and exposure to second hand smoke in New York City's Asian American community. Our partnership include a Federally Qualified Health Center (Charles B. Wang Community Health Center), one of the nation's premiere academic medical centers, (NYU Langone Medical Center), two well-established community organizations (Asian Americans for Equality, Korean Community Services of Metropolitan New York) and a medical society (Chinese American Medical Society). We strongly support legislation that will reduce tobacco use, raise the minimum price of cigarettes and reduce the number of stores that may sell tobacco products.

New York City has been a national leader in tobacco control and has achieved remarkable reductions in smoking prevalence, from 21.5% in 2002 to 14.3% in 2015. However, not all groups benefit equally from these policy interventions; immigrant communities, for example, face linguistic, cultural and economic barriers that prevent them from accessing and benefitting from the policy interventions and important resources including public health campaigns and smoking cessation counseling and treatment from physicians. Asian American men are the only group in New York City that saw an increase in smoking rate – from 19.6% in 2002 to 25.4% in 2015.

Previous tobacco control policies have had limited impact in Asian American communities. For example, anecdotal evidence suggests that cigarettes may be picked

up by friends and family in duty-free shops.[1] Less expensive Chinese brand cigarettes and "untaxed" US brands are easily available for purchase within the community, both in retail outlets as well as from untaxed sources. Friends and family members also bring home cigarettes when they visit China.[2] Despite New York having the highest excise tax out of the 50 states, cost of cigarettes is not necessarily a barrier for our demographic.[3] In a recent unpublished survey of 250 Chinese American residents of Chinatown and Sunset Park, NYU Langone Medical Center (NYULMC) and Charles B. Wang Community Health Center (CBWCHC) found the average price paid for a pack of cigarettes was $7.62, with some paying as low as $2.[4] This is compared to the average retail price of $10.45 statewide.[5] Raising the minimum prices for all tobacco products may be an effective way to reduce tobacco use among New York City smokers; however, this proposed legislation will not have an impact in our community unless we tackle the availability of untaxed cigarettes.

In addition, when a smoker is ready to quit, cessation resources are not always culturally and linguistically adapted. The NYS Quitline is an essential resource for smoking cessation but it is not readily accessible in Chinese or other Asian languages. Monolingual patients who call the Quitline have complained of being put on hold for 20 minutes and longer to connect to an interpreter or not getting return phone calls when they leave their names and contact information.[15] The Quitline is not widely marketed in the Asian community. As a result, providers in the Asian American community who serve monolingual patients may hesitate to make referrals. Similarly, the NYC Quits tobacco cessation website has extremely limited resources in Chinese.

NYC Council members, especially Chairperson Johnson, have led recent tobacco control efforts. Our smoking partnership is seeking NYC Council's support to continue the forward momentum in making NYC truly smoke free. We propose the following strategies/action steps to be taken by NYC Council and other city agencies in collaboration with our partnership members:

1. Reduce the availability of untaxed cigarettes in Chinatown in Manhattan, and Sunset Park in Brooklyn and Flushing in Queens. Form a task force with agencies such as the United States Bureau of Alcohol, Tobacco, Firearms and Explosives, New York State Department of Taxation and Finance to disrupt the network of cigarette smuggling.

2. Ensure language equity in accessing smoking cessation services for Asian Americans and other populations that are limited in English proficiency. For example, NYCDOHMH could collaborate with NYS DOH to promote referrals to Asian Smokers Quitline, the only quitline in the nation that provides in-language outreach, education and telephone counseling services in Chinese, Korean and Vietnamese.

NYC is widely regarded as a leader in smoking prevention, and successfully implemented several initiatives to reduce tobacco use and sales; however, there is a disparity in terms of who benefits from these policies. Smoking has declined for all racial and ethnic groups across the city except Asian American men. While these bills will help ensure that we continue to decrease smoking rates, we urge the NYC Council to implement policies and program to reduce the tobacco use disparity among Asian Americans which represents the fastest growing racial and ethnic group in NYC.

Sincerely,

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ASH ACTION ON SMOKING & HEALTH

Global action for everyone's health.

Honorable Corey Johnson
Chair, Health Committee
New York City Council
City Hall
New York, NY 10007

April 25, 2017

Dear Mr. Johnson:

I am writing to support the proposed tobacco legislation that will be heard by the Health Committee on April 27. New York City has made extraordinary efforts to combat the death and disease caused by tobacco. Tobacco products and non-tobacco shisha are dangerous. Their use is a major public health concern that we cannot overlook. These bills will help take the next step towards ending the tobacco epidemic for good.

The World Health Organization's Framework Convention on Tobacco Control (FCTC)[1] is the world's first public health treaty. The treaty and its guidelines provide international best practices for tobacco control. While the U.S. has signed the treaty, it is not yet a Party. However, 179 countries and the European Union representing nearly 90% of the world's population are Parties to the FCTC[2]; a clear indication of the near global acceptance of these strategies. These bills incorporate several of these best practices. I mention just a few of the bills below, but Action on Smoking and Health finds all of the bills in this package worthwhile, and I believe that they will have a significant, positive impact on the health of New Yorkers.

Proposal Int 1544-2017- increased prices and tax

This bill raises the minimum price for tobacco products and imposes a new 10% local tax on other tobacco products. The international community has recognized price and tax increases as an effective way to reduce smoking rates, and therefore included it in Article 6 of the FCTC[3]. Domestically, the U.S. Surgeon General has called raising prices on cigarettes "one of the most effective tobacco control interventions." [4] In high-income countries, like the United States, a 10% increase in tobacco

[1] World Health Organization, Framework Convention on Tobacco Control, http://apps.who.int/iris/bitstream/10665/42811/1/9241591013.pdf?ua=1.

[2] WHO FCTC, Parties to the Framewok Convention on Tobacco Control, http://www.who.int/fctc/signatories_parties/en/.

[3] WHO FCTC, Article 6. http://apps.who.int/iris/bitstream/10665/42811/1/9241591013.pdf?ua=1.

[4] U.S. Department of Health and Human Services (HHS), The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General, Atlanta, GA: HHS, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. http://www.surgeongeneral.gov/library/reports/50-years-ofprogress/index.html

prices will reduce consumption by about 4% for adults.[5] Tobacco taxes are particularly effective in preventing or reducing tobacco use among young people. A 10% price increase decreases youth smoking by about 7%.[6]

Proposal Int 1131-2016- pharmacies

This bill prohibits pharmacies from selling tobacco products. Tobacco products are the number one cause of preventable death and disease[7], and selling them is antithetical to pharmacies' goals of improving people's health. Several cities, including San Francisco and Boston[8], have already taken this step to protect the health of their citizens, and New York should as well.

Int 1585-2017- disclosure of smoking policies

This bill requires owners of residential buildings to create a policy on smoking and disclose it to both current and prospective residents. Although this bill does not require a building to adopt a no smoking policy, it allows prospective tenants to make a fully informed decision about whether or not they want to live in a building. In 2011-2012, more than 1 in 3 (36.8%) nonsmokers who lived in rental housing were exposed to secondhand smoke.[9] This is no small problem; since 1964, approximately 2,500,000 nonsmokers have died from health problems caused by exposure to secondhand smoke.[10]

This bill allows potential tenants to decide whether or not living in a building that allows smoking is an acceptable level of risk to their health and that of their children. The disclosure that this bill requires is supported by Article 8 of the FCTC which calls for universal protection from exposure to tobacco smoke[11], and also Article 12[12], which encourages public education and awareness.

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[5] World Health Organization, Raise Taxes on Tobacco, http://www.who.int/tobacco/mpower/publications/en_tfi_mpower_brochure_r.pdf.

[6] Campaign for Tobacco Free Kids, RAISING CIGARETTE TAXES REDUCES SMOKING, ESPECIALLY AMONG KIDS, https://www.tobaccofreekids.org/research/factsheets/pdf/0146.pdf.

[7] Centers for Disease Control and Prevention (CDC), Smoking and Tobacco Use. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/.

[8] Americans for Non-Smokers Rights, Tobacco Free Pharmacies, http://no-smoke.org/learnmore.php?id=615.

[9] Centers for Disease Control and Prevention (CDC), Secondhand Smoke Facts. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/general_facts/.

[10] *Id*.

[11] WHO FCTC, Article 8. http://apps.who.int/iris/bitstream/10665/42811/1/9241591013.pdf?ua=1.

[12] WHO FCTC, Article 12. http://apps.who.int/iris/bitstream/10665/42811/1/9241591013.pdf?ua=1.

Conclusion

Unfortunately, tobacco use is still the leading cause of preventable death in the United States.[13] Every year, over 480,000 people in the United States[14] and over 28,000 New Yorkers[15] die from tobacco related diseases. New York City has taken a progressive role as a leader in the area of tobacco control. This legislation can continue that tradition and save many people from tobacco related death and disease. I urge the committee to pass these important policies.

Best Regards,

Laurent Huber
Executive Director, Action on Smoking & Health
Ambassador, Framework Convention Alliance on Tobacco Control

[13] *Supra* note 7.

[14]Centers for Disease Control and Prevention (CDC), Tobacco Related Mortality. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/tobacco_related_mortality.

[15] Campaign for Tobacco Free Kids, The Toll of Tobacco in New York. https://www.tobaccofreekids.org/facts_issues/toll_us/new_york.

27110 Grand Central Parkway
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Floral Park, New York

April 25, 2017

Honorable Corey Johnson
Chair, Health Committee
New York City Council
City Hall
New York, NY 10007

Dear Sir:
Thank you for allowing me these few minutes to speak.
I heartily endorse and support the resolutions that will curb smoking in New York City. We should be on the forefront of healthy living.

I particularly applaud the bill that requires rental apartment buildings, as well as co-op and condo buildings, to create a smoking policy for the building. I also support the bill banning smoking in the common areas of all multiply dwellings.
I am a director on the Board of North Shore Towers and Country Club, a complex of 3 high rises of 33 floors containing 1844 units on 110 acres in eastern Queens.

As of January 1, 2017 our community has been smoke free in ALL interior areas including apartments, balconies, terraces.

We amended our proprietary lease by voting and getting the requisite 66 2/3% shares necessary to make this ban happen. Actually 72% voted in the affirmative. People said it couldn't be done…we did it. We are thought to be the largest private co-op in the country to go smoke free.

We took this path because we had a problem with second hand smoke traveling and impacting units in our buildings. Smoke travels through the vents, seeps under doors and walls and cannot be isolated or contained in the smokers unit.

We put together a group of 50 residents (2 building captains in each building; the remaining residents floor captains in there respective buildings.). These people were committed and focused to get the vote out.

On Aug. 1, 2016 we had a presentation to our residents by the Queens team…Joel Bhuiyan, Nancy Copperman, Phil Konigsberg and Eileen Miller about the harmful effects of second hand smoke. We also had a resident engineer describe the impossibility of sealing a smokers apartment. The stage was set for an all out push to eliminate smoke in the interiors of our complex. At the end of the voting period, Sept. 30, the community spoke!

Our commitment to and execution of amending the proprietary lease was the March cover story in Habitat magazine. We receive calls from other co-ops and condos to find out how we did it.

When people understand that second hand smoke is destructive to people and property the only answer is eliminating it. It is the only positive approach.

North Shore Towers and Country Club is proud to be on the forefront of this issue!

Yours truly,

Phyllis Goldstein

TESTIMONY OF
THE NEW YORK PUBLIC INTEREST RESEARCH GROUP
BEFORE THE NEW YORK CITY COUNCIL HEALTH COMMITTEE
REGARDING TOBACCO BILLS: INTRO 1547, INTRO 1544, INTRO 1532, INTRO 1131-2016
April 27, 2017
New York City, NY

Good afternoon, my name is Smitha Varghese, a policy associate with the New York Public Interest Research Group (NYPIRG) and a student at Queens College, with me today is Megan Ahearn, NYPIRG's program director. NYPIRG is a non-partisan, not-for-profit, research and advocacy organization. Consumer protection, environmental preservation, health care, higher education, and governmental reforms are our principal areas of concern. We appreciate the opportunity to testify on the City Council's proposed bills regarding tobacco.

Virtually all New Yorkers have had an experience with cancer. According to the U.S. Centers for Disease Control and Prevention (CDC), cancer is the second leading cause of death in America.[1] *As seen below, the top five cancer killers account for more than half of all the estimated cancer deaths.*

Estimated Number of New Cancer Cases and Deaths Exceeding 1,000, 2017[2]

Type of Cancer	New Cases	Deaths
Total, all sites	*107,530*	*35,960*
Lung & Bronchus	12,700	8,660
Colon & Rectum	8,490	2,870
Pancreas	3,490	2,750
Female Breast	16,310	2,410
Prostate	10,060	1,560
Leukemia	4,320	1,460
Liver & IBD	2,520	1,680
Non-Hodgkin Lymphoma	4,760	1,210
Urinary Bladder	5,410	1,050

Breast cancer is the leading form of cancer affecting women and the second biggest killer. Yet, it is not the leading cause of cancer deaths for women. Prostate cancer is a leading cause of cancer in men, but it is not the leading cause of cancer deaths in men. *That terrible distinction belongs to lung cancer.*

[1] Centers for Disease Control and Prevention, see: https://www.cdc.gov/cancer/dcpc/data/types.htm.
[2] American Cancer Society, Cancer Facts & Figures, Supplemental Data, see: https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-andfigures/2017/estimated-deaths-for-selected-cancers-by-state-us-2017.pdf.

As you see in the above chart, lung cancer is what drives cancer deaths in New York State: *Nearly one quarter of all cancer deaths result from lung cancer.* It is a cancer that is deadly, and that afflicts men and women alike. It is also a cancer for which we know how to dramatically reduce its impact: by reducing the use of tobacco products.

The leading cause of lung cancer is tobacco use. Today nearly 9 out of 10 lung cancers are caused by smoking cigarettes.[3] Not only are smokers at risk, but even non-smokers can be afflicted by exposure to tobacco smoke. In the U.S., more than 7,300 nonsmoking lung cancer patients die each year from exposure to secondhand smoke alone.[4]

The State budget adds no new revenues to the state's program designed to combat tobacco use. Because the Governor has failed (again) to meet the scientifically-identified goals for how much money New York should spend on combating tobacco and ultimately, fighting lung cancer, it is up to local leaders to mend the damage that has been done. While fiscal issues regarding the State budget can't be fixed, regulations at the City level can be made to further protect the health and well-being of all New Yorkers from the tobacco industry.

Int. No. 1547 updates the City retail license for selling cigarettes to include all types of tobacco. At the same time, the bill will also limit tobacco retail dealer licenses available in each community by setting caps within their districts.

City officials already have their hands full with current tobacco retail license holders. From 2013-2014, more than 2,600 tobacco retailers were penalized for violating the Tobacco Product Regulation Act (TPRA).[5] Such violations included offering "loosies" to consumers instead of selling cigarettes within packages, selling tobacco products to minors, and failure to produce public health messages.[6] By capping the number of tobacco retailer licenses at 50 percent of the current number, this legislation will improve enforcement of existing laws by narrowing the number of retailers that need to be monitored.

What's more, reducing tobacco retailer licenses stands to reduce tobacco product marketing. The U.S. Surgeon General has found that the more tobacco advertising and marketing youth see, the more likely they are to smoke.[7] For the past three years, NYPIRG has worked with students to administer a community mapping survey of tobacco advertisements – the results of which were shared in three reports. The reports are neighborhood snapshots and collected anecdotal evidence, and therefore does not constitute a scientific report.

Areas surrounding 10 high schools in nine neighborhoods of the Bronx, Brooklyn, and Queens were surveyed. In the last two reports (2015 and 2016), surveyors were asked to identify tobacco product displays – visible displays of items for sale such as cigarettes, cigars, chewing tobacco, e-cigarettes, and

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[3] Smoking also causes cancers of the esophagus, larynx, mouth, throat, kidney, bladder, liver, pancreas, stomach, cervix, colon, and rectum, as well as acute myeloid leukemia (1-3). Source: National Cancer Institute, available at https://www.cancer.gov/about-cancer/causes-prevention/risk/tobacco/cessation-fact-sheet#q2.

[4] U.S. Centers for Disease Control and Prevention, "Secondhand Smoke Facts, 2015" see: https://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/general_facts/index.htm.

[5] Department of Health, see: https://www.health.ny.gov/prevention/tobacco_control/docs/tobacco_enforcement_annual_report_2012-2014.pdf.

[6] Tobacco Product Regulation Act, see: https://www1.nyc.gov/assets/doh/downloads/pdf/smoke/tpra-title17chap7.pdf.

[7] U.S. Department of Health and Human Services. Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General. Atlanta, GA: 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.

more. Surveyors observed 170 total tobacco product displays, representing about one-third of all marketing observed for those reports.

Surveyors also remarked about the amount of non-traditional tobacco products they saw. Jean Pierre Felder, Borough of Manhattan Community College student and survey participant shared, "There were a lot of advertisements on store banners and on the outside of the stores. There were a lot of e-cigarettes and hookahs visible, it was so obvious."

Tiffany Brown, a former Queens College NYPIRG Project Coordinator and survey participant stated, "While surveying, I was really surprised at the amount of non-traditional tobacco products I saw. Many of the walls were covered with e-cigarette brands and flavors, as well as multiple brands of rolling papers and loose tobacco."

Renella Thomas, a Brooklyn College student and survey participant said "There were three shelves of hookahs and other electronic smokes in the display window – I was surprised at the amount! I was also astonished at the four shelves of cigarettes near the candy...They are placed in the stores strategically to look enticing."

Licensing requirements act as a powerful tool to ensure compliance with tobacco control policies and protect the public health in the process. **NYPIRG supports this bill.**

Int. No. 1544 increases the price floor of a cigarette package from $10.50 to $13. If this bill passes, smokeless tobacco will also cost at least $8 and shisha packages, $17. All other tobacco products such as cigars and loose tobacco will be, for the first time, taxed at a rate of 10 percent of the minimum price and the new price floor for cigars would be $2 per cigar in a package, and a minimum of $8.

It is a fact that increasing tobacco prices serves as one of the most effective ways to reduce smoking, especially among kids.[8] Big Tobacco knows this. Back in 1993, Philip Morris, one of the largest cigarette manufacturers in the world, went on record saying "A high cigarette price... has the most dramatic impact on the share of the quitting population... price, not tar level, is the main driving force for quitting."[9]

That statement made by Big Tobacco is still relevant today. According to the Campaign for Tobacco-free Kids, every ten percent increase in cigarette prices reduces youth smoking by about seven percent.[10] The US Surgeon General also agrees, stating "evidence shows that large tax and, hence, price increases will decrease tobacco use each time they are implemented."[11] **NYPIRG supports this bill.**

Int. No. 1532 would require electronic cigarette retailers to have a license to sell their devices. This is a common-sense bill. Electronic or e-cigarettes are nicotine delivery devices and nicotine is a highly addictive drug. Given the dramatic increase in youth consumption of e-cigarettes recently, this is a public health matter worthy of attention. Last year, the Surgeon General released a report on the health issues stemming from e-cigarettes. The report highlighted the unfortunate reality that e-cigarette consumption among high schoolers increased "an astounding 900 percent" from 2011 to 2015. Also in the report was the revelation that cigarette marketing techniques that have been "found to be appealing to youth and young adults," are being mimicked by the $3.5 billion e-cigarette industry.

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[8] The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General, 2014, see: https://www.surgeongeneral.gov/library/reports/50-years-of-progress/#fullreport.
[9] Philip Morris Executive Claude Schwab, "Cigarette Attributes and Quitting," March 4, 1993, Bates No. 2045447810.
[10] Campaign for Tobacco-Free Kids, see: http://www.tobaccofreekids.org/what_we_do/state_local/taxes/.
[11] HHS, *The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General,* 2014, see: http://www.surgeongeneral.gov/library/reports/50-years-of-progress/index.html.

Requiring retailers to be licensed would be a step forward, especially since current laws only require them to be *registered* as retailers of e-cigarettes. License requirements place heavier governmental oversight on products being sold. Whereas retailers are only required to register once with the Department of Health, a license mandates annual renewals,[12] which can aid with retailer compliance and help state and city officials manage the location and concentration of e-cigarette retailers. Licensing is a powerful tool, and has been rightly used in New York to regulate the sale and marketing of products posing risks to public health. **NYPIRG supports this bill.**

Lastly, Int. No. 1131 restricts pharmacies, or retail stores that contain pharmacies within them, from selling tobacco products. This piece of good legislation seeks to uphold pharmacies for their true purpose: to help people attain better health. For too long, pharmacy chains have been contradicting this public health mission statement by selling dangerous and harmful tobacco products.

In 2014, CVS became the first pharmacy chain to stop selling tobacco products in its stores. The company stated that the sale of tobacco products was inconsistent with their purpose.[13] One year later, the company reported their impact. Since its ban on tobacco products, cigarette pack sales across all retailers in states where CVS had a 15 percent or greater share of the retail pharmacy market, dropped by one percent, compared to states with no CVS stores.[14] This resulted in five fewer packs being consumed per smoker and 95 million fewer packs being sold overall. The study also concluded that nicotine patches were purchased at a four percent increase within the same states mentioned before. This small yet significant increase indicates that the end of pharmaceutical tobacco sales could encourage smokers to quit.

Retailers that provide health care services should not continue to sell harmful tobacco products. **NYPIRG supports this bill.**

Thank you for the opportunity to testify today.

[12] Department of Health, see: https://www1.nyc.gov/nycbusiness/description/electronic-cigarette-retail-store-registration.
[13] Who Sells Cigarettes? The Tobacco-free Status of Major Retailers, see: https://truthinitiative.org/news/who-sells-cigarettes-tobacco-free-status-major-retailers.
[14] CVS; We Quit Tobacco, Here's What Happened Next, see: https://cvshealth.com/thought-leadership/cvs-health-research-institute/we-quit-tobacco-heres-what-happened-next.

NEW YORK STATE ASSOCIATION FOR AFFORDABLE HOUSING

Hearing of the New York City Council Committee on Health
NYSAFAH Testimony on Int. 977 – April 27, 2017

The New York State Association for Affordable Housing (NYSAFAH) thanks the Committee on Health for the opportunity to submit testimony regarding Int. 977, which would ban smoking in city-financed multiple dwelling building, the kind developed and managed by NYSAFAH members.

NYSAFAH opposes the blanket policy as set forth in this legislation. Anti-smoking goals are laudable, but must be considered with the real-world impacts in mind. To mandate a new rule means that inevitably it is a rule that will be broken by some tenants. NYSAFAH's management company members do not wish to evict individuals or families on account of a tenant smoking in their apartment units. But by mandating a new rule that will be written into leases, that is the position we are asking these companies to be in.

For instance, if a neighbor is bothered by a tenant on the other side of the wall smoking, they may approach their management and rightly claim that smoking is prohibited in the lease, and demand that their management representative act. If attempts to approach the offending tenant are unsuccessful, the management is put in the heartbreaking position of having to decide whether to escalate the situation further, to a housing court context. This is an outcome that no side wants, as it creates tension and discord within properties, both between management and tenant, and neighbor to neighbor.

Some developers or managers of affordable housing may wish to set an anti-smoking policy for their building, but we feel the decision should be theirs, based upon such considerations as building design, as well as their comfort level with ensuring such a policy is enforced. Thank you for your consideration.

Contact: Patrick Boyle, Policy Director patrick@nysafah.org (646) 473-1209

Public Health and Tobacco Policy Center

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tobaccopolicycenter.org

May 1, 2017

Honorable Corey D. Johnson
Chairperson
Committee on Health
New York City Council
New York City Hall
New York, New York 10007

RE: **Int. No. 977: In relation to banning smoking in city-financed housing**
Int. No. 484: In relation to banning smoking in the common areas of all multiple dwellings
Pro. Int. No. 139-B: In relation to the regulation of non-tobacco smoking products, and to amend the fire code of the city of New York, and the New York city mechanical code, in relation to the operation of non-tobacco smoking establishments.

Dear Chairperson Johnson:

The Public Health and Tobacco Policy Center is a not-for-profit legal research center focused on public health law and affiliated with Northeastern University School of Law. Through funding by the New York Department of Health, the Center provides policy education and legal technical assistance to develop, implement, and enforce policies intended to reduce tobacco-related morbidity and mortality in New York. Our support includes drafting model policies and review of applicable legal and scientific authority. It is in this capacity that we submit the following information **in support of the above-referenced proposals**

PROHIBITING SMOKING IN CITY-FINANCED HOUSING (INT. NO. 977), AND EXPANDING THE PROHIBITION ON SMOKING TO COMMON AREAS OF ALL MULTIPLE DWELLINGS (INT. NO. 484), WILL IMPROVE PUBLIC HEALTH AND SAFETY, AND WILL PROMOTE HEALTH EQUITY.

Secondhand smoke is toxic and inevitably travels between dwelling units in multi-unit buildings.

Each year, 7,300 U.S. nonsmokers die from lung cancers that are attributable to exposure to secondhand smoke (SHS).[1] SHS exposure also increases the risk of stroke by up to 30 percent in adults[2] and causes 34,000 heart disease deaths every year.[3] Children who are exposed to SHS are more likely to experience bronchitis, pneumonia, more frequent and severe asthma attacks, and other respiratory ailments and diminished lung functioning.[4] Further, SHS exposure causes Sudden Infant Death Syndrome (SIDS) among infants and increases nonsmoking women's risk of pregnancy loss.[5] Despite New York City's laudable low smoking prevalence, its non-smoking residents are more highly exposed to SHS than U.S. residents overall, due to the prevalence of multi-unit dwellings and high population density. Notably, individuals living in high-poverty neighborhoods are even more likely to be exposed to SHS.[6]

SHS infiltrates into neighboring units in multi-unit dwellings. Tobacco smoke easily passes through heating, ventilating, air conditioning systems,[7] and electrical outlets, as well as cracks in windows, fixtures, water pipes, and baseboards. In order to shield residents in multi-unit housing from SHS, smoking must be prohibited throughout the building, including in individual dwelling units, common areas, and within 25 feet of buildings.

Prohibiting smoking in City-financed and other multi-unit dwellings will promote health equity.

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[1] *See* U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, SMOKING AND TOBACCO USE, HEALTH EFFECTS OF SECONDHAND SMOKE (2017), http://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/health_effects/index.htm.

[2] U.S. DEP'T OF HEALTH & HUMAN SERVS., THE HEALTH CONSEQUENCES OF INVOLUNTARY EXPOSURE TO TOBACCO SMOKE: A REPORT OF THE SURGEON GENERAL (2006), http://www.ncbi.nlm.nih.gov/books/NBK44324/pdf/Bookshelf_NBK44324.pdf

[3] *See* U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, SMOKING AND TOBACCO USE, HEALTH EFFECTS OF SECONDHAND SMOKE (2017), http://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/health_effects/index.htm.

[4] *See* U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, SMOKING AND TOBACCO USE, HEALTH EFFECTS OF SECONDHAND SMOKE (2017), http://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/health_effects/index.htm

[5] *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., THE HEALTH CONSEQUENCES OF INVOLUNTARY EXPOSURE TO TOBACCO SMOKE: A REPORT OF THE SURGEON GENERAL (2006), http://www.ncbi.nlm.nih.gov/books/NBK44324/pdf/Bookshelf_NBK44324.pdf Andrew Hyland et al., *Associations Of Lifetime Active and Passive Smoking With Spontaneous Abortion, Stillbirth and Tubal Ectopic Pregnancy: A Cross-Sectional Analysis Of Historical Data From the Women's Health Initiative*, 24 TOB. CONTROL 328 (2015).

[6] Sharon E. Perlman et al., *Exposure to Secondhand Smoke Among Nonsmokers in New York City in the Context of Recent Tobacco Control Policies: Current Status, Changes Over the Past Decade, and National Comparisons*, 18 NICOTINE TOB. RES. 2065 (2016); Jennifer A. Ellis et al., *Secondhand Smoke Exposure among Nonsmokers Nationally and in New York City*, 11 NICOTINE TOB. RES. 362 (2009).

[7] U.S. DEP'T OF HEALTH & HUMAN SERVS., THE HEALTH CONSEQUENCES OF INVOLUNTARY EXPOSURE TO TOBACCO SMOKE: A REPORT OF THE SURGEON GENERAL AT 92 (2006), http://www.ncbi.nlm.nih.gov/books/NBK44324/pdf/Bookshelf_NBK44324.pdf.

Public Health and Tobacco Policy Center
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Involuntary exposure to SHS disproportionately burdens residents living in affordable housing.[8] For example, nonsmokers in New York City with annual incomes less than $20,000 show significantly elevated cotinine levels (a biomarker of SHS exposure) compared with higher-income groups.[9] Families who are trying to maintain a tobacco-free home in affordable housing often cannot do so solely because they happen to live in affordable housing, and are less mobile in their housing choices. On the other hand, families residing in market-rate households can afford to move away from the smoke or pay for legal representation to stop the exposure.

By narrowing areas in which smoking and e-cigarette use are detected and seen, these proposals help to continue the shift in public appreciation of the risks of tobacco use while also helping to reduce environmental cues to smoke. The perceived risk of tobacco use (increased by public smoking behavior) is a known factor driving youth initiation of tobacco use.[10] Similarly, smoking cues drive tobacco use (with low-income groups using tobacco at higher rates) and thwart cessation attempts[11] (with low-income groups less likely to successfully quit).[12]

Prohibiting smoking in City-financed and other multi-unit dwellings will reduce the risk of fire.

Beyond involuntary exposure to SHS, indoor cigarette smoking is the leading cause of fire-related deaths in U.S. homes, which kill seven people every day.[13] Fires are especially dangerous in multi-unit housing, as they can quickly spread from unit to unit.[14] In 2014 alone, 7,600 fires in the U.S. were caused by neglected cigarettes, resulting in 325 deaths, 775 injuries, and over $200 million in damage.[15]

New York City's proposal brings the City's public housing into compliance with Housing and Urban Development requirements.

In 2016, the U.S. Department of Housing and Urban Development (HUD) finalized rules that require public housing authorities to prohibit smoking in public housing units, offices and within 25 feet of entrances and exits.[16] The rule applies to interior common areas (including but not

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[8] Veronica E. Helms, Brian A. King & Peter J. Ashley, *Cigarette Smoking and Adverse Health Outcomes Among Adults Receiving Federal Housing Assistance*, 99 PREV. MED. 171 (2017).
[9] Jennifer A. Ellis et al., *Secondhand Smoke Exposure among Nonsmokers Nationally and in New York City*, 11 NICOTINE TOB. RES. 362 (2009).
[10] *See* U.S. DEP'T. OF HEALTH & HUMAN SERVS., PREVENTING TOBACCO USE AMONG YOUTH AND YOUNG ADULTS: A REPORT OF THE SURGEON GENERAL 3 (2012), https://www.ncbi.nlm.nih.gov/books/NBK99237/pdf/Bookshelf_NBK99237.pdf.
[11] TR Kirchner, et al. . . . *Geospatial Exposure to Point-of-Sale Tobacco: Real-Time Craving and Smoking-Cessation Outcomes* 45 AM. J. PREV. MEDICINE 379 (2013).
[12] Jane A. Allen et al., RTI International, Dismantling Disparities in Smoking Cessation: The New York Example (manuscript), 7, 16 (June 2015) (on file with author).
[13] Marty Ahrens, *Home Structure Fires*, NAT'L FIRE PROTECTION ASS'N (Sept. 2016), http://www.nfpa.org/news-and-research/fire-statistics-and-reports/fire-statistics/fires-by-property-type/residential/home-structure-fires.
[14] FIRE DEP'T CITY OF N.Y. FIRE SAFETY EDUC., RESIDENTIAL APARTMENT BUILDING FIRE SAFETY (Jan. 23, 2005), *available at* http://www.nyc.gov/html/fdny/pdf/safety/fire_safety_education/2010_02/07_residential_apartment_fire_safety_english.pdf.
[15] U.S. FIRE ADMIN., RESIDENTIAL BLDG. FIRE TRENDS (2005-2014) (June 2016), *available at* https://www.usfa.fema.gov/downloads/pdf/statistics/res_bldg_fire_estimates.pdf.
[16] 24 C.F.R. § 965.653 (2017).

limited to hallways, rental and administrative offices, community centers, day care centers, laundry centers, and similar structures).[17] Housing authorities have 18 months from February 2, 2017 to comply with the new rule, and the instant proposal does just that.

New York City will benefit from using a comprehensive definition for "smoking" that applies Int. No. 977 to a broader category of combustible products and aerosol devices.

New York City's proposal to prohibit smoking in City-financed housing does not cover use of aerosol products or tobacco-free shisha. This gap will permit public (non-tobacco) smoking and aerosol use in City-financed housing, and thus involuntary exposure to harmful emissions, interference with enforcement efforts, and increased perceptions of tobacco use acceptability. The City's current definition of "smoking" provided in Section 17-502 of the Administrative Code (which definition is applied through the proposal) only includes products that are "lighted" and that contain "tobacco." A more comprehensive definition, such as the one below, would address a wide and growing variety of tobacco, tobacco-like, and aerosol products not covered by the proposed law. Including aerosol and tobacco-free shisha products in the definition improves the enforceability of tobacco controls.

Adopting the following definition of smoking would close a gap in the City's proposal:

> The term "smoking" shall include the combustion, vaporization or aerosolizing of any cigarette, cigar, pipe, or other product containing any amount of tobacco or like substance, or any derivative thereof. "Smoking" includes the use of electronic aerosol delivery systems (including but not limited to devices known as electronic cigarettes, e-cigarettes, vape pens or electronic hookah). "Smoking does not include the use of tobacco cessation products that are approved by the U.S. Food and Drug Administration for that purpose.

New York City should prohibit the use of e-cigarettes in City-financed housing.

Electronic cigarettes (or "e-cigarettes") deliver nicotine to users through aerosolized liquid nicotine, rather than through burning cut tobacco leaf (like a cigarette or cigar). There are several public health reasons why the proposal to amend Section 17-503 of the administrative code should extend to e-cigarettes.

First, a growing body of scientific literature suggests that aerosol emissions from e-cigarettes could pose health risks.[18] E-cigarette emissions, which include nicotine, ultra-fine particles, and volatile organic compounds, become mixed with air and, as such, may circulate in a manner similar to tobacco smoke.[19] Some recent research has focused on the flavorings used in e-cigarettes. A widely-cited study revealed that many e-cigarette brands contain diacetyl, which is a known respiratory hazard.[20] Problems with inhaled diacetyl first occurred in popcorn factories

[17] 24 C.F.R. § 965.653(a) (2017)
[18] *See* Esteve Fernández et al., *Particulate Matter from Electronic Cigarettes and Conventional Cigarettes: a Systematic Review and Observational Study*, 2 CURRENT ENVTL. HEALTH REP. 423 (2015).
[19] *See* Tobias Schripp et al., *Does E-Cigarette Consumption Cause Passive Vaping?*, 23 INDOOR AIR 25 (2013).
[20] *See* Joseph G. Allen et al., *Flavoring Chemicals in E-Cigarettes: Diacetyl, 2,3-Pentanedione, and Acetoin in a Sample of 51 Products, Including Fruit-, Candy-, and Cocktail-Flavored E-Cigarettes*, 124

over 10 years ago, when the diacetyl in popcorn butter flavoring was released into workplace air.[21] In some cases, the exposure caused severe bronchiolitis obliterans, "an irreversible loss of pulmonary function that can become so severe that the only treatment option may be a lung transplant."[22]

Second, permitting e-cigarette use, which looks similar to using combusted products, can create confusion and complicate enforcement of the proposed smoke-free policy.[23] Further, allowing e-cigarette use may reduce perceived risks of smoking.[24] E-cigarettes are not approved for marketing as risk-reduction or cessation products, yet permissive use can imply just that. In fact, long-term population and individual health risks posed by these products are not known.[25]

New York City must prohibit hookah use in federally-financed public housing, and we encourage the City to prohibit it in all other public housing financed by the City.

Hookah is a water pipe used to smoke tobacco. Hookah tobacco, sometimes known as shisha, is very moist and usually sweetened with either molasses or fruit. Confusingly, shisha also refers to tobacco-free herbal mixtures, which is similarly used in a hookah and virtually indistinguishable from tobacco-shisha. (Also problematic, tobacco is frequently present in shisha identified as tobacco-free.[26])

Under the new HUD smoke-free rule, New York City may not exempt hookah from its proposed smoke free laws as applied to federally-financed housing. For public housing that is not federally-funded, the City should prohibit hookah use for two primary reasons.

First, the smoke generated from hookah is actually more dangerous than the smoke generated by cigarettes. Recent research has debunked the notion that hookah use is somehow safer than other tobacco use. A recent meta-analysis of 17 peer-reviewed studies found "that, compared with a single cigarette, one hookah session delivers approximately 125 times the smoke, 25

ENVTL. HEALTH PERSP. 733 (2016), *available at* http://ehp.niehs.nih.gov/wp-content/uploads/advpub/2015/12/ehp.1510185.acco.pdf.

[21] *See* Joseph G. Allen et al., *Flavoring Chemicals in E-Cigarettes: Diacetyl, 2,3-Pentanedione, and Acetoin in a Sample of 51 Products, Including Fruit-, Candy-, and Cocktail-Flavored E-Cigarettes*, 124 ENVTL. HEALTH PERSP. 733 (2016), *available at* http://ehp.niehs.nih.gov/wp-content/uploads/advpub/2015/12/ehp.1510185.acco.pdf.

[22] *See* Joseph G. Allen et al., *Flavoring Chemicals in E-Cigarettes: Diacetyl, 2,3-Pentanedione, and Acetoin in a Sample of 51 Products, Including Fruit-, Candy-, and Cocktail-Flavored E-Cigarettes*, 124 ENVTL. HEALTH PERSP. 733 (2016), *available at* http://ehp.niehs.nih.gov/wp-content/uploads/advpub/2015/12/ehp.1510185.acco.pdf.

[23] Kristy Marynak, et al., *State Laws Prohibiting Sales To Minors And Indoor Use Of Electronic Nicotine Delivery Systems—United States, November 2014*, 63 MORBIDITY & MORTALITY WKLY. 1145 (Dec. 12, 2014).

[24] *See* Kristy Marynak, et al., *State Laws Prohibiting Sales To Minors And Indoor Use Of Electronic Nicotine Delivery Systems—United States, November 2014*, 63 MORBIDITY & MORTALITY WKLY. 1145 (Dec. 12, 2014).

[25] *See*, *e.g.*, Rachel Grana et al., *E-Cigarettes: A Scientific Review*, 129 CIRCULATION 1972 (2014).

[26] An undercover sting by the New York City Health Department in 2015 caught 13 hookah bars serving tobacco-containing shisha in violation of the Clean Indoor Air Act. Erin Durkin, *City Health Department Busts 13 Hookah Bars For Violating Smoking Ban*, NY DAILY NEWS DAILY POLITICS BLOG (Jan. 7, 2015, 5:00 PM), www.nydailynews.com/ blogs/dailypolitics/city-health-department-busts-13-hookah-bars-blog-entry-1.2069318 (last visited Jan 20, 2017).

times the tar, 2.5 times the nicotine and 10 times the carbon monoxide."[27] The study also noted the increased prevalence in hookah use, suggesting that residents who are prevented from smoking cigarettes may switch to hookah.

Second, exempting hookah would make the proposed rules largely unenforceable. The smoke generated from hookah would mask the smoke generated from cigarettes and other tobacco. In fact, a resident who wants to smoke cigarettes or cigars in violation of the law would simply need to buy a cheap, small hookah device for his or her household, and claim that smoke drifting into his neighbors' homes is hookah smoke, not cigarette smoke.

NEW YORK CITY SHOULD REGULATE HOOKAH BARS IN THE INTEREST OF PUBLIC HEALTH (INT. 139-B).

New York State's Clean Indoor Air Act is insufficient to regulate hookah use in public places.

Indoor hookah use is also a problem outside of residential areas. Generally, a hookah bar cannot allow the smoking of tobacco products in its establishment. The state's Clean Indoor Air Act (CIAA) prohibits smoking in indoor public places and places of employment.[28] The law's definition of "smoking" covers burning tobacco in hookahs, but not the burning of non-tobacco shisha in hookahs.[29]

Non-tobacco hookah bars complicate enforcement of clean air laws because it is difficult for officers to determine whether the products being smoked contain tobacco or not. In fact, recent New York City enforcement activities have found that hookah bars claiming to sell non-tobacco shisha may actually be selling tobacco-containing shisha.[30] Given the difficulty in determining whether shisha is tobacco-containing or tobacco-free, and the negative health effects of using either kind,[31] New York City will benefit from incorporating hookah bars into their tobacco controls.

The proposed age restriction for entry into hookah bars will support enforcement of restrictions on sales to minors and reduce smoking cues absorbed by minors

Adolescent hookah use is increasing[32] and tobacco bars that sell shisha and permit hookah smoking are growing in popularity throughout the U.S., particularly in cities and near college

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[27] *See* Brian Primack et al., *Systematic Review and Meta-Analysis of Inhaled Toxicants from Waterpipe and Cigarette Smoking*, 131 PUBLIC HEALTH REP. 76 (2016)
[28] N.Y. PUB. HEALTH LAW § 1399-o (2017).
[29] N.Y. PUB. HEALTH LAW § 1399-n (2017)
[30] An undercover sting by the New York City Health Department in 2015 caught 13 hookah bars serving tobacco-containing shisha in violation of the Clean Indoor Air Act. City Health Department busts 13 hookah bars, NY DAILY NEWS, http://www.nydailynews.com/blogs/dailypolitics/city-health-department-busts-13-hookah-bars-blog-entry-1.2069318 (last visited Jan 20, 2017).
[31] U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, HOOKAHS, http://www.cdc.gov/tobacco/data_statistics/fact_sheets/tobacco_industry/hookahs/ (last visited June 21, 2016)
[32] U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, *Tobacco Use among Middle and High School Students—United States, 2011–2015* 65 MORBIDITY AND MORTALITY WEEKLY REPORT 361 (2016), *available at* http://www.cdc.gov/mmwr/volumes/65/wr/mm6514a1.htm?s_cid=mm6514a1_w.

campuses.[33] New York's Adolescent Tobacco Use and Prevention Act (ATUPA) prohibits the sale of shisha to persons under the age of 18 years.[34] However, adolescents and young adults are currently permitted to enter non-tobacco hookah lounges. This undermines the progress achieved by clean air laws and not only exposes youth to SHS, but also lowers the perceived risks of smoking, which is a factor in youth tobacco initiation.

CONCLUSION

In sum, New York City's proposals to prohibit smoking in all City-financed housing and common areas of all multiple dwellings will safeguard public health, and promote health equity among those most burdened by involuntary exposure to secondhand smoke in their homes. The City will benefit from expanding its definition of "smoking" to restrict emissions from hookah and other combusted and aerosol products in City-financed housing. This will reduce unwanted exposure to emissions, and also reduce confusion over compliance, and ultimately improve compliance with and enforcement of the law. The proposal to regulate non-tobacco hookah bars will advance public health by closing a critical legislative loophole and thus enhance enforcement of beneficial tobacco controls.

Thank you for the invitation to share information pertaining to these important public health proposals. Should you have any questions or concerns about the information contained in this testimony, please do not hesitate to contact me.

Sincerely,

Ilana M. Knopf, J.D.
Director

Cc: Honorable Inez D. Barron
Honorable James G. Van Bramer
Honorable Robert E. Cornegy, Jr.
Honorable Mathieu Eugene
Honorable Rafael L. Espinal, Jr.
Honorable Peter A. Koo
Honorable Rosie Mendez
Honorable James Vacca

[33] AM. LUNG ASS'N, AN EMERGING DEADLY TREND: WATERPIPE TOBACCO USE (2007), http://www.lungusa2.org/embargo/slati/Trendalert_Waterpipes.pdf (last visited Jan 12, 2017).

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tobaccopolicycenter.org

May 1, 2017

Honorable Corey D. Johnson
Chairperson
Committee on Health
New York City Council
New York City Hall
New York, New York 10007

RE: **Pro. Int. No. 1544-A: In relation to the regulation of retail dealers of tobacco of a tax on tobacco products other than cigarettes.**
Int. No. 1547: In relation to expanding the retail dealer license to include retailers of tobacco products and setting caps on retail dealer licenses.
Pro. Int. No. 1131-A: In relation to the sale of tobacco products in pharmacies.
Int. No. 1532: In relation to the licensing of electronic cigarette retail dealers.
Int. No. 1471: In relation to increasing the retail cigarette dealer license fee.

Dear Chairperson Johnson:

The Public Health and Tobacco Policy Center is a not-for-profit legal research center focused on public health law and is affiliated with Northeastern University School of Law. Through funding by the New York Department of Health, the Center provides policy education and legal technical assistance to develop, implement, and enforce policies intended to reduce tobacco-related morbidity and mortality in New York. Our support includes drafting model policies and review of applicable legal and scientific authority. It is in this capacity that we submit the following information **in support of the above referenced proposals.**

NEW YORK CITY'S PROPOSED TOBACCO SALES REGULATIONS ADDRESS FACTORS INFLUENCING TOBACCO USE – SUCH AS OUTLET DENSITY AND PRODUCT PRICE – AND WILL REDUCE TOBACCO USE, PROMOTE HEALTH EQUITY, AND SAVE LIVES.

Tobacco use remains the leading cause of preventable death in the U.S., and in New York State, and thus New York City has a legitimate interest in reducing the impact of tobacco use on its residents.

Tobacco is a unique consumer product—it is the only legal product which kills up to half its users when used exactly as the manufacturer intended.[1] Tobacco products are highly

[1] *See* Robert N. Proctor, *Why Ban The Sale Of Cigarettes? The Case for Abolition*, 22 Tob. Control i27 (Issue Suppl. 1) (2013); *see also* WORLD HEALTH ORGANIZATION, REPORT ON THE GLOBAL TOBACCO EPIDEMIC (2008), http://www.who.int/tobacco/mpower/mpower_report_tobacco_crisis_2008.pdf.

carcinogenic, highly addictive, and use is overwhelmingly initiated during adolescence.[2] Each year New York State loses over 28,000 residents due to smoking-related deaths,[3] suffers more than $7.33 billion in lost productivity,[4] and spends $10.4 billion on tobacco-related healthcare.[5]

Critical factors influencing tobacco use include exposure to product marketing, physical access to products (actual and perceived), perceptions of product acceptability and risk, product affordability (actual and perceived), and retailers' compliance with sales laws. Tobacco outlet proliferation magnifies these influences.

There are about 375,000 stores that sell cigarettes in the U.S., and each store contains an average of 30 tobacco advertisements.[6] In New York City, there are over 8,000 licensed tobacco outlets—recently as high as one for every 196 children—and this density is even higher in certain areas of the City.[7] Policy interventions can address this oversaturation and the health inequities it creates through limits on the number, location, and type of outlets allowed to sell tobacco products in NYC.

Tobacco outlet density is a factor in youth tobacco use**.**

High density of tobacco outlets (which are packed with tobacco marketing) is critical to forming early impressions of tobacco's normalcy and appeal—factors leading to eventual use.[8] The Surgeon General has concluded that tobacco marketing, including retail marketing, causes

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[2] U.S. DEP'T OF HEALTH & HUMAN SERVS., THE HEALTH CONSEQUENCES OF SMOKING: 50 YEARS OF PROGRESS: A REPORT OF THE SURGEON GENERAL (2014), https://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf

[3] N.Y. State Dep't of Health Tobacco Control Program, Smoking and Tobacco Use Cigarettes and Other Tobacco Products, https://www.health.ny.gov/prevention/tobacco_control/ (last visited March 8, 2016).

[4] Campaign for Tobacco-Free Kids, The Toll of Tobacco in New York (2016), https://www.tobaccofreekids.org/facts_issues/toll_us/new_york (last visited Apr. 27, 2017).

[5] Campaign for Tobacco-Free Kids, The Toll of Tobacco in New York (2016), https://www.tobaccofreekids.org/facts_issues/toll_us/new_york (last visited Apr. 27, 2017).

[6] Joseph G. L. Lee et al., *Inequalities in tobacco outlet density by race, ethnicity and socioeconomic status, 2012, USA: results from the ASPiRE Study*, J EPIDEMIOL COMMUNITY HEALTH, 1 (2017) *citing* CTR FOR PUBLIC HEALTH SYSTEMS SCIENCE, POINT-OF-SALE REPORT TO THE NATION: THE RETAIL AND POLICY LANDSCAPE (2014), https://cphss.wustl.edu/Products/Documents/ASPiRE_2014_ReportToTheNation.pdf (last visited Jun 28, 2016).

[7] AM. CANCER SOC'Y CANCER ACTION NETWORK, OVERSATURATED: HOW AN OVERSATURATION OF LICENSED TOBACCO RETAIL OUTLETS IN NEW YORK CITY IS IMPACTING PUBLIC HEALTH (2017), https://www.acscan.org/sites/default/files/Oversaturated%20Report%20for%20publication_0.pdf

[8] *See* U.S. DEP'T OF HEALTH AND HUMAN SERVICES, PREVENTING TOBACCO USE AMONG YOUTH AND YOUNG ADULTS: A REPORT OF THE SURGEON GENERAL 851–2 (2012) (youth and young adults more sensitive to retail advertising which make tobacco products "appear attractive and broadly acceptable"); Scott P. Novak et al., *Retail tobacco outlet density and youth cigarette smoking: a propensity-modeling approach*, 96 AM. J. PUBLIC HEALTH, 673–674 (2006); Lisa Henriksen et al., *Is adolescent smoking related to the density and proximity of tobacco outlets and retail cigarette advertising near schools?*, 47 PREV. MED, 210–214 (2008); Joanna E. Cohen & Lise Anglin, *Outlet density: a new frontier for tobacco control*, 104 ADDICTION 2–3 (2009); Sharon Lipperman-Kreda, Joel W. Grube & Karen B. Friend, *Local tobacco policy and tobacco outlet density: associations with youth smoking*, 50 J. ADOLESC. HEALTH OFF. PUBL. SOC. ADOLESC. MED. 547 (2012).

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youth tobacco initiation and progression to regular use.[9] And an abundance of retail outlets eases access to tobacco products and increases exposure to pro-tobacco messaging.[10] This is problematic for several reasons; for example, one study found that youth living in areas with the highest tobacco outlet density were 20 percent more likely to have smoked in the past month than those in areas with the lowest density.[11]

Tobacco companies prioritize their spending on controlling the retail environment.[12] Through coercive contracts with retailers, tobacco companies (over)stock their products in as many outlets as possible and flood those outlets with pro-tobacco marketing, resulting in successful recruitment of "replacement smokers" (overwhelmingly youth). At least two studies have *directly* linked higher neighborhood tobacco retailer density with higher odds of ever smoking.[13]

Tobacco outlet density hinders tobacco cessation attempts by current tobacco users.

In 2015, fewer than one in ten smokers successfully quit using tobacco in the past year, despite nearly 70 percent of smokers reporting a desire to do so.[14] Research shows that retail marketing influences current smokers to make impulse purchases of tobacco, and undermines quit attempts. For example, one study found that a third of smokers who had recently quit experienced urges to buy cigarettes after seeing retail displays, and that a quarter of current smokers purchased tobacco on impulse when shopping for other items.[15]

Tobacco outlet density is concentrated in certain communities, and likewise, quit success varies across income and education groups. In high-poverty census tracts that have more tobacco outlets, residents are less likely to succeed in quitting.[16] New York smokers with less than a high

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[9] U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 8 at 8, 487, 508; O. B. J. Carter, B. W. Mills & R. J. Donovan, *The effect of retail cigarette pack displays on unplanned purchases: results from immediate postpurchase interviews*, 18 TOB. CONTROL 218, 220 (2009); Ellen C. Feighery et al., *Cigarette advertising and promotional strategies in retail outlets: results of a statewide survey in California*, 10 TOB. CONTROL 184 (2001); Melanie Wakefield, Daniella Germain & Lisa Henriksen, *The effect of retail cigarette pack displays on impulse purchase*, 103 ADDICT. ABINGDON ENGL. 322, 325 (2008).

[10] Lisa Henriksen et al., *Is adolescent smoking related to the density and proximity of tobacco outlets and retail cigarette advertising near schools?*, 47 PREVENTIVE MEDICINE 210, 211-212 (2008).

[11] Scott P. Novak et al., *Retail tobacco outlet density and youth cigarette smoking: a propensity-modeling approach*, 96 AM. J. PUBLIC HEALTH 670, 673-674 (2006).

[12] FED. TRADE COMM'N, CIGARETTE REPORT FOR 2014 (2016); FED. TRADE COMM'N, SMOKELESS TOBACCO REPORT FOR 2014 (2016).

[13] Lisa Henriksen, et al., The Retail Environment for Tobacco, Presentation at the Emerging Science in State and Community Tobacco Control Policy and Practice Forum (May 4, 2016), *available at* https://www.eventbrite.com/e/emerging-science-in-state-and-community-tobacco-control-policy-and-practice-registration-19689007351 (last visited July 28, 2016); Lisa Henriksen et al., *Is adolescent smoking related to the density and proximity of tobacco outlets and retail cigarette advertising near schools?*, 47 PREVENTIVE MEDICINE 210 (2008).

[14] Jane A. Allen et al., RTI International, Dismantling Disparities in Smoking Cessation: The New York Example (manuscript), 7, 16 (June 2015) (on file with author).

[15] Melanie Wakefield, Daniella Germain & Lisa Henriksen, *The effect of retail cigarette pack displays on impulse purchase*, 103 ADDICT. ABINGDON ENGL. 322, 322 (2008)

[16] Jennifer Cantrell et al., *The impact of the tobacco retail outlet environment on adult cessation and differences by neighborhood poverty,* 110 ADDICTION 152, 152 (2015).

school education are 34 percent *more* likely to try to quit than better-educated smokers (but are less successful in achieving long-term cessation).[17] The result is an additional health and financial burden on a population already facing higher stress, fewer resources, and fewer opportunities—the costs of which are borne by all.

Tobacco outlet density drives tobacco use disparities.

Tobacco companies heavily market their products to socioeconomically disadvantaged communities, primarily through local stores. These communities are exposed to more tobacco retailers,[18] more prolific and prominent tobacco advertising in these stores,[19] and more frequent and steeper tobacco price discounts.[20] This proliferation of retailers and marketing contributes to growing use[21] and health[22] disparities between groups with low income or less education and their more affluent and educated peers.

While reasons for tobacco use disparities are complex, the environments in which people live and work cast a central role. An unmistakable (yet adjustable) factor is the tobacco industry's role in shaping the environment to promote tobacco use, especially environments frequented by low socioeconomic status (low-SES) populations: tobacco outlet density is higher in low-SES communities, even accounting for population density.[23] Thus low-SES populations are exposed to more retail marketing, and typically have more access tobacco products. Low-SES youth are more likely than their more affluent peers to live within walking distance of a tobacco retailer[24]

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[17] Jane A. Allen et al., RTI International, Dismantling Disparities in Smoking Cessation: The New York Example (manuscript), 16 (June 2015) (on file with author).
[18] Daniel Rodriguez et al., *Predictors of tobacco outlet density nationwide: a geographic analysis*, 22 TOBACCO CONTROL 349 (2013).
[19] Michael Barton Laws et al., *Tobacco availability and point of sale marketing in demographically contrasting districts of Massachusetts*, 11 TOBACCO CONTROL ii71–73 (2002); Elizabeth M. Barbeau et al., *Tobacco advertising in communities: associations with race and class*, 40 Preventive Medicine 16 (2005).
[20] Tess Boley-Cruz et al., *The menthol marketing mix: targeted promotions for focus communities in the United States*, 12 Nicotine & Tobacco Research S147-153 (2010).
[21] U.S. DEP'T OF HEALTH AND HUMAN SERVICES, THE HEALTH CONSEQUENCES OF SMOKING--50 YEARS OF PROGRESS: A REPORT OF THE SURGEON GENERAL 7 (2014); *see also* Brandi N. Martell, Bridgette E. Garrett & Ralph S. Caraballo, *Disparities in Adult Cigarette Smoking — United States, 2002–2005 and 2010–2013*, 65 MORB. MORTAL. WKLY. REP. 753, 753–758 (2016).
[22] PEBBLES FAGAN, HEALTH DISPARITIES IN TOBACCO SMOKING AND SMOKE EXPOSURE, HEALTH DISPARITIES IN RESPIRATORY MEDICINE 9–39 (Lynn B. Gerald & Cristine E. Berry eds., 2016), http://link.springer.com/10.1007/978-3-319-23675-9_2 (last visited Jun 15, 2016).
[23] B. R. Loomis et al., *Density of tobacco retailers and its association with sociodemographic characteristics of communities across New York*, 127 PUBLIC HEALTH 333 (2013); Yelena Ogneva-Himmelberger et al., *Using geographic information systems to compare the density of stores selling tobacco and alcohol: youth making an argument for increased regulation of the tobacco permitting process in Worcester, Massachusetts, USA*, 19 TOB. CONTROL 475 (2010); Scott P. Novak et al., *Retail tobacco outlet density and youth cigarette smoking: a propensity-modeling approach*, 96 AM. J. PUBLIC HEALTH 670, 673-674 (2006); John E. Schneider et al., *Tobacco Outlet Density and Demographics at the Tract Level of Analysis in Iowa: Implications for Environmentally Based Prevention Initiatives*, 6 Prevention Science 319 (2005); Andrew Hyland et al., *Tobacco outlet density and demographics in Erie County, New York*, 93 AMERICAN JOURNAL OF PUBLIC HEALTH 1075 (2003).
[24] Nina C. Schleicher et al., *Tobacco outlet density near home and school: Associations with smoking and norms among US teens*, 91 PREV. MED. 287, 290 (2016) ("Adjusting for teen race and ethnicity, each

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and use tobacco at higher rates.[25] The prominence of tobacco marketing in low-SES communities creates an environment which contributes to youth experimentation with tobacco products, and in which successful quit attempts are exceedingly difficult.

Policy interventions are a legitimate and necessary means to reduce tobacco use disparities. First, permitting the circumstances of someone's birth to dictate his or her health status and life-expectancy is unacceptable in a country that values self-determination.[26] Second, improving the health of underserved populations who are disproportionately burdened by tobacco use and tobacco-related disease improves the health status of all.[27] Finally, implementing strategies to improve health equity and reduce illness among those most burdened by tobacco-related disease could greatly reduce public healthcare spending.

Tobacco product affordability is a significant factor in use.

The retail price of tobacco products is a key determinant of consumption. Product price is strongly correlated with tobacco use: Higher tobacco prices lead to reduced rates of tobacco initiation, increased cessation rates, and reductions in consumption frequency and intensity among consumers continuing use.[28] This correlation is especially dramatic among price-sensitive groups, including youth and people of low SES.[29]

Tobacco companies employ discounting strategies to counter the effects of taxes or other price increases.[30] Price-sensitive populations such as youth, people trying to quit, and low-income communities are often targeted by tobacco company pricing schemes.[31]

$10K increase in household income was associated with a 7% decrease in the odds of living near a tobacco retailer.").

[25] U.S. DEP'T OF HEALTH & HUMAN SERVS., PREVENTING TOBACCO USE AMONG YOUTH AND YOUNG ADULTS: A REPORT OF THE SURGEON GENERAL 9 (2012).

[26] U.S. Declaration of Independence, para 2 (identifying the unalienable rights to Life, Liberty, and the pursuit of Happiness; see U.S. Constitution, preamble (securing the "Blessings of Liberty"); *see also* Marina Oshana, *How Much Should we Value Autonomy?*, 20 SOCIAL PHILOSOPHY & POLICY FOUNDATION 99, 99 (2003) (describing autonomy as highly valued by "liberal" persons, including those in the U.S.)

[27] LAWRENCE O. GOSTIN, LINDSAY F. WILEY & THOMAS R. FRIEDEN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 18–19 (3rd edition ed. 2016).

[28] U.S. DEP'T. HEALTH AND HUMAN SERVS., THE ECONOMICS OF TOBACCO AND TOBACCO CONTROL, 21 NATIONAL CANCER INSTITUTE TOBACCO CONTROL MONOGRAPH SERIES, Ch. 4 (2016); U.S. DEP'T OF HEALTH AND HUMAN SERVICES, REDUCING TOBACCO USE: A REPORT OF THE SURGEON GENERAL (2000); Michael Tynan et al., *Impact of Cigarette Minimum Price Laws on the Retail Price of Cigarettes in the USA,* 22(e1) TOB. CONTROL e78, e78 (2013); Frank J. Chaloupka, Kurt Straif & Maria E. Leon, *Effectiveness of tax and price policies in tobacco control*, 20 TOB. CONTROL 235 (2011).

[29] Pearl Bader, David Boisclair & Roberta Ferrence, *Effects of Tobacco Taxation and Pricing on Smoking Behavior in High Risk Populations: A Knowledge Synthesis*, 8 INT. J. ENVIRON. RES. PUBLIC. HEALTH 4118, 4118 (2011).

[30] *See* U.S. DEP'T HEALTH AND HUMAN SERVS., PREVENTING TOBACCO USE AMONG YOUTH AND YOUNG ADULTS: A REPORT OF THE SURGEON GENERAL 526-28 (2012) (explaining, tobacco companies engage in price-related marketing efforts to soften the impact of tax increases; industry price promotions are targeted in states with strong tobacco control policies other than taxes to offset the effect of those policies.

[31] *See, e.g.,* Cati G. Brown-Johnson et al., *Tobacco Industry Marketing to Low Socioeconomic Status Women in the USA*, TOBACCO CONTROL ONLINE FIRST (Jan. 21, 2014), http://tobaccocontrol.bmj.com/content/early/2014/01/21/tobaccocontrol-2013-051224.full.pdf+html.

New York City's proposed *Int. No. 1547*; *Pro. Int. No. 1131-A*; and *Int. No. 1532* will reduce tobacco outlet density, which influences residents' exposure to tobacco marketing, access to tobacco products, perceptions of product risks, and ultimate tobacco use.

Tobacco products are inherently dangerous and addictive and their sales are deserving of far more oversight as compared to other consumer products; namely, tobacco products need not be more accessible than pizza.[32] Reducing the density of tobacco outlets is a legitimate government interest and a vital component of any tobacco control program. Indeed, research shows that having to expend greater effort to find and obtain tobacco products leads to a decrease in (and cessation of[33]) tobacco use, particularly among youth.[34] Finally, outlet density can have a persistent effect on behavior over time; higher retail density is associated with higher lifetime use of tobacco by youth.[35]

New York City's proposal to license retailers of other tobacco products and reduce, over time, the number of these retailers (**Int. No. 1547**) will effectively reduce demand for tobacco products by reducing exposure to pro-tobacco marketing and the ease of product availability, while correcting misperceptions of risk associated with tobacco use.

New York City proposes to expand its cigarette dealer license to include retailers of all tobacco products while capping the number of licenses issued in each community district. Based on the evidence outlined above, the proposal will not only reduce the proliferation of tobacco outlets and the impact of that proliferation on tobacco use, but it will also promote health equity. Fewer outlets mean less exposure to tobacco marketing and more difficult access to products. Additionally, capping the number of outlets per district may reduce the disparate density of tobacco outlets in lower-SES districts.

Similar approaches have been successfully implemented in other jurisdictions, including San Francisco, CA, Philadelphia, PA, and Newburgh, NY.

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[32] AM. CANCER SOC'Y CANCER ACTION NETWORK, OVERSATURATED: HOW AN OVERSATURATION OF LICENSED TOBACCO RETAIL OUTLETS IN NEW YORK CITY IS IMPACTING PUBLIC HEALTH, 6 (2017), https://www.acscan.org/sites/default/files/Oversaturated%20Report%20for%20publication_0.pdf (identifying 3.5 times as many NYC tobacco outlets as compared to pizza vendors).

[33] Anna Pulakka et al., *Association between Distance From Home to Tobacco Outlet and Smoking Cessation and Relapse*, 176 JAMA INTERN. MED. 1512 (2016).

[34] U.S. DEP'T OF HEALTH AND HUMAN SERVICES, PREVENTING TOBACCO USE AMONG YOUTH AND YOUNG ADULTS: A REPORT OF THE SURGEON GENERAL at 523, 528 (2012); Andrew Hyland et al., *Tobacco outlet density and demographics in Erie County, New York*, 93 AM. J. PUBLIC HEALTH 1075–1076, 1075 (2003); ROBERT L. RABIN, TOBACCO CONTROL STRATEGIES: PAST EFFICACY AND FUTURE PROMISE 1762 (2008), http://papers.ssrn.com/abstract=1262529 (last visited Jul 13, 2016); *See also* B. R. Loomis et al., *Density of tobacco retailers and its association with sociodemographic characteristics of communities across New York*, 127 PUBLIC HEALTH 333, 468 (2013); John E. Schneider et al., *Tobacco Outlet Density and Demographics at the Tract Level of Analysis in Iowa: Implications for Environmentally Based Prevention Initiatives*, 6 PREV. SCI. 319, 322 (2005) (travel distance and related search costs are components of consumer net price, and have been shown to be negatively associated with the quantity consumed.").

[35] Sharon Lipperman-Kreda et al., *Tobacco outlet density, retailer cigarette sales without ID checks and enforcement of underage tobacco laws: associations with youths' cigarette smoking and beliefs*, 111 ADDICT. ABINGDON ENGL. 525 (2016).

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In 2014, San Francisco implemented a limit on tobacco retail permits that included, among other regulations, a restriction on the number of permissible tobacco outlets in each supervisorial district.[36] Specifically, the city imposed a cap of 45 permits on each of 11 districts. While existing outlets are allowed to retain their tobacco retail permit, no new permits will be issued in a supervisorial district with 45 or more tobacco outlets. Thus, the number of permits will be reduced through attrition until the cap is reached.

The new law has already had a positive effect—the total number of tobacco outlets in San Francisco decreased by 10.2 percent in the first 15 months of the ordinance's effect. The decrease was especially impactful in the supervisorial districts with the highest baseline density, which are also low-SES communities with high levels of ethnic and racial minorities.[37]

In 2017, Philadelphia, PA implemented a cap on the number of tobacco permits issued. Specifically, the city restricts the number of retail licenses in each planning district to 1 per 1,000 daytime residents.[38] Closer to home, the city of Newburgh, NY in 2014 adopted a law capping the number of tobacco outlets at the number existing six months prior to the law's enactment.[39] The law further winnows the number of tobacco outlets by issuing only one new license for every two licenses voluntarily non-renewed or revoked.[40]

Prohibiting the sale of tobacco products in pharmacies (**Pro. Int. 1131-A**) will reduce tobacco use and promote health equity by correcting misperceptions about tobacco product risks, regulating access to tobacco products and reducing the proliferation of tobacco outlets.

Restricting pharmacy sales of tobacco reduces overall tobacco retailer density, an important tobacco control strategy.

Tobacco-free pharmacy laws decrease tobacco's overall community presence and influence on tobacco use. Removing tobacco from pharmacies decreases tobacco outlet density and related factors contributing to tobacco use. Moreover, addressing pharmacy tobacco pharmacies is a key strategy in New York State; a 2011 study by the Bureau of Tobacco Control found that pharmacies allocated 56 percent more space for indoor tobacco displays than did all other tobacco retailers.[41] As previously presented, reducing tobacco retailer density reduces not only

[36] SAN FRANCISCO, CALIF. ORD. § 19H.5.
[37] Derek Smith, TOBACCO DENSITY REDUCTION FOR HEALTH EQUITY 15, 21 (2016), www.changelabsolutions.org/sites/default/files/Reduce%20Retailer%20Density_3May2016.pdf (last visited Jun 9, 2016).
[38] PHILADELPHIA, PA, BOARD OF PUBLIC HEALTH REG., REGULATION RELATING TO TOBACCO RETAILING (December 8, 2016), *available at* http://www.phila.gov/health/pdfs/TobaccoRetailingRegulation.pdf (last visited January 20, 2017).
[39] NEWBURGH, NY CODE § 276-2.
[40] NEWBURGH, NY CODE § 276-2.
[41] N.Y. STATE DEP'T OF HEALTH, 'POWER WALL' DISPLAY OF TOBACCO PRODUCTS BY NEW YORK STATE LICENSED TOBACCO RETAILERS, BUREAU OF TOBACCO CONTROL STATSHOT (Jan 2012), *available at* http://www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume5/n1_display_of_tobacco_products_by_retailers.pdf (last visited Sept 8, 2016); *see also* Akiko S. Hosler et al., *Longitudinal Trends in Tobacco Availability, Tobacco Advertising, and Ownership Changes of Food Stores, Albany, New York, 2003–2015*, 13 Preventing Chronic Disease (May 2016), www.cdc.gov/pcd/issues/2016/16_0002.htm (explaining pharmacies selling tobacco continue to exhibit displays and indoor advertising).

exposure to marketing (a key factor in youth initiation), but also reduces cues triggering cravings and hindering cessation, such as product visibility, use, and acceptability.[42]

The evidence of tobacco use reductions after pharmacy sales restrictions bears out in early research. California and Massachusetts municipalities which prohibit pharmacy tobacco sales realized relative reductions of retailer density that were 1.44 and 3.18 times greater, respectively, than communities that have not enacted such laws in those states.[43] Additionally, a recent study found a reduction of 0.14 packs purchased per smoker across *all* stores when CVS independently decided to stop selling tobacco products.[44] Other major chains have not followed CVS' lead, and 600 New York City pharmacies continue to sell tobacco products and market them alongside cessation products.[45]

Restricting pharmacy sales of tobacco corrects misperceptions about tobacco product risks.

Pharmacy tobacco sales and marketing of tobacco products in pharmacies send a mixed message about the risks of tobacco use, a factor that contributes to use rates.[46] Pharmacies market themselves as a community a health-promoting, health care resource; they now routinely act as direct healthcare providers after dramatically expanding the number and scope of their retail clinics, which provide health services such as immunizations and diabetes treatments.[47] Additionally, customers visit pharmacies to purchase medicines to treat tobacco-related diseases and to obtain assistance with tobacco product cessation. Despite pharmacies' changing role in the community, however, many continue to sell cigarettes and other tobacco products and permit the tobacco industry to market their deadly products alongside medications and smoking cessations aids: This is contradictory and detrimental to smoking cessation efforts

[42] AMERICAN HEART ASSOC, ELIMINATING THE SALE OF TOBACCO PRODUCTS IN PHARMACIES, (June 4, 2009), *available at* heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_304805.pdf (last visited Sept 8, 2016) (highlighting that removing pharmacy tobacco products denormalizes products, signals social unacceptability and has is an important influence on both initiation and quitting).
[43] Yue Jin et al., *Tobacco-Free Pharmacy Laws and Trends in Tobacco Retailer Density in California and Massachusetts*, 106 AMERICAN JOURNAL OF PUBLIC HEALTH e1, e5 (2016).
[44] J.M. Polinski, et al. *Impact of CVS Pharmacy's discontinuance of tobacco sales on cigarette purchasing (2012–2014),* 107 AM J PUBLIC HEALTH 556 (2017).
[45] AM. CANCER SOC'Y CANCER ACTION NETWORK, OVERSATURATED: HOW AN OVERSATURATION OF LICENSED TOBACCO RETAIL OUTLETS IN NEW YORK CITY IS IMPACTING PUBLIC HEALTH at 6 (2017), https://www.acscan.org/sites/default/files/Oversaturated%20Report%20for%20publication_0.pdf.
[46] *See* K. Suchanek Hudmon et al., *Tobacco Sales in Pharmacies: Time to Quit*, 15 TOBACCO CONTROL 35, 38 (2006); *see also* Mitchell H. Katz, *Banning Tobacco Sales in Pharmacies: The Right Prescription*, 300 J. AM. MED. ASS. 1451, 1451 (2008); *see also* Mitchell H. Katz, *Tobacco-Free Pharmacies: Can We Extend the Ban?,* 22 TOBACCO CONTROL 363 (2013).
[47] *See* DELOITTE, RETAIL MEDICAL CLINICS: UPDATE AND IMPLICATIONS (2009), *available at* www.openminds.com/wp-content/uploads/indres/111209shcndeloitteretail.pdf (last visited Sept 8, 2016); GBI RESEARCH, RETAIL CLINICS - 2012 YEARBOOK, *available at* http://www.gbiresearch.com/report-store/market-reports/archive/retail-clinics-2012-yearbook (last visited Sept 8, 2016) (reporting a dramatic rise in the number of national pharmacy retail clinics, and forecast expansion in scope offered services).

and public health.[48] In effect, pharmacies that sell tobacco products simultaneously sell products that cause and cure the same diseases.[49]

Pharmacy tobacco sales restrictions have been successfully implemented in other jurisdictions.

Many communities have already implemented pharmacy tobacco sales restrictions. In 2008, San Francisco became the first city in the nation to prohibit the sale of tobacco products in pharmacies. Boston, MA has prohibited tobacco sales by all pharmacies since 2009, finding that "[t]he sale of tobacco products is incompatible with the mission of health care institutions because it is detrimental to the public health and undermines efforts to educate patients on the safe and effective use of medication[.]"[50] Since then, many jurisdictions in California and Massachusetts have prohibited tobacco product sales by pharmacies,[51] and in 2017, Rockland County became the first New York jurisdiction to adopt a pharmacy tobacco sales restriction.[52]

Locally regulating e-cigarette retailers (**Int. No. 1532**) will help the City enforce youth access laws, correct misperceptions about the risk of e-cigarettes, and reduce youth initiation.

Adolescent exposure to nicotine can have serious cognitive and other health repercussions, regardless of delivery method.[53] E-cigarettes comprise the most commonly used tobacco product category among national[54] and New York[55] youth. Nearly 5 million U.S. middle and high school students reported using e-cigarettes in 2015, over twice the reported users in 2014.[56]

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[48] Mitchell H. Katz, *Banning Tobacco Sales in Pharmacies: The Right Prescription*, 300 J. AM. MED. ASS. 1451, 1451 (2008).
[49] *See* Mitchell H. Katz, *Banning Tobacco Sales in Pharmacies: The Right Prescription*, 300 J. AM. MED. ASS. 1451, 1451 (2008).
[50] *See* Boston Pub. Health Comm'n, City of Boston, Mass., Boston Public Health Commission Regulation Restricting the Sale of Tobacco Products in the City of Boston, § 3 (2008) (effective Feb. 9, 2009), *available at* http://www.bphc.org/boardofhealth/regulations/Forms%20%20Documents/regs_TobaccoRestrictionRegulation_12-11-08.pdf.
[51] MASS. MUNICIPAL ASSOC., LOCAL SUMMARY ON TOBACCO SALES BANS IN PHARMACIES at 5 (2016) (on file with author).
[52] ROCKLAND COUNTY, NY LOCAL LAW 1 of 2017.
[53] Menglu Yuan et al., *Nicotine and the adolescent brain*, 593 J. PHYSIOL. 3397 (2015).
[54] Tushar Singh et al., *Tobacco Use among Middle and High School Students — United States, 2011–2015*, 65 MORB. MORTAL. WKLY. REP. 361, 365–366 (2016); LLOYD D. JOHNSTON ET AL., MONITORING THE FUTURE NATIONAL SURVEY RESULTS ON DRUG USE, 1975-2015: OVERVIEW, KEY FINDINGS ON ADOLESCENT DRUG USE. (2016); N.Y. DEP'T. OF HEALTH, PREVALENCE OF CIGARETTE SMOKING, USE OF ELECTRONIC NICOTINE DELIVERY SYSTEMS, AND DUAL USE BY YOUTH, YOUNG ADULTS, AND ADULTS IN NYS, 2014 1 (2015), https://www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume8/n5_cigarette_ends_and_dual_use_2014.pdf.
[55] N.Y. DEP'T. OF HEALTH, PREVALENCE OF CIGARETTE SMOKING, USE OF ELECTRONIC NICOTINE DELIVERY SYSTEMS, AND DUAL USE BY YOUTH, YOUNG ADULTS, AND ADULTS IN NYS, 2014 1 (2015), www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume8/n5_cigarette_ends_and_dual_use_2014.pdf; *see* Lauren M. Dutra & Stanton A. Glantz, *Electronic Cigarettes and Conventional Cigarette Use among U.S. Adolescents: a Cross-Sectional Study*, 168 JAMA PEDIATR. 610, 615 (2014).
[56] *See* Tushar Singh et al., *Tobacco Use among Middle and High School Students — United States, 2011–2015*, 65 MORB. MORTAL. WKLY. REP. 361, 361 (2016) (reporting 4.7 million total student users in 2015); Rene Arrazola et al., *Tobacco Use among Middle and High School Students—United States, 2011–2014*, 64 Morb. Mortal. Wkly. Rep. 381 (2015).

New York State does not currently regulate who may sell e-cigarettes and similar aerosol devices, and e-cigarette outlets and product marketing are proliferating. E-cigarettes are heavily marketed (including in the retail environment) and studies confirm that e-cigarette marketing is particularly appealing to youth.[57] E-cigarette marketing contributes to the rapid rise in youth use of the products[58]

E-cigarettes are sold by traditional tobacco outlets, such as gas stations, bodegas, pharmacies, convenience stores, and supermarkets,[59] as well as in specialty "vape shops," which are proliferating across the country.[60] They are also sold in outlets where the sale of traditional tobacco products is prohibited or not tolerated, such as shopping mall kiosks and other mobile outlets. While the FDA has imposed some restrictions on e-cigarette sales (*e.g.*, prohibiting sales to minors,[61] and requiring health warnings on packaging of nicotine-containing e-liquids[62]), state and local governments may exercise their authority to fill the gaps in federal regulation and regulate product sales alongside those of conventional tobacco products.

Licensing e-cigarette retailers is an important public health initiative; retail licensing is recognized and recommended by the Institute of Medicine.[63] Licensure will ease identification of all e-cigarette vendors within the City, thereby supporting enforcement of the Adolescent Tobacco Use Prevention Act (ATUPA) which prohibits the sale of e-cigarettes to minors.[64]

Capping the number of e-cigarette vendors within the City will over time reduce the density of e-cigarette retail outlets, as well as residents' exposure to associated product marketing. In short, the proposal furthers the City's significant interest in reducing youth use of nicotine products.

New York City's proposed *Int. 1544-A* will reduce the affordability of tobacco products, increase and optimize the impact of existing tobacco taxes, and aid detection of illicit product sales—tools for reducing initiation and promoting cessation and health equity.

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[57] Alisa A. Padon, Erin K. Maloney & Joseph N. Cappella, *Youth-Targeted E-cigarette Marketing in the US*, 3 TOB. REGUL. SCI. 95, 95 (2017).
[58] Dale S. Mantey et al., *E-Cigarette Marketing Exposure Is Associated With E-Cigarette Use Among US Youth*, 58 J. ADOLESC. HEALTH OFF. PUBL. SOC. ADOLESC. MED. 686 (2016).
[59] Youn Ok Lee & Annice E. Kim, *"Vape shops" and "E-Cigarette Lounges" Open across the USA to Promote ENDS*, 24 TOB. CONTROL 410, 410 (2015); *see also* Tripp Mickle, *FDA Cloud Hangs Over Vape Shops*, WALL STREET JOURNAL, July 7, 2015, https://www.wsj.com/articles /SB10130211234592774869404581088451777513530 (last visited Jul 13, 2016).
[60] Youn Ok Lee & Annice E. Kim, *"Vape shops" and "E-Cigarette Lounges" Open across the USA to Promote ENDS*, 24 TOB. CONTROL 410, 410 (2015); *see also* Tripp Mickle, *FDA Cloud Hangs Over Vape Shops*, WALL STREET JOURNAL, July 7, 2015,https://www.wsj.com/articles/SB10130211234592774869404 581088451777513530 (last visited Jul 13, 2016); *see* PUBLIC HEALTH AND TOBACCO POLICY CENTER, E-CIGARETTES FACT SHEET, *available at* http://www.tobaccopolicycenter.org/documents/PHTPC%20e-cig%20fact %20sheet%204-5%2013%202016-01-18.pdf, 1 (2013).
[61] 21 C.F.R. §1140.14(b)(1) (2017);
[62] 21 C.F.R. §1143.3(a)(1) (2017)
[63] Institute of Medicine. *Ending the tobacco problem: a blueprint for the nation. Committee on reducing tobacco use: strategies, barriers, and consequences*. Washington, DC: National Academies Press (2007), http://www.legacyforhealth.org/content/download/571/6842/file/tobacco_final_report.pdf
[64] N.Y. Public Health Law § 1399-cc (2017).

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Lower priced products undermine the public health impact of tax increases by discouraging consumers from quitting and encouraging them to switch to similar cheaper products.[65] Lower prices and price promotions are associated with youth progression to regular smoking[66] and also make it harder for price-sensitive users to quit.[67] This proposal optimizes the public health impact of the City's current tobacco taxes by closing loopholes for reducing all tobacco products' prices below a clearly identified minimum price, and reducing price disparities between similar tobacco products, and thus opportunities for product substitution.[68] Further, the proposed price floors and packaging requirements help more easily identify illegal products and sales.[69] Enforcing existing sales laws remains an important component of the City's comprehensive tobacco control program.[70]

<u>The tobacco industry manipulates prices to avoid the positive public health impact of excise taxes and retain consumers, particularly in low-socioeconomic neighborhoods.</u>

The tobacco industry's marketing budget reveals its aggressive strategy of saturating the market with discounted tobacco products. Tobacco companies designated nearly 85 percent ($7.68 billion) of their combined 2014 marketing budget to reducing the price consumers pay for tobacco products.[71] Price promotions include direct discounts, such as coupons and multipack discounts, and also special marketing and displays associated with indirect promotions (*e.g.*, retailer and wholesaler incentive programs).[72]

Tobacco companies marketing strategies differ by neighborhood demographics. Specifically, companies more heavily advertise and offer steeper price discounts and lower prices in outlets

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65 Abraham K Brown, et al., *Trends and socioeconomic differences in roll-your-own tobacco use: Findings from the ITC Europe Surveys*; 24 Tobacco Control Suppl. 3, iii11-iii16 (2015).
66 Sandy J. Slater et al., *The impact of retail cigarette marketing practices on youth smoking uptake*, 161 ARCH. PEDIATR. ADOLESC. MED. 440, 440, 444 (2007).
67 *See* Kelvin Choi et al., *Receipt and redemption of cigarette coupons, perceptions of cigarette companies and smoking cessation*, 22 TOB. CONTROL 418, 421 (2013) (finding a negative association between use of cigarette coupons and smoking cessation); *see* Dave Sweanor et al., *Effect of cost on cessation*, SMOK. TOB. CONTROL MONOGR. NO. 12, 174 (2000) (citing evidence that cessation fell when cigarette costs fell in early 1990s as part of competition).
68 Shelley D. Golden et al., *Beyond excise taxes: a systematic review of literature on non-tax policy approaches to raising tobacco product prices*, 25 TOB. CONTROL 377, 383 (2016) (concluding "[tax] policies alone may be insufficient for maintaining high prices, or reducing price discrimination, due to industry tactics to keep at least some prices low"); PUBLIC HEALTH AND TOBACCO POLICY CENTER, TOBACCO PRODUCT PRICING IN VERMONT 9-10 (2014).
69 CTR FOR PUBLIC HEALTH SYSTEMS SCIENCE, POINT-OF-SALE REPORT TO THE NATION: THE RETAIL AND POLICY LANDSCAPE. (2014), https://cphss.wustl.edu/Products/Documents/ASPiRE_2014_ReportToTheNation.pdf (last visited May 1, 2017).
70 Centers for Disease Control and Prevention, PREVENTING AND REDUCING ILLICIT TOBACCO TRADE IN THE UNITED STATES (2016)
71 FED. TRADE COMM'N, CIGARETTE REPORT FOR 2014 (2016); FED. TRADE COMM'N, SMOKELESS TOBACCO REPORT FOR 2014 (2016).
72 FED. TRADE COMM'N, CIGARETTE REPORT FOR 2014 (2016); FED. TRADE COMM'N, SMOKELESS TOBACCO REPORT FOR 2014 (2016).

located in minority and low-income neighborhoods than in white and more affluent neighborhoods.[73]

Increased tobacco product taxes are not regressive.

Although cigarette taxes may fall most heavily on lower income smokers,[74] low income tobacco product consumers respond to a tax increase with significantly greater reductions in smoking as compared to more affluent smokers.[75] Studies show that a 10 percent increase in the price of cigarettes results in a 3-7 percent decrease in smoking among adult consumers and a 5-15 percent decrease in consumers under age 18,[76] and forecast sharper declines across price sensitive populations such as youth, young adults, women, African Americans and low-income adults.[77] While recent studies report inconsistent conclusions, numerous studies continue to find the lowest socioeconomic groups most responsive to changes in tobacco product prices, with that responsiveness decreasing as income and education levels rise.[78]

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[73] Andrew B. Seidenberg et al., *Storefront cigarette advertising differs by community demographic profile*, 24 AM. J. HEALTH PROMOT e26 (2010); Emma Dalglish et al., *Cigarette availability and price in low and high socioeconomic areas*, 37 AUST. N. Z. J. PUBLIC HEALTH 371 (2013); Jennifer Cantrell et al., *Marketing little cigars and cigarillos: advertising, price, and associations with neighborhood demographics*, 103 AM. J. PUBLIC HEALTH 1902 (2013); Elizabeth M. Barbeau et al., *Tobacco advertising in communities: associations with race and class*, 40 PREV. MED. 16 (2005); Joseph G. L. Lee et al., *A Systematic Review of Neighborhood Disparities in Point-of-Sale Tobacco Marketing*, 105 AM. J. PUBLIC HEALTH e8 (2015); Lisa Henriksen et al., *Targeted Advertising, Promotion, and Price For Menthol Cigarettes in California High School Neighborhoods*, 14 NICOTINE TOB. RES. 116 (2012).

[74] *See* Centers for Disease Control and Prevention, *Current Cigarette Smoking Among Adults in the United State* (Aug. 25, 2015), http://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/ (last visited May 1 2017) (identifying higher smoking rates among those living below poverty level than more affluent consumers).

[75] *See* Frank J. Chaloupka, Ayda Yurekli, & Geoffrey T. Fong, *Tobacco Taxes as a Tobacco Control Strategy*, 21(2) TOBACCO CONTROL 172, 175 (2012) (evidence demonstrates lower-SES populations are more responsive to price than are higher-SES populations in high-income countries like the U.S.).

[76] CHUCK MARR ET AL., CTR. ON BUDGET AND POLICY PRIORITIES, HIGHER TOBACCO TAXES CAN IMPROVE HEALTH AND RAISE REVENUE 2 (June 19, 2013) (citing U.S. CONG. BUDGET OFFICE, RAISING THE EXCISE TAX ON CIGARETTES: EFFECTS ON HEALTH AND THE FEDERAL BUDGET 8 (2012) available at http://www.cbo.gov—/sites/default/files/cbofiles/attachments/06-13-Smoking_Reduction.pdf); *see also* U.S. DEP'T OF HEALTH & HUMAN SERVS., SURGEON GENERAL'S REPORT: REDUCING TOBACCO USE 337 (2000); U.S. DEP'T. OF HEALTH & HUMAN SERVS. PREVENTING TOBACCO USE AMONG YOUTH AND YOUNG ADULTS, A REPORT OF THE SURGEON GENERAL 528, 530, 699 (2012).

[77] *See* Pearl Bader et al., *Effects of Tobacco Taxation and Pricing on Smoking Behavior in High Risk Populations: A Knowledge Synthesis*, 8 INT. J. ENVIRON. RES. PUBLIC HEALTH 4118, 4127 (2011) (concluding increasing cigarette prices through tobacco taxation is a powerful strategy for achieving major reductions in smoking among youth, young adults and persons of low socioeconomic status); Victoria M. White et al., *Cigarette Promotional Offers: Who Takes Advantage?*, 30 AM. J. PREV. MED. 228, 228, 230 (2006) (concluding tobacco industry promotional offers are particularly appealing to young adults, women, African Americans, those with higher daily consumption levels, and those worried about cigarette cost); Lisa Henrikson et al., *Targeted Advertising, Promotion, and Price For Menthol Cigarettes in California High School Neighborhoods*, 14 NICOTINE & TOBACCO RESEARCH 116, 118-119 (2012).

[78] U.S. DEP'T. HEALTH AND HUMAN SERVS., THE ECONOMICS OF TOBACCO AND TOBACCO CONTROL, 21 NATIONAL CANCER INSTITUTE TOBACCO CONTROL MONOGRAPH SERIES 575-576 (2016).

Further, reducing tobacco use among low-income populations, can help break the cyclical relationship between tobacco use and poverty: Poverty is exacerbated by increased health care costs, reduced incomes, decreased productivity, and diversion of limited resources from basic needs.[79]

Given the disparate response to tax and price increases, and the exacerbating role tobacco use has on poverty, maintaining high tobacco product prices contributes to reducing health disparities and are not "anti-poor." Still, the City would benefit by designating some portion of the City's tobacco tax revenue for programs aimed at helping low-income tobacco consumers quit. Meanwhile, policies promoting high retail prices are an important component of any tobacco "endgame" strategy.

Tax avoidance and evasion do not eliminate the health impact of higher prices; illicit tobacco sales are not justification for failing to implement policies proven to reduce tobacco use.

Evidence supports the significant impact of price increases on reducing tobacco use.[80] Tobacco products sold at a lower price through illegally circumventing federal, state and/or New York City tobacco excise taxes diminish but do not undermine public health gains earned through product price increases.[81] Further, despite protests from tobacco companies and retailers to the contrary, research demonstrates that many factors besides tobacco taxes are of equal or greater importance in determining the level of tax evasion, and that governments can raise taxes and at the same time effectively decrease tax evasion.[82]

Consistent with best practices,[83] New York City continues to aggressively curb illegal tobacco product sales occurring within the City in conjunction with implementing evidence-based policies

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[79] U.S. DEP'T. HEALTH AND HUMAN SERVS., THE ECONOMICS OF TOBACCO AND TOBACCO CONTROL, 21 NATIONAL CANCER INSTITUTE TOBACCO CONTROL MONOGRAPH SERIES (2016).

[80] Community Preventive Services Task Force, Reducing Tobacco Use and Secondhand Smoke Exposure: Interventions to Increase the Unit Price for Tobacco Products, The Community Guide, http://www.thecommunityguide.org/tobacco/increasingunitprice.html (last visited May 26, 2016). For more information about the role of price in tobacco control, see PUBLIC HEALTH AND TOBACCO POLICY CENTER, TOBACCO PRICE PROMOTION: LOCAL REGULATION OF DISCOUNT COUPONS AND CERTAIN VALUE-ADDED SALES, *available at*: www.tobaccopolicycenter.org/documents/Price%20Promotion%20Local%20Regulation%20FINAL.pdf

[81]. U.S. DEP'T. HEALTH AND HUMAN SERVS., THE ECONOMICS OF TOBACCO AND TOBACCO CONTROL, 21 NATIONAL CANCER INSTITUTE TOBACCO CONTROL MONOGRAPH SERIES, 507 (2016); Centers for Disease Control and Prevention, *Preventing and Reducing Illicit Tobacco Trade in the United States* (2015), https://www.cdc.gov/tobacco/stateandcommunity/pdfs/illicit-trade-report-121815-508tagged.pdf (last visited May 1, 2017) ("[S]ignificant increases in state and local tobacco taxes generate reductions in tobacco use and raise tobacco tax revenues for the jurisdiction, despite the tax avoidance and evasion that results from significant tax and price differentials in the United States").

[82] U.S. DEP'T. HEALTH AND HUMAN SERVS., THE ECONOMICS OF TOBACCO AND TOBACCO CONTROL, 21 NATIONAL CANCER INSTITUTE TOBACCO CONTROL MONOGRAPH SERIES (2016).

[83] Centers for Disease Control and Prevention, *Preventing and Reducing Illicit Tobacco Trade in the United States* (2015), https://www.cdc.gov/tobacco/stateandcommunity/pdfs/illicit-trade-report-121815-508tagged.pdf (last visited May 1, 2017) ("A comprehensive approach at state and local levels to curb tax evasion includes: [1] Enhancing coordination and enforcement efforts and strengthening penalties for those engaged in illicit tobacco trade. [2] Adopting a "three-legged stool" strategy comprising licensing

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that reduce consumer demand for tobacco products. In 2014 the City supplemented existing tobacco controls with "Sensible Tobacco Enforcement Policies," a comprehensive set of price- which included enhanced coordination, enforcement and penalties for tax evasion and repeat sales violations.[84] The instant package of tobacco control proposals will further enhance enforcement efforts, in part through simplifying detection of contraband by imposing minimum floor prices on additional tobacco products and expanding retail licensure (discussed below). The City will would be remiss if it failed to implement **Pro. Int. No. 1544-A**'s evidence-based approach for reducing tobacco use out of concern for unintended consequences that the city is aggressively addressing through other means.

Increasing retail license fees (*Int. No. 1471*) is integral to the City's comprehensive efforts bolster retailer compliance with tobacco control laws and combat illicit trade.

Licensing tobacco product and e-cigarette outlets allows authorities to identify and monitor individuals and businesses involved in the tobacco trade, thereby better controlling the supply chain and reducing sales of contraband through facilitating inspections and enforcement [85] The Institute of Medicine recommends that all authorized U.S. jurisdictions license tobacco retail sales outlets.[86]

Meaningful of enforcement of tobacco retails laws is costly, and the City is authorized to assess license fees to fund both the administration of the licensing system and related tobacco control enforcement efforts. The proposed fee increase is necessary to support the City's enforcement of its comprehensive retail tobacco controls. Only with adequate enforcement may the City minimize unintended consequences, such as increased sales of contraband, and realize the full public health gains these laws promote.

CONCLUSION

The proposed tobacco product sales regulations are effective tools for promoting cessation and reducing tobacco initiation and tobacco-related health disparities. The proliferation of tobacco outlets and consequent exposure to tobacco marketing disproportionately negatively impacts low-SES communities. Policies identifying and restricting the number and type of tobacco and e -cigarette outlets, while also maintaining high retail prices is a necessary and overdue next step

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and enforcement (and associated penalties) of tobacco supply and distribution chain, tax stamps, and other product markings. [3] Conducting public education. [4] Implementing policies for sale of tobacco products on tribal lands.")

[84] See N.Y.C. Admin. Code, amending §§ 17-176, 17-702, 17-704, 17-706; and adding §§ 17- 176.1 (Prohibition on the Sale of Discounted Cigarettes and Tobacco Products), 17-703.1 (Sign Required), 17-703.2 (Requirements for Retail Dealers Concerning Cigarette Tax), and 17-709.1 (Rules).

[85] Centers for Disease Control and Prevention, *Preventing and Reducing Illicit Tobacco Trade in the United States* (2015), https://www.cdc.gov/tobacco/stateandcommunity/pdfs/illicit-trade-report-121815-508tagged.pdf (last visited May 1, 2017).

[86] Institute of Medicine. *Ending the tobacco problem: a blueprint for the nation. Committee on reducing tobacco use: strategies, barriers, and consequences*. Washington, DC: National Academies Press (2007), http://www.legacyforhealth.org/content/download/571/6842/file/tobacco_final_report.pdf.

for the City and one which will especially promote health among populations most negatively impacted by tobacco company marketing and sales strategies.

Thank you for the invitation to share information pertaining to these important public health proposals. Should you have any questions or concerns about the information contained in this testimony, please do not hesitate to contact me.

Sincerely,

Ilana M. Knopf, J.D.
Director

Cc: Honorable Inez D. Barron
Honorable James G. Van Bramer
Honorable Robert E. Cornegy, Jr.
Honorable Mathieu Eugene
Honorable Rafael L. Espinal, Jr.
Honorable Peter A. Koo
Honorable Rosie Mendez
Honorable James Vacca

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card | 1532

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Jessie Alcivo

Address: 2451 Westchester Ave Bronx NY 10461

I represent: Beard Plusvape

Address: 2451 Westchester Ave Bronx NY 10461

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1532 Res. No. 2017

☑ in favor ☐ in opposition

Date: 4/27/2017

(PLEASE PRINT)

Name: Lou Ruggeri

Address: 3277 43rd St, Astoria NY 11103

I represent: NYC Vapor Alliance

Address: 3620 30th Ave, Astoria NY 11103

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Appearance Card

I intend to appear and speak on Int. No. 1532 Res. No. _____

☐ in favor ☑ in opposition

Date: _____

(PLEASE PRINT)

Name: DREW

Address: _____

I represent: NYC vaping community

Address: _____

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Need to leave at 3pm Medical

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Appearance Card

I intend to appear and speak on Int. No. 1547-A Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Elizabeth Carde

Address: 35 ST Nicholas Terrace NYC

I represent: American Cancer Society

Address: W32 ST NYC

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THE CITY OF NEW YORK

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I intend to appear and speak on Int. No. 1547 A Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Aunede Spellen

Address: 206 Weirfield ST. Brooklyn

I represent: ACS

Address: _____

Must leave by 2

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Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 1131-A

☐ in favor ☐ in opposition

Date: 4/27/2017

(PLEASE PRINT)

Name: Jennifer Polinski

Address: CVS, 400 Scenic View Dr #4036 Cumberland RI 02864

I represent: CVS Health

Address: _____

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53

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927 1532 ☑ in favor ☐ in opposition
1131 1544
1471 1547 5930

Date: _____

(PLEASE PRINT)

Name: Robin Vitale

Address: 122 E. 42nd St. 18th Fl, New York NY 10168

I represent: American Heart Association

Address: _____

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52

Appearance Card

I intend to appear and speak on Int. No. 1140 Res. No. _____

☐ in favor ☒ in opposition

Date: 4/27/2017

(PLEASE PRINT)

Name: Rebecca Shafir

Address: 68 E. Mulberry St

I represent: Mulberry Theatre

Address: 307 Spring St.

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51

Appearance Card

I intend to appear and speak on Int. No. 1140-2016 Res. No. _____

☒ in favor ☐ in opposition

Date: 4/27/2017

(PLEASE PRINT)

Name: Assemblyman David Weprin

Address: _____

I represent: 24th Assembly District - Queens

Address: _____

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1532 Res. No. _____

☐ in favor ☒ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: Spike Babajan

Address: 675 86 St #B5

I represent: New York State Vapor Association

Address: _____

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Jennifer Polinski

Address: _____

I represent: CVS

Address: _____

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Appearance Card

I intend to appear and speak on Int. No. 1547, 1544, ~~1532, 1131-2016~~ Res. No. _____

☑ in favor ☐ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: Smitha Varghese

Address: 9 Murray St NY, NY

I represent: NYPIRG

Address: same

Please complete this card and return to the Sergeant-at-Arms

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1532 Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Stewart Bowers

Address: 2088 Flatbush Ave

I represent: _____

Address: _____

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THE CITY OF NEW YORK

4b

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Michael Deitzman MD

Address: 755 West End Ave apt 9C NY 10025

I represent: Myself

Address: _____

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THE CITY OF NEW YORK

45

Appearance Card

I intend to appear and speak on Int. No. 1532 Res. No. _____

☐ in favor ☒ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: Cheryl Richter

Address: 688 Webster Ave. NR NY

I represent: New York State Vapor Assoc

Address: 1 W Chestnut

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: Kathleen Knopf

Address: DC Tobacco Policy Center

I represent: DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr. Mary Bassett, Commissioner

Address: 42-09 28th Street, CIC

I represent: DOHMH

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1044 A + OTHERS Res. No. _____

☒ in favor ☐ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: KEVIN O'FLAHERTY

Address: 1400 I STREET, NW #1200 WASHINGTON, DC 20005

I represent: CAMPAIGN FOR TOBACCO FREE KIDS

Address: SAME

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. All Bills Res. No. _____

☒ in favor ☐ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: Michael Davoli

Address: 132 W. 32nd St NY NY

I represent: American Cancer Society Cancer Action Network

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. Package Res. No. _____

☒ in favor ☐ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: Michael Seilback

Address:

I represent: American Lung Association

Address: 250 W 18th St NY NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

CHELSEA MAYOUF *Date:* _____

(PLEASE PRINT)

Name: STUDENTS & PACE U. ENVIRONMENTAL CLINIC

Address: PACE UNIVERSITY, ONE PACE PLAZA

I represent: Professor John Cronin

Address: One Pace Plaza, NY NY

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: Stan Harmon

Address: 1112 Paris Ave, Mt, NY 10528

I represent: Action on Smoking and Health

Address: Washington, D.C.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1532 Res. No. _____

☐ in favor ☒ in opposition

Date: _____

(PLEASE PRINT)

Name: Gregory Conley

Address: 231 Church Rd, Medford, NJ

I represent: American Vaping Association

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1471 1547 1532 Res. No. _____

☐ in favor ☒ in opposition

Date: _____

(PLEASE PRINT)

Name: Issam Hassan

Address: 125 67th Brooklyn, NY 11220

I represent: The Newsroom

Address: 168 7th Ave Brooklyn, NY 11215

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1547 Res. No. _____

☐ in favor ☑ in opposition

Date: _____

(PLEASE PRINT)

Name: Zaid Nagi

Address: 2445 Woodhull Ave

I represent: Yemen American merchant Ass.

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1547 Res. No. _____

☐ in favor ☑ in opposition

Date: _____

(PLEASE PRINT)

Name: SAM SHLIMAN

Address: 240 SICKLES CAFE

I represent: Retail Association

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1532 Res. No. _____

☐ in favor ☑ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: Igor Gromadskiy

Address: 393 Ave S

I represent: Nextgen Vapeshop

Address: 2417 Ave U Brooklyn, NY 11229

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1532 Res. No. _____

☐ in favor ☒ in opposition

Date: _____

(PLEASE PRINT)

Name: Michael Bowers

Address: 18 Irving Place Harrison NY

I represent: White Plains Mayors

Address: 210 Mamaroneck Ave WP NY 10601

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1398 Res. No. _____

☒ in favor ☐ in opposition

Date: 4/27/2017

(PLEASE PRINT)

Name: Josephine Beckmann

Address: CB10 819 5 Ave

I represent: Community Board Ten

Address: 819 5 Ave

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. All Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: STAN Goldstein

Address: 35-37 170 St

I represent: My self

Address: Flushing NY 11358

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: Margaret Doyle

Address: 733 Bush Dr Fair Lawn NJ 07652

I represent: Pace U. Environmental Policy Clinic

Address: 1 Pace Plaza, New York, NY 10038

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: 4/27/2017

(PLEASE PRINT)

Name: Rowan Lanning

Address: 33 Beekman st, New York NY

I represent: Pace University's Environmental Policy Clinic

Address: 1 Pace Plaza, New York, NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: Erin Mosso

Address: 125 Diamond Ave Medford NY 11954

I represent: Pace University Environmental Policy

Address: Pace Plaza New York, NY 10038

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Chelsea Malouf

Address: 241 E 24th St. APT #10

I represent: Pace University Enviromental Clinic

Address: 1 Pace Plaza

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. All Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Phyllis Goldstein

Address: 2910 Grand Cent Pkwy

I represent: Queens Tobacco Control Coal

Address: Queens NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ALL Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Phil Konigsberg

Address: 23-25 BELL BLVD BAY TERR

I represent: Queens Tobacco Control Coalition

Address: Queen NY

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. All Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Eileen Miller

Address: Bayside

I represent: Queens Tobacco Control Coal

Address: Queens NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1471, 1532, 1544 Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: MARLA TEPPER

Address: 40 WORTH Street

I represent: Public Health Solutions / NYC Smoke Free

Address: 40 Worth Street NYC

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☒ in opposition

Date: _____

(PLEASE PRINT)

Name: Lawrence West

Address: 277 Nichols Ave

I represent: 7-Eleven

Address: 60-31 Metropolitan Ave Queens 11385

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1532 Res. No. _____

☐ in favor ☒ in opposition

Date: _____

(PLEASE PRINT)

Name: Philip Roseman

Address: 76 & Grand Central Pky

I represent: The Five Ten Vape Shoppe

Address: 7232 Austin Street, Forest Hills, NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1532 Res. No. _____

☐ in favor ☑ in opposition

Date: _____

(PLEASE PRINT)

Name: Alex Clark

Address: 2003 Summit Ave Apt E Union City, NJ 07087

I represent: CASAA

Address: 4225 Fleur Dr. #189 Des Moines, IA

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1544/1547 Res. No. _____

☐ in favor ☒ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: THOMAS BRIANT

Address: 12100 SINGLETREE LANE, MINNEAPOLIS, MN

I represent: NATIONAL ASSOCIATION OF TOBACCO OUTLETS

Address: SAME AS ABOVE

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1532 Res. No. _____

☐ in favor ☒ in opposition

Date: _____

(PLEASE PRINT)

Name: Andrew Rahiman

Address: 443 W 35th Street Apt 7A NY, NY 10001

I represent: ~~Ent~~ empire City Vape

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1131, 1462, 1532, 1547 Res. No. _____

☐ in favor ☒ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: Ian Poulos

Address: 1399 Franklin Ave, ste 200 Garden City

I represent: Logic Technology Development LLC

Address: 600 College Rd East 1100 Princeton, NJ

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: Nelson Eusebio

Address: _____

I represent: National Supermarket Assoc.

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1547/1532 Res. No. _____

☐ in favor ☐ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: Jay Peltz

Address: 135 E Boston Post Rd, Mamaroneck, NY

I represent: Ford Injustice, Alliance of NYS

Address: Same

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ~~1532~~ Res. No. _____

☐ in favor ☒ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: Omar Farraj

Address: _____

I represent: Smoke Scene

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. AL Res. No. _____

☐ in favor ☒ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: Anowarul Hague

Address: _____

I represent: Times Square News

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1445 Res. No. _____

☐ in favor ☑ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: Sourin Desai

Address: 7 Eleven

I represent: 300 E. 96 Street

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1445 Res. No. _____

☐ in favor ☐ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: Larry West

Address: 79 Eleven

I represent: 66-31 Metropolitan Ave.

Address: Middle Village

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. All on Agenda Res. No. _____

☐ in favor ☑ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: Abdul Mubarez

Address: Yemeni American Merchants

I represent: Association

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 411 Res. No. _____

☐ in favor ☑ in opposition

Date: 4/27

(PLEASE PRINT)

Name: Robert S. Bookman

Address: 325 Broadway, Ste. 501, NY NY 10007

I represent: NYC Newsstand Operators Association

Address: Same as Above

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1471 Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Mithr Chadha

Address: 3508 East Tremont ave. bkny. NY 10465

I represent: Myself (7-Eleven franchisee)

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1471 Res. No. _____

☐ in favor ☑ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: Adam Cheney

Address: 111 FULTON ST NY, NY

I represent: My FRANCHISEE (7-ELEVEN)

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ALL Res. No. _____

☐ in favor ☒ in opposition

Date: 4/27/17

(PLEASE PRINT)

Name: Ramon Murphy

Address: _____

I represent: Bodega Association

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1547, 1544, 532, 1131-2016 Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Regina Lee

Address: 268 Canal St. NYC 10013

I represent: Asian American Tobacco Free Partnership

Address: 268 Canal St NYC 10013

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 139 Res. No. _____

☒ in favor ☐ in opposition

Date: 4-27-2017

(PLEASE PRINT)

Name: Deidre Sulla

Address: 40 Worth st. NYC 10013

I represent: NYC Smoke-Free

Address: 40 Worth St, 5th fl, NYC 10013

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1131A, 1547 Res. No. _____

☑ in favor ☐ in opposition

Date: 4-27-2017

(PLEASE PRINT)

Name: Patrick Kwan

Address: 40 Worth St, 5th fl, NYC 10013

I represent: NYC Smoke-Free

Address: 40 Worth St, 5th Fl NYC 10013

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 484, 977 Res. No. _____

☑ in favor ☐ in opposition

Date: 4-27-2017

(PLEASE PRINT)

Name: Lisa Spitzer

Address: 40 Worth St, 5th floor, NYC 10013

I represent: NYC Smoke-Free

Address: 40 Worth St, 5th Fl, NYC 10013

Please complete this card and return to the Sergeant-at-Arms