NLWJC - Kagan
DPC - Box 052 - Folder-013

Tobacco-Settlement: Public Health Outreach

Tob-rel-public health outreach

THE WHITE HOUSE

WASHINGTON

June 11, 1998

MEMORANDUM FOR THE CHIEF OF STAFF

FROM: Bruce Reed

SUBJECT: Meeting with ENACT

As you are aware, the ENACT Coalition is extremely concerned that the Coverdell and Gramm amendments will significantly reduce funding for the public health programs in the bill. Your goal for this meeting should be to make clear our commitment to restoring adequate funding for public health, while encouraging them to work hard over the next few days to see that the Senate passes this bill. You could say:

- The McCain bill continues to have a very strong anti-tobacco provisions: a significant price hike, full FDA jurisdiction, tough environmental smoke provisions, and very strong penalties on companies that market tobacco to children.

- We realize, though, that the votes in the last few days significantly cut into funding for the public health programs needed to reduce youth smoking -- first with the Coverdell drug amendment, and then with the Gramm tax amendment.

- We opposed these amendments, and we will work hard as the process goes forward to restore the money needed for public health programs to reduce youth smoking.

- But we also have to recognize the advantages of forward motion on this bill. We have to do everything we can over the next few days to make sure this bill passes the Senate, even though there are improvements that need to be made. After that, we can and will work hard together to ensure that the final bill contains adequate funding for public health programs in order to reduce youth smoking.

Tobacco - settlement - public health outreach

Statement of David A. Kessler, M.D.

The public health community calls upon the Congress with a united voice to enact for the first time since the 1964 Surgeon General's report effective anti-tobacco legislation.

There should be one focus and one focus only – the public's health.

The focus has to be on the public health. Tobacco legislation should not become a political football. We need to remember that this is about tobacco. This is about children and adolescents becoming addicted to a deadly product.

The focus has to be on measures that will work.

The focus has to be on raising the price of cigarettes to reduce the number of young people who smoke – not on spending the money.

Full FDA authority, a $1.50 price hike and strong measures to limit the industry's advertising and promotion are essential.

A watered down version enacted simply so Congress can say it passed anti-tobacco legislation will not be acceptable.

Given all the evidence that has come to light, it is simply not credible for Congress to grant this industry any limits on liability.

For the first time, Congress needs to enact tobacco legislation without asking the industry's permission.

There should be no concessions to this industry.

The public health community is united.

There is no light between us.

We support comprehensive anti-tobacco measures.

We oppose attempts to water that down.

We oppose granting the industry any form of immunity.

There should be no ambiguity. There should be legislation that raises the price of cigarettes enough so that there will be a real reduction in the number of young people who smoke. There should be legislation that reaffirms FDA's full authority. There should be legislation that limits the tobacco industry's practices that have proven so tragically effective in addicting generation after generation.

There should be NO settlement, NO deals.

There needs to be real anti-tobacco legislation enacted on a bipartisan basis.

PRESS CONFERENCE ON TOBACCO LEGISLATION
REMARKS BY DR. C. EVERETT KOOP, M.D., SC.D.

RAYBURN HOUSE OFFICE BUILDING, WASHINGTON, DC

FEBRUARY 17, 1998

THANK YOU FOR ASSEMBLING HERE THIS MORNING. YOU ALL ARE MOST WELCOME.

THE PRESIDENT, THE PUBLIC HEALTH COMMUNITY AND SOME FARSIGHTED, CONSCIENTIOUS MEMBERS OF CONGRESS WANT TO SEE COMPREHENSIVE, EFFECTIVE TOBACCO LEGISLATION ENACTED DURING THIS SESSION OF CONGRESS. MOST IMPORTANTLY, THE PUBLIC WANTS IT, AND SUFFERS THE CONSEQUENCES OF ITS ABSENCE. IF THERE CAN BE ONLY ONE MESSAGE THAT I WOULD LIKE CONGRESS TO HEAR TODAY, THIS IS IT.

WITH NEARLY ONE OF EVERY FIVE DEATHS CAUSED BY TOBACCO. WITH BILLIONS OF DOLLARS SPENT ON ENTIRELY PREVENTABLE TOBACCO-RELATED DISEASES AND DISABILITIES, THE PUBLIC PAYS FOR TOBACCO MANY TIMES AND IN MANY WAYS. ONLY THE TOBACCO INDUSTRY PROFITS FROM THIS HARM AND THIS WASTE OF RESOURCES AND POTENTIAL.

IN SPITE OF GROWING PUBLIC AWARENESS OF THE SERIOUS CONSEQUENCES OF TOBACCO USE, IN SPITE OF THE REVELATIONS OF HOW THE TOBACCO INDUSTRY HAS HIDDEN TRUTHS IT HAS LONG KNOWN ABOUT THE HARM THEIR PRODUCTS CAUSE, LIED WHEN CONFRONTED AND DENIED THE ACCOMPLISHMENTS OF SCIENCE AND THE PUBLIC HEALTH COMMUNITY; THE SITUATION IS GETTING WORSE. THE ILLEGAL USE OF TOBACCO, THAT IS, USE BY CHILDREN AND YOUTHS, HAS BEEN INCREASING STEADILY FOR THE PAST SEVEN YEARS. THE

DECLINE IN ADULT USE HAS STOPPED, AND BEGINNING TO RISE AGAIN IN YOUNGER ADULTS. SPIT TOBACCO AND CIGAR USE IS SKYROCKETING.

YET, WE KNOW THAT CONGRESS CAN CHANGE THAT. THE PUBLIC AT LARGE DOES NOT HAVE TO BE SACRIFICED FOR THE SPECIAL INTERESTS OF A FEW. IT ISN'T FAIR AND IT ISN'T RIGHT -- AND IT ISN'T A PARTISAN ISSUE.

EVERY CONGRESSMAN AND CONGRESS WOMAN MUST KNOW IN THEIR HEARTS THAT:

* PREVENTING NICOTINE ADDICTION BY YOUTH IS BIPARTISAN.
* PREVENTING CITIZENS FROM SUFFERING THE AGONIES OF TOBACCO-INDUCED CARDIOVASCULAR DISEASE, EMPHYSEMA, AND CANCER IS BIPATISAN.
* PROTECTING NON-SMOKERS FROM SECOND HAND SMOKE, INCLUDING CHILDREN, BEFORE AND AFTER BIRTH, IS BIPARTISAN.
* PROTECTING JUSTICE IS BIPARTISAN.
* PROTECTING STATES AND COMMUNITIES FROM PREEMPTION OF THEIR PUBLIC HEALTH LAWS IS BIPARTISAN.

THESE ARE HONORABLE ISSUES THAT WILL BE DEFENDED IN CONGRESS BY HONORABLE PEOPLE.

THE MAJORITY OF TOBACCO-CONTROL BILLS THAT HAVE BEEN PRESENTED IN CONGRESS ARE FROM THE DEMOCRATIC SIDE OF THE AISLE. ONE OF THEM, THE CONRAD BILL IS THE PRODUCT OF THE DEMOCRATIC CAUCUS. THE PRESIDENT, AND MOST OF US IN THE WORLD OF PUBLIC HEALTH, ARE ANXIOUSLY AWAITING A STRONG, COMPREHENSIVE BIPARTISAN BILL. ONE OF THOSE, STILL IN OUTLINE FORM, IS IN THE MAKING BY SENATOR CHAFEE, A REPUBLICAN, AND

SENATOR HARKIN, A DEMOCRAT.

IT DOESN'T TAKE SUPERIOR INTELLECT OR EVEN ADULTHOOD TO KNOW THAT IF A SINK IS OVERFLOWING, ONE NEEDS TO TURN OFF THE WATER BEFORE STARTING TO CLEAN UP THE MESS. THIS IS COMMON SENSE. BY THE SAME LOGIC, THE ADMINISTRATION AND PUBLIC HEALTH COMMUNITY WANTS TO CUT OFF NICOTINE ADDICTION BEFORE IT BEGINS. EVEN MANY YOUTHS WHO SMOKE WANT TO QUIT, BUT IT IS HARD TO DO AND FEW SUCCEED. NOW THAT SOME OF THE HITHERTO SECRET TOBACCO INDUSTRY DOCUMENTS REVEAL THAT THEY HAVE LONG UNDERSTOOD THAT NICOTINE IS HIGHLY ADDICTIVE, AND HAVE SYSTEMATICALLY AND CLEVERLY MARKETED THEIR PRODUCTS TO CHILDREN, THAT FOCUS IS EVEN SHARPER.

FEDERAL STATUTES MUST INCLUDE MEASURES THAT DO NOT ENCOURAGE DESIRE FOR TOBACCO BY YOUNGSTERS AND MAKE IT DIFFICULT FOR THEM TO OBTAIN IT. AND WHY NOT? THROUGHOUT THE COUNTRY TOBACCO IS AN ILLEGAL PRODUCT FOR EVERYONE UNDER THE AGE OF 18. WHAT MEASURES COMPOSE COMPREHENSIVE LEGISLATION? WHAT MEASURES ARE SOUND AND REASONABLE TO PROTECT CHILDREN AND YOUTHS?

FIRST, FEDERAL STATUTES MUST EDUCATE THE PUBLIC. THIS MUST INCLUDE REQUIRING EFFECTIVE WARNING LABELS ON PRODUCTS, FULL DISCLOSURE OF TOBACCO INGREDIENTS, EFFECTIVE CURTAILMENT OF ADVERTISING AND PROMOTIONS THAT CAN INFLUENCE CHILDREN AND YOUTH, AND, OF COURSE, HEALTH EDUCATION FOR YOUTH AND ADULTS. RESEARCH IS NEEDED TO UNDERSTAND YOUTH BEHAVIOR AND DEVELOP EFFECTIVE COUNTERMEASURES TO THE BEGUILING MESSAGES COMING FROM THE TOBACCO INDUSTRY.

SECOND, FEDERAL STATUTES MUST REDUCE YOUTH ACCESS. THIS MUST INCLUDE MAKING THE PRICE OF TOBACCO TOO COSTLY FOR YOUTH TO PURCHASE, SUBSTANTIAL PENALTIES FOR DISTRIBUTING TOBACCO PRODUCTS TO YOUTH, OTHER FINES AND ENFORCEMENT MEASURES, AND FUNDING FOR ORGANIZATIONS THAT ACT TO PROTECT YOUTH FROM TOBACCO.

THIRD, THE FDA MUST HAVE FULL REGULATING AUTHORITY OVER TOBACCO, ITS INGREDIENTS, INCLUDING NICOTINE, AND ITS ADDITIVES, AS WELL AS ANY DEVICE THAT DELIVERS NICOTINE.

FOURTH, INDIVIDUALS WHO WANT TO QUIT SHOULD BE ABLE TO RECEIVE SOUND HELP. OVER TWO-THIRDS OF ADULTS AND MANY YOUTH WANT TO QUIT, BUT FEW SUCCEED WITHOUT HELP. SUCH HELP, USING EXISTING CLINICAL PRACTICE GUIDELINES, CAN SIGNIFICANTLY INCREASE PATIENT QUIT RATES FROM THIS CHRONIC, PROGRESSIVE, RELAPSING DISEASE. THESE PREVENTIVE SERVICES HAVE BEEN SHOWN TO BE MORE COST-EFFECTIVE THAN ANY OTHER PREVENTIVE SERVICE IN TERMS OF LIVES SAVED PER DOLLAR INVESTED, AS REPORTED IN DECEMBER IN JAMA. THUS, MEDICAL FINANCING SYSTEMS SHOULD BE USED. PUBLIC AND PROFESSIONAL EDUCATION, CESSATION RESEARCH SHOULD BE FUNDED, BUT NOT BY MEANS THAT THE TOBACCO INDUSTRY COULD INFLUENCE.

FIFTH, ENVIRONMENTAL TOBACCO SMOKE MUST BE BETTER REGULATED. IN ADDITION TO A BASIC LEVEL OF PROTECTION ESTABLISHED BY FEDERAL STATUTE, INCENTIVES ARE NEEDED SO THE STATES AND COMMUNITIES CAN ESTABLISH, REFINE AND EXPAND THEIR LAWS AND REGULATIONS. PROVISIONS SHOULD INCLUDE FUNDS FOR ESTABLISHING AND ENFORCING SMOKE-FREE PUBLIC AND WORK ENVIRONMENTS, RESEARCH ON RISK-ASSESSMENT, AND

FULLER EDUCATION OF THE PUBLIC ABOUT HOW ENVIRONMENTAL TOBACCO SMOKE HARMS THEMSELVES, THEIR LOVED ONES -- ESPECIALLY THEIR CHILDREN.

SIXTH, FEDERAL STATUTES SHOULD BE WRITTEN TO SPECIFICALLY AND EXPRESSLY PREVENT FEDERAL LAW FROM OVERRIDING STRONGER AND/OR MORE DIVERSE STATE AND COMMUNITY STATUTES. FEDERAL LAW DESIGNED TO PROTECT THE PUBLIC'S HEALTH SHOULD ALWAYS BE A FLOOR THAT STATE AND LOCAL GOVERNMENTS CAN ADD TO AND STRENGTHEN. INNOVATIVE PUBLIC HEALTH MEASURES COMMONLY ARE DEVELOPED WITHIN THESE LEVELS OF GOVERNMENT.

SEVENTH, FEDERAL STATUTES MUST BE FAIR. FOR EXAMPLE, MEANS TO ENSURE THAT TOBACCO FARMERS AND THEIR LANDS ARE ABLE TO MAKE A TRANSITION TO OTHER CROPS WITHOUT BEARING UNDUE HARDSHIP. STANDARDS THAT APPLY TO TOBACCO PRODUCTS SOLD IN THIS NATION MUST BE APPLIED EQUALLY TO THOSE EXPORTED, AND TOBACCO PRODUCTS NOT GIVEN FAVOR OVER OTHER EXPORT PRODUCTS. AND, OF COURSE, THE TOBACCO INDUSTRY, EACH COMPANY, AND ALL OFFICERS, MUST BE HELD ACCOUNTABLE FOR THE HAVOC THEIR PRODUCTS HAVE WROUGHT IN THIS SOCIETY. THEY MUST NOT RECEIVE IMMUNITY FROM THE CIVIL JUSTICE SYSTEM THAT EVERY OTHER BUSINESS IS REQUIRED TO RESPECT. ANY EXCEPTION, IN ADDITION TO BEING UNJUST IN ITSELF, WOULD ESTABLISH A UNFAIR PRECEDENT FOR OTHER BUSINESSES.

YOU ARE INVITED TO TAKE DR. KESSLER AND MY STATEMENTS, THE ADVISORY COMMITTEE REPORT WHICH CONTAINS GREATER DETAIL, AND A COPY OF THE JAMA ISSUE, RELEASED JUST TODAY, THAT CONTAINS THE TWO RESEARCH

PAPERS DESCRIBED THIS MORNING AND AN EDITORIAL COVERING MANY OF THESE SAME POINTS FOR COMPREHENSIVE LEGISLATION. THE LETTER THAT MANY OF US HAVE SIGNED THIS MORNING IS ON BEHALF OF NUMBER OF PUBLIC HEALTH ORGANIZATIONS. OTHER ORGANIZATIONS THAT WERE NOT REPRESENTED ON THE ADVISORY COMMITTEE WOULD LIKE TO SIGN THE LETTER, AND THAT OPPORTUNITY WILL BE PROVIDED LATER.

IN CLOSING, FEDERAL STATUTES MUST ESTABLISH A GROUNDWORK FOR A MUCH BETTER FUTURE ACCOUNTABILITY AND CONTROL OF THE TOBACCO INDUSTRY. ITS PRODUCTS ARE TOO DANGEROUS. ITS RESPECT FOR THE LAWS OF THIS LAND TOO ABUSED. ITS HONORING OF PUBLIC TRUST TO DEFILED.

THE CONGRESS, THE MEDICAL, HEALTH AND SCIENCE PROFESSIONS, AND PUBLIC ALIKE HAVE A MORAL RESPONSIBILITY TO PREVENT UNNECESSARY DISEASE, DISABILITY AND DEATH. IT IS TIME FOR THE CONGRESS TO (1) DEVELOP COMPREHENSIVE LEGISLATION THAT DEFENDS THE PUBLIC'S HEALTH, (2) STRENGTHEN BUSINESS AND THE ECONOMY THROUGH THE PRODUCTIVITY OF A HEALTHIER POPULACE, AND (3) BRING ACCOUNTABILITY TO AN INDUSTRY THAT ERODES THE IDEALS OF THIS GREAT NATION. CHILDREN AND YOUTHS DESERVE BETTER PROTECTION. THE PUBLIC DESERVES GOOD LEGISLATION.

The Advisory Committee on Tobacco Policy and Public Health
Co-Chairs: C. Everett Koop, M.D., and David A. Kessler, M.D.

February 17, 1998

House Speaker Newt Gingrich
Senate Majority Leader Trent Lott
U.S. Congress
Washington, DC

Dear Sirs:

This year may be the most important moment in the history of the tobacco wars, a moment when America chooses between a path toward social repair or one toward irrevocable public loss. After years of growing public awareness of the addictiveness of nicotine, the adverse health effects of tobacco on users and non-smokers, and the tobacco industry's extensive efforts targeted at children and youths, the public is excited about the prospect that federal laws may be enacted that will bring about fundamental change in how the tobacco industry does business and that will save millions of lives. Conversely, there is the risk that the tobacco industry could further entrench its ability to stand outside the ordinary rules of commerce in society.

Despite all of the disclosures of tobacco industry malfeasance during the last four years, tobacco use among children is up, the long term decline in tobacco use among African-American teenage boys has been reversed, and the decline in adult rates has stopped. The need for decisive action to protect the public's health has never been greater. No one should underestimate the importance of Congress acting now and acting decisively, nor the proven ability of the tobacco industry to make a mockery of its implied ethical and moral responsibilities to society.

We the undersigned are in agreement. Our first priority is to ensure the passage of comprehensive tobacco control legislation in this session of Congress. We would hate to see a watered-down version of the public health community's standards. We are committed to evaluating any legislation in its entirety based on its overall impact on the public health.

With evidence of tobacco industry misdeeds and mendacity on hand and growing, with sound public health proposals on the table, with broad popular support for action, Congress has the opportunity to make fundamental changes in tobacco policy based solely and exclusively on what is good for the public's health without making unnecessary concessions to the tobacco industry. Only a comprehensive approach that combines the best of what we know today with a process for making change as we learn more tomorrow should be enacted.

The recent disclosure of RJR-Lorillard, Philip Morris and BAT documents confirm what the public health community has said for years, namely, that the tobacco industry aggressively attempted to market cigarettes to children and youths. Additional evidence of renegade tobacco industry behavior is beginning to emerge in the case currently being brought against the industry by the state of Minnesota and Minnesota Blue Cross and Blue Shield, as well as from other cases. For this reason, it would not be responsible public stewardship to grant immunity to this industry, especially since it has diligently tried to hook children and youths on nicotine and deny their own research findings on the harmful effects of tobacco.

The public health community is united in the type of legislation that should be enacted.
It is a condensation of recommendations stated in the *Final Report of the Advisory Committee on Tobacco Policy and Public Health*, July 1997, a document that was developed by many of the cosigners of this letter. Essential public health goals include:

1) FDA: Reaffirm that the FDA has full authority to regulate all areas of nicotine and all other constituents and ingredients in tobacco. The FDA must have authority to increase its tobacco research and scientific

communication abilities and be provided with adequate funds to implement all of its various regulatory, enforcement, public education and research activities. New, burdensome requirements placed on the FDA would be unfair and erode public health.

2) Youths: Protect children and youths from influences that create demand for or acceptance of tobacco use, and prevent their obtaining tobacco, an illegal substance for youth. Specific measures that reduce youth demand and access include:

a) Provide for a well-funded nationwide education campaign independent of tobacco industry interference.

b) Significantly increase the price of cigarettes and other tobacco products so that children and youths are discouraged from buying them. An increase of at least $1.50 per pack is a reasonable starting point. Once implemented, an independent National Academy of Science/ Institute of Medicine commission should be set to determine what additional increases will significantly reduce youth smoking.

c) Ban advertising and promotions that entice children and youths. This should be coupled with tough restrictions on youth access to tobacco products, large, strong and effective warning labels on cigarette packs and other tobacco products, necessary funds to monitor compliance, and other deterrents.

d) Levy substantial penalties for underage use. Assessments should be on a company-by-company basis if reduced youth smoking targets are not met soon, e.g., there must be specific fines at specific times for specific shortfalls from user target levels.

3) Cessation: Provide adequate funds for sound, scientifically established cessation programs to help nicotine-dependent adults and youths to quit smoking or using spit tobacco. Such programs should be integrated into health care financing systems, including managed care programs; accredited professional and public education programs; and support behavioral and cessation research.

4) ETS: Establish, refine and expand environmental tobacco smoke (ETS) laws and regulations. Authorities and appropriations should fully enforce smoke-free public and work environments and risk assessment research, and public education.

5) Justice: Protect and administer the justice system so that evidence of tobacco industry misdeeds becomes public. All legal remedies should remain available and the opportunity for individuals and groups of individuals to recover should not be diminished. It is critical, for instance, to know how companies added certain ingredients to enhance the nicotine effect for children and youths and how they used sophisticated marketing techniques to reach those same children. Only when such things are public can we make sure they never happen again.

We oppose granting the tobacco industry immunity against liability for past, present, or future misdeeds. Congress should focus its efforts on public health, not on the concessions the tobacco industry seeks. Congress should not alter the legal system in any way that would weaken its ability to protect the public health, or permit the tobacco industry or others to engage in any behavior that otherwise would be condemned. Congress must make sure that any legislation does not make it more difficult for injured citizens to exercise their fundamental right to seek just compensation for their injuries.

6) Preemption: Protect state and local governments by shielding them from federal preemption clauses that weaken, incapacitate or make onerous the ability of states and local governments to develop novel public health approaches and pursue public health standards which are higher than federal standards. Federal laws designed to protect public health should always be a "floor" that state and local governments can add to and strengthen.

7) Farmers: Adequately compensate tobacco farmers as the opportunity to sell their domestic product to manufacturers declines.

8) International: Implement strong international trade policies that use the same public health standards applied to tobacco products marketed and sold here. U.S. trade policies should reflect U.S. domestic policy; no federal funds should be spent to promote the sale of tobacco products abroad; and the U.S should take a leadership role in bringing the protections provided to Americans to all citizens of the world.

If public-health-based tobacco control measures are enacted, and the threat of litigation is not removed in the process, this nation will finally experience improvement in the public's health. Youth smoking will almost certainly begin to decline, individuals who wish to quit smoking will find the scientifically sound professional help they need (including benefiting from an increasing array of effective FDA-approved pharmacological agents) and the public will be healthier and nation stronger.

In the presence of a massive, ubiquitous, agonizing public burden -- including more than 1,100 deaths each day, strong anti-tobacco public health measures are long overdue. The public will approve of such measures and expects ethical, courageous, bold action. We urge you to heed its call.

Sincerely,

C. Everett Koop
Co-Chair

David A. Kessler
Co-Chair

Matt Myers
National Campaign
for Tobacco- Free Kids

John Garrison
American Lung
Association

John R. Seffrin
American Cancer
Society

Randolf Smoak
American Medical
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Quentin Young
American Public
Health Association

Cass Wheeler
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Maine Department
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Jeffrey A. Nesbit
Science and Public
Policy Institute

Richard A. Daynard
Tobacco Products
Liability Project

cc: House Commerce Committee Chairman Tom Bliley
House Judiciary Committee Chairman Henry Hyde
Rep. Deborah Pryce
Senator Don Nickles
Senate Commerce, Science and Transportation Committee Chairman John McCain
Senate Labor and Human Resources Committee Chairman James Jeffords
Senate Judiciary Committee Chairman Orrin Hatch
House Democratic Leader Richard Gephardt
Senate Democratic Leader Thomas Daschle
House Commerce Committee Ranking Member John Dingell
House Judiciary Committee Ranking Member John Conyers
Senate Commerce, Science and Transportation Committee Ranking Member Ernest Hollings
Senate Labor and Human Resources Committee Ranking Member Edward Kennedy
Senate Judiciary Committee Ranking Member Patrick Leahy

February 16, 1998

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The following letter was sent today to Drs. Koop and Kessler by the American Cancer Society, the American Heart Association, the American College of Chest Physicians, Partnership for Prevention and the National Center for Tobacco-Free Kids.

February 16, 1998

C. Everett Koop, M.D.
6707 Democracy Boulevard
Bethesda, Maryland 20817-1129

David Kessler, M.D.
Dean
Yale University School of Medicine
New Haven, Connecticut

Dear Dr. Koop and Dr. Kessler,

We want to thank you for your continued leadership. We have reviewed the letter that you intend to send to the Congressional Leadership and are delighted that we were able to reach agreement on a letter that will help bring the public health community together and insure that from now on the focus will be on the need to pass strong, comprehensive legislation this year.

Like you, we believe strongly that Congress has a unique opportunity this year to pass strong, comprehensive, effective tobacco control legislation. As public health organizations, we also believe that our emphasis and the first and foremost emphasis of our communications to Congress should be on urging

Congress to act to accomplish these public health goals. Only last week the Department of Treasury concluded that the enactment of legislation in accordance with the President's public health principles could reduce youth smoking by up to 46% in the next five years and save one million children now alive from a tobacco related death. The Treasury Department's conclusion mirrors the conclusion of an analysis conducted by the American Cancer Society.

We also share the goal articulated in the joint letter that the tobacco industry should not be granted immunity from wrongdoing. Litigation against the tobacco industry and other industries has been and continues to be a powerful public health tool. We will oppose any effort to alter the legal system in any way that would weaken the system's ability to protect the public health, that would permit the tobacco industry or others the freedom to operate outside of the normal legal system or to engage in any behavior that would otherwise be sanctioned, or that would effectively deny individuals the opportunity to seek just compensation for their tobacco related injuries.

We are pleased that the joint letter to Congress reflects our commitment to evaluate any legislation in its entirety, including the legislation's impact on the ability of the civil justice system to protect the public health. As public health organizations, it is only right that we base our final position on any legislation on its overall impact on the public health and its potential to reduce the number of people who become addicted to tobacco, experience tobacco related disease, and die from tobacco use.

We will only support strong, comprehensive legislation that addresses the needs of the American public and the June 20, 1997 Agreement as negotiated does not meet those criteria. We will oppose and urge the President to veto any legislation that undercuts our public health goals now or the public health community's ability to deal with unanticipated actions by the tobacco industry in the future either as the result of weak public health provisions or as the result of a broad grant of immunity to the tobacco industry.

Despite this position, it is possible that we may very well be confronted with legislation that meets our public health goals and the President's public health criteria, that includes provisions that the public health community agrees would save millions of lives by reducing tobacco use dramatically, but which also addresses the tobacco industry's liability in some limited way that does not grant the industry immunity or weaken the ability of the civil justice system to protect the public health or defend fundamental rights. Given that possibility and our commitment to the public health, we believe it would be wrong for us to take a position that would prevent us from fully evaluating such a proposal in its entirety at that time. As you are aware, we also believe it is important that we carefully articulate our views because it would be unfair to our members and members of Congress to take a position only to turn around at the end of the process and

support legislation that does not meet these criteria.

Just this past week, we evaluated a bill introduced by Senator Kent Conrad by examining its overall impact on the public health. But, the bill also includes provisions that will prevent the federal government from suing the tobacco industry to recover Medicare (and Medicaid) costs associated with tobacco-caused disease. These provisions provide a level of liability protection for the tobacco industry. But, on balance, we believe the bill offered by Senator Conrad has the potential to save millions of lives and would support its passage. We are concerned about sending a signal to the Congressional leadership that even Senator Conrad's bill is unacceptable. We are also aware that bipartisan legislation is being drafted that meets our public health criteria, but which may never see the light of day if the message we deliver does not accurately reflect our position.

Our shared goals provide the type of common ground that should permit us to work together closely. It is for that reason we are willing to work with all organizations striving to enact strong, comprehensive legislation this year.

Sincerely,

John Seffrin
American Cancer Society

Cass Wheeler
American Heart Association

D. Robert McCaffree, M.D.
American College of
Chest Physicians

Jud Richland
Partnership for
Prevention

William Novelli
National Center for
Tobacco-Free Kids

Matthew Myers
National Center for
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HUBERT H. HUMPHREY III
ATTORNEY GENERAL

STATE OF MINNESOTA

OFFICE OF THE ATTORNEY GENERAL

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Statement of Hubert Humphrey III, Attorney General of Minnesota, in Response to Letter From the Koop-Kessler Commission to Congress February 17, 1998

"Today, a united public health community put the last nail in the coffin of the tobacco industry's quest for unprecedented immunity from the laws that govern all other American businesses. For nearly a year, I have urged Congress to remember what our public health leaders have said so clearly today: the Constitution entrusts American health policy to the people and their elected representatives; and it does not give Big Tobacco a line-item veto.

"Congress does not need the permission of this outlaw industry to protect future generations from the most deadly products ever sold. All it needs is the courage to do what's right. Under the leadership of Doctors Koop and Kessler, health leaders are closing ranks to help Congress do the right thing, and to hold this outlaw industry accountable at last for its decades of denial, deception and double-talk."

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Statement of Michael Siegel, MD, MPH
Assistant Professor, Boston University School of Public Health
February 17, 1998

The question of what effect cigarette advertising has on children is an important one.

In particular, this question is central to the current Congressional debate over tobacco legislation and a possible tobacco settlement.

There are two major questions:

Does the tobacco industry specifically target youth in its cigarette marketing?

Does tobacco marketing actually cause children to start smoking?

Today, it is my pleasure to present two new studies, appearing in this week's *Journal of the American Medical Association*, that go a long way toward answering each of these questions.

Adolescent Exposure to Cigarette Advertising in Magazines

The first study, which I co-authored, is entitled "Adolescent Exposure to Cigarette Advertising in Magazines: An Evaluation of Brand-Specific Advertising in Relation to Youth Readership."

I would first like to acknowledge the work of my co-authors: Dr. Charles King of Harvard Business School, and Drs. Greg Connolly and Carolyn Celebucki of the Massachusetts Department of Public Health.

This is the first study to systematically examine the relationship between brand-specific cigarette advertising and magazine readership

The main question we asked in this study was: "Do cigarette companies specifically target youth in their magazine advertising?"

To answer this question, we looked at the top 39 U.S. magazines in 1994, and examined the relationship between the presence of advertising for different cigarette brands and the number of youth and adult readers in each magazine.

We defined youth readers as those between the ages of 12 and 17. Adult readers were those aged 18 and up.

We controlled for the total number of readers in each magazine and for the percentage of young adult readers (ages 18-24) in each magazine.
Rather than lumping all cigarette brands together, we looked separately at what we called youth cigarette brands and adult cigarette brands. Youth cigarette brands were those that are popular among youth smokers. Adult cigarette brands were those that are smoked almost exclusively by adults.

The youth brands were: Marlboro, Camel, Newport, Kool, and Winston. The adult brands were Salem, Virginia Slims, Benson & Hedges, Parliament, Merit, Capri, and Kent.

The percentage of youth readers for the 39 magazines ranged from a low of 4% (Family Circle) to a high of 34% (Sport).

The results of our analysis were striking:

Cigarette brands that are popular among youth are more likely to advertise in magazines with a higher percentage of youth readers.

In contrast, adult cigarette brands are less likely to advertise in magazines with higher levels of youth readership.

At the lowest youth readership level of 4%, youth brands are only *half as likely* as adult brands to advertise in the magazine. But at the highest youth readership level of 34%, youth brands are *5 times more likely* than adult brands to advertise in the magazine.

So what do these results mean?

This study demonstrates that cigarette companies specifically target youth in their magazine advertising.

This study adds to the growing body of evidence that the tobacco industry is marketing its deadly products to our nation's youth.

The tobacco industry has argued that it targeting young adults, the 18-24 year-old market, rather than youths. **Our study demonstrates that this is simply not the case. Cigarette companies are preferentially advertising to reach 12-17 year-old kids.**

To summarize the findings of this study:

1. **Cigarette brands that are popular among youth are more likely to advertise in magazines with a higher percentage of youth readers. Cigarette companies are preferentially advertising to reach 12-17 year-old kids.**

2. **This study demonstrates that cigarette companies specifically target youth in their magazine advertising.**

3. **This study adds to the growing body of evidence that the tobacco industry is marketing its products to our nation's youth.**

Tobacco Industry Promotion of Cigarettes and Adolescent Smoking

The second study, conducted by Dr. John Pierce, Dr. Won Choi, Elizabeth Gilpin, Dr. Arthur Farkas, and Dr. Charles Berry at the University of California, San Diego, is entitled "Tobacco Industry Promotion of Cigarettes and Adolescent Smoking." Dr. Pierce is unable to be here to present his study, but asked me to present the study for him.

This is the first longitudinal study to examine whether exposure to cigarette advertising and promotion actually causes children to start smoking.

Previous studies have shown that children who smoke are more likely to report exposure to cigarette advertising and promotion than children who don't smoke. But because these are cross-sectional studies, conducted at a single point in time, we cannot tell whether it is the advertising exposure that causes children to start smoking, or whether children who start smoking are more likely to be exposed to and recall exposure to cigarette advertising.

The advantage of a longitudinal study, in which children are followed over a period of time, is that we can tell which came first: the exposure to the advertising or the initiation of smoking.

In this study, Dr. Pierce and colleagues followed a large sample of California adolescents over a three-year period to determine which children started smoking and whether their initial exposure to cigarette advertising and promotions was related to the probability of starting to smoke.

The sample consisted of about 1,700 adolescents who were between the ages of 12 and 17 in 1993. All were nonsmokers at that time. In addition, they were not considered susceptible to start smoking, meaning that they had no intention to smoke in the future.

The adolescents were followed up, using a random-digit-dial telephone survey, in 1996.

Dr. Pierce and colleagues determined which of the adolescents had become susceptible to smoking, meaning that they now expressed a possible intention to smoke in the future. Pierce also determined which of the adolescents had experimented with smoking, meaning that they had at least a few puffs on a cigarette. Finally, Pierce determined which adolescents progressed to become established smokers, defined as those who smoked at least 100 cigarettes in their life.

In the analysis, the researchers compared the probability that adolescents became susceptible to smoking, experimented with smoking, or became established smokers for those who were and were not exposed to cigarette advertising and promotion.

Exposure to cigarette advertising and promotion was based on whether a youth was able to recall the name of the brand of a cigarette they had seen advertised, whether they had a favorite cigarette advertisement, whether they owned a tobacco promotional item, such as a cap or t-shirt, and whether they were willing to use such a promotional item if they had one.

The analysis controlled for exposure to family members and peers who smoked.

The findings of the study were as follows:

During the 3-year study period, about 17% of the adolescents became susceptible to smoking, 30% experimented with smoking, and 4% became established smokers.

Adolescents with moderate exposure to cigarette advertising and promotion were about *twice as likely* as those with minimal exposure to become susceptible to smoking, experiment with smoking, or become an established smoker.

Moderate exposure to advertising and promotion was defined as having a favorite cigarette advertisement. Thus, having a favorite cigarette advertisement doubled the risk of progression toward smoking.

Adolescents with high exposure to cigarette advertising and promotion were about *3 times more likely* than those with minimal exposure to progress toward smoking.

High exposure to advertising and promotion was defined as owning or being willing to use a tobacco promotional item. Thus, owning or being willing to use a tobacco promotional item tripled the risk of progression toward smoking.

Exposure to family and friends who smoked had only a small effect on whether these adolescents progressed toward smoking, increasing their chances by only 20%.

Cigarette advertising and promotion was the single most important factor in predicting which adolescents progressed toward smoking. Cigarette advertising and promotion was far more important than exposure to family and peers who smoked.

So what do these results mean?

This study demonstrates that exposure to cigarette advertising and promotion causes kids to start the process of becoming addicted to cigarettes.

Cigarette advertising and promotion is the single most important predictor of smoking experimentation.

Based on these findings, the authors estimate that 34% of all smoking experimentation among 12-17 year-old adolescents is caused by exposure to cigarette advertising and promotion. This means that nationally, **700,000 kids each year experiment with smoking because of their exposure to cigarette advertising and promotion**.

To summarize the findings of this study:

1. **This study demonstrates that exposure to cigarette advertising and promotion causes kids to start the process of becoming addicted to cigarettes.**

2. **Cigarette advertising and promotion is the single most important predictor of smoking experimentation.**

3. **700,000 kids each year experiment with smoking because of their exposure to cigarette advertising and promotion.**

Implications of the Study Findings for Public Health Policy

Taken together, these two studies provide strong new evidence that cigarette companies specifically target youth in their marketing and that this marketing is effective in causing kids to start the process of becoming addicted to cigarettes.

Given all of the evidence that cigarette companies deliberately recruit and addict youth smokers, it is unconscionable to even consider granting these companies immunity from wrongdoing as they are seeking in a Congressional tobacco settlement.

Tobacco - sit - public health outreach

NEXT GENERATION
CALIFORNIA TOBACCO CONTROL ALLIANCE

BR/EK
This looks pretty interesting.
TDB

September 18, 1997

Ms. Elizabeth Drye
Associate Director
Domestic Policy Council
The White House
Washington, D.C.

Tom/Bruce - anything we know about what they think? Ask Jason. Thanks. Elena

Dear Ms. Drye:

I received a copy of a letter sent to you by Suzanne Mercure from Southern California Edison dated July 21, 1997, introducing you to our new organization: The Next Generation California Tobacco Control Alliance.

As you will see, our organization is part of the Robert Wood Johnson Smokeless States Initiative. Our group has a wide range of supporters and we feel we have a power-house steering committee and thus are positioned to coordinate a California position on the proposed settlement.

In addition we have two significant private sector initiatives, including a entertainment working group, chaired by Richard Masur, President of Screen Actors Guild and includes such people as Joe Roth, Chairman of Disney. We are also planning a managed care initiative to promote smoking cessation and related assistance through our " healthy worker" program in the private sector.

VP OTUS?

We are planning a "state summit" conference on the proposed global settlement in February and would love to have President Clinton or Secretary Shalala or Mrs. Clinton serve as key-note speaker at the summit.

Let me also say that we are most pleased with President Clinton's position regarding the so-called global settlement. We will do an analysis of the President's plan as soon as we get a complete copy, and would happy to send our comments to you, for what they are worth.

Thank you for your interest in the Next Generation. I look forward to speaking with you soon.

Sincerely,

Paul J. Minicucci
Executive Director

1201 'K' Street, Room 815 Sacramento, CA 95814 Telephone (916) 552-7643
Executive Director - Paul Minicucci

Tobacco settlement - public health outreach

NATIONAL WOMEN'S LAW CENTER

Women's Legal Defense Fund

August 11, 1997

The Honorable Bruce Reed
Assistant to the President for Domestic Policy
The White House
1600 Pennsylvania Avenue, N.W.
Second Floor, West Wing
Washington, D.C. 20500

EK

Dear Mr. Reed:

The National Women's Law Center and Women's Legal Defense Fund, on behalf of the undersigned women's groups, are pleased to share with you our views on the tobacco settlement agreement. This agreement is, we believe, an important step forward in the effort to establish a meaningful national tobacco control policy, but, in its current form, fails to protect women's health in several important respects. We urge the Administration to press for a stronger agreement in these key areas:

- Restrictions on marketing and advertising should be strengthened to prevent the tobacco industry from evading the spirit of the agreement or devising other means to target their appeal to young girls.

- The FDA must have full authority to regulate tobacco and the unjustified restrictions on nicotine regulation must be lifted. Women have a tremendous stake in strong and uniform FDA standards.

- The "look back" provisions should be further to ensure that smoking among young girls drops at a pace that reflects their incidence in the current population of smokers.

- Federal law must not be allowed to pre-empt stronger and more protective state consumer protection laws. These laws have been vital to protecting women from practices injurious to their health.

- Public health funds must be designated to address the specific and unique problems of smoking among women through public education, media campaigns, cessation and other programs.

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• Address the severe restrictions on litigation that can be brought against the tobacco industry. Victims of discrimination in many contexts, women have a special concern about limitations on legal claims that can be brought to redress injustice.

• Standards for releasing previously confidential documents should be re-fashioned in order to prevent the tobacco industry from hiding from public scrutiny the materials that could be useful in helping to reduce smoking generally and among women, especially.

We believe that a tremendous opportunity exists to reduce dramatically the incidence of smoking and the influence of the tobacco industry. We urge the Task Force on the tobacco settlement to seize this opportunity and to strengthen the settlement agreement along the lines suggested above.

Thank you for considering our views.

Sincerely,

Marcia D. Greenberger
Co-President
National Women's Law Center

Judith Lichtman
President
Women's Legal Defense Fund

Comments of Women's Groups on the Settlement Agreement Between the Tobacco Industry and the States Attorney General

The National Women's Law Center and the Women's Legal Defense Fund, on behalf of themselves and the undersigned groups that are concerned about the adverse effects of smoking on women, are pleased to submit the following comments on the settlement agreement reached between the tobacco industry and the state Attorneys General. Women have a tremendous stake in the development of a comprehensive tobacco control policy that establishes a solid framework for significantly reducing smoking among women; imposes stringent controls on the tobacco industry's marketing and distribution practices, especially as they are targeted to young women; and fairly compensates women for health and other damages incurred from smoking.

While the settlement agreement reached in late June is a large and important step in that direction, and many of the provisions agreed on are far-reaching and would have been considered unattainable just several years ago, from the women's perspective the agreement as written falls short in several key respects. Discussed below are the provisions of special concern to women, and our suggestions for improving them.

Title I: Reformation of the Tobacco Industry

A. Restrictions on Marketing and Advertising

The settlement document expands the FDA Rule promulgated in August, 1996, restricting advertising and promotional activities targeting young people by banning the use of human images and cartoon characters in all tobacco advertising, banning all outdoor tobacco advertising, prohibiting payments to "glamorize" tobacco use in media appealing to minors and in other ways. We applaud these additional restrictions on advertising and promotional activities. We are concerned however, that there will still be an opportunity for tobacco companies to limit their effectiveness, and indirectly continue to appeal to young women.

The agreement limits the authority of the FDA to change these rules for five years except in "extraordinary circumstances." It is unclear what, if anything, the FDA could do if the industry evaded the spirit of the rules by promoting products not covered by the rule, such as cigars (increasingly targeted to women and young people) or pipe tobacco, or by shifting some sponsorships and promotional products from tobacco brand names to tobacco corporate names.

We are also concerned that tobacco companies will devise other means to target their appeal to young women. Our concern derives in part from the preoccupation that many young women have about weight control and their belief - whether valid or not - that smoking can help them control their weight. While the prohibition on the use of human images will help sever the connection some young women make between smoking and weight control, the industry will still be able to use other pictorial ways of depicting smoking as a means of weight control and make

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written claims about this purported benefit of smoking. Therefore, we urge the Administration to maintain FDA authority, and to refine further the advertising restrictions to ensure that the tobacco industry cannot evade the prohibitions on advertising targeted to young people.

B. Regulation of Tobacco Product Development and Manufacturing

In this section of the agreement, requirements are set out that FDA must follow in order to regulate the content of cigarettes - requirements that differ from FDA's current authority over drugs and devices. With respect to the regulation of tobacco, for 12 years, FDA is permitted to adopt performance standards that will result in lowering (but not eliminating) the amount of nicotine and other components in cigarettes, based on "substantial evidence" that changes recommended by FDA will significantly reduce health risks, are technologically feasible, and will not result in a demand for contraband products. After the 12 year period, FDA will be granted the authority to require manufacturers to eliminate nicotine, but any such action cannot become effective until two years after promulgation to permit Congressional review.

Many public health groups have decried this provision as one that must be changed substantially before they can support the agreement, and women's groups add their voices to this call as well. Women have a particular stake in nicotine regulation, in light of recent research showing that young women and girls find it harder to cut back on or quit smoking. We are strongly opposed to the provision as written for two reasons. First, we share the concern expressed by the Koop-Kessler Commission that limits on FDA authority are unjustified and unfairly limit FDA's authority over cigarettes. Second, as groups that are very concerned about a range of women's health issues, we have a tremendous stake in strong and uniform FDA standards. Giving one set of products "favorable" treatment at the FDA could open the door to lowering FDA standards or making the case for different sets of standards for other products, with women's health jeopardized in the process. Thus, it is critically important that the settlement agreement be revised to eliminate the provision limiting FDA's authority over tobacco and ensuring that at a minimum, FDA has no more limited authority in this area than it does over other drugs and devices.

Title II: "Look Back" Provisions

This section of the agreement establishes targets for reducing dramatically tobacco use by minors, sets out a process by which achievement of the target levels will be measured, and gives FDA authority to levy a fine - not to exceed $2 billion per year - if the targets are not met.

As written, the provision is a good start, but we believe it warrants strengthening in several ways. First, with adolescent women the fastest growing group of smokers in the country, we are very concerned that the targets could be met without significant reductions in smoking by young women. Thus, we suggest that specific language be added to the agreement that ensures that when the targets are met, the reductions are not disproportionately concentrated in one population group. Alternatively, the new language could spell out that in meeting the targets, reductions shown must reflect the gender and ethnic breakout of the population of smokers.

Our second concern with the "look back" section is that it only considers trends in cigarette and smokeless tobacco use. Although current use of other tobacco products, such as cigars and pipe tobacco, is small among youth, the agreement should ensure that their use does not increase.

Finally, we are concerned the penalties for non-compliance are not stiff enough to serve as an incentive to the tobacco industry to make serious efforts to meet the targets. To increase the pressure on industry to comply with the targets, we suggest removing the annual cap of $2 billion- the "surcharge" that industry must pay if targets are not met, and eliminating the 75% rebate on this surcharge that the tobacco industry would be entitled to if they could show that they had taken all reasonable measures to reduce youth smoking. Experts who have monitored the industry for many years believe that these changes are necessary to secure tobacco industry changes in their marketing and promotion practices in ways that will really make a difference, and we concur with their judgment.

Title III: Penalties and Enforcement

As negotiated, the agreement invests both the federal government, including FDA, and the states with enforcement authority. The agreement preserves state authority to adopt stricter enforcement measures in some areas - such as the regulation of environmental tobacco smoke. However, in many other areas, stronger state laws are pre-empted - thereby precluding states with stronger anti-smoking laws from enforcing them. We vigorously oppose this provision. Strong consumer protection laws - state as well as federal - have been absolutely vital in protecting women from practices injurious to their health and safety. Because of the fundamental importance of these laws to women, we cannot support giving up additional protections afforded by state laws. We urge that this provision be dropped from the agreement, during the revision process.

Title VI & VII: Programs/Funding & Public Health Funds

These sections of the agreement specify the funds that the tobacco industry must contribute to public health programs and activities, set out general terms of the payment scheme, and allocate these funds in broad categories. The total package is $368.5 billion, (over 25 years)

with $10 billion paid "up front", and annual payments adjusted for inflation made in subsequent years. The tobacco industry, however, is permitted to treat these payments as a tax deductible business expense, thus reducing the actual cost to the industry considerably.
The funds are earmarked for major public education, research, and tobacco control activities in the following way:

- $125,000,000, for the first three years, and $225,000,000 annually afterwards to HHS for public education, prevention and cessation campaigns.

- $300,000,000 annually to FDA for enforcement.

- $75,000, 000 initially - expanding to $125,000,000 annually to fund state and local tobacco control programs.

- $100,000,000 annually to fund research and related activities to discourage smoking and help people quit.

- $75,000,000 annually for ten years to compensate events, teams and other activities sponsored by the tobacco industry.

As groups concerned about women's health, we are extremely pleased to see significant sums of money earmarked for a combination of efforts - state and local, research and programmatic, public education and enforcement - designed to reduce dramatically tobacco use in all population sectors and the influence of the tobacco industry in our society. The availability of substantial funds for a 25 year period to promote public health is, for groups concerned about women's health, a key piece of the settlement agreement. There are ways however, that these provisions could be refined to ensure that the specific and unique problems that smoking poses for women are addressed. We urge the Administration to improve on this important section in the following ways.

1) The agreement makes passing reference to the need for public health activities to "take into account the needs of particular populations", but does not go beyond that in specifying those particular populations or their unique needs. We urge that the agreement be amended to state that needs of women and minorities be given special recognition in each category of public health expenditures, and where appropriate, the unique needs of women and minorities be defined and accommodated.

2) In the section allocating funds for research and development of methods to discourage people from smoking or helping them stop, funds must be earmarked to address the issues around tobacco dependence and weight control that figure prominently for some women.

3) The public education campaigns which are funded at both the state and local and national levels should be cognizant of the fact that children's views and values are strongly influenced by their parents. It would be appropriate therefore, for some of the public education efforts to take a family centered approach to reaching children. Programs developed by school boards and school based clinics are logical places for this "family centered " approach, and WIC and other health facilities could promote a maternal and child health approach.

4) The agreement should specify that smoking cessation programs must be specifically targeted to address the needs and health concerns of women and minorities.

5) The various boards and commissions set up by the settlement agreement must include women's health and minority health representatives to help ensure that health, education and other expenditures reach these communities and are appropriately targeted.

On the overall issue of the payment level by the tobacco industry, we are very troubled by the windfall which the tobacco industry received in the Budget Reconciliation Agreement. Under terms negotiated as part of the agreement to increase the tobacco tax to fund health insurance for uninsured children, the tobacco industry secured a provision that allows the tobacco tax increase to count as credit towards the tobacco industry's payment for public health programs required by the settlement agreement. This provision reducing the payment required by the tobacco industry was obtained beyond the settlement table and must not be allowed to stand. We strongly urge the Administration to press for a sizeable increase in funds that the tobacco industry must contribute to public health and education programs - an increase that is at least commensurate with the relief received by the industry in the Budget Agreement, and more if possible.

Title VIII: Civil Liability

The provisions in this title severely limit litigation that can be brought against the tobacco industry. All pending Attorney General and governmental and class action lawsuits are settled; in the future no class action lawsuits may be brought, although individual lawsuits will be permitted; all pending punitive damages claims are resolved by the settlement and punitive damages in future cases are banned; and the industry's annual tort liability is capped at $5 billion - if judgments exceed that amount in any year they will be rolled over and paid out the following year.

These severe limits on future litigation raise serious questions. Class action suits, although not used frequently, have been an extremely important vehicle in protecting women's health. Moreover, artificial caps on relief can work a hardship on individual women's recovery of damages they have suffered, as well as diminish incentives on the part of the tobacco industry to avoid future harm. Thus, we urge the Administration to address these limitations in order to give women who bring claims against the tobacco industry a chance for the kind of relief that they are entitled to under current law.

Appendix VIII, Disclosure of Documents

Appendix VIII of the agreement requires that some previously confidential documents from the files of the tobacco industry - including the results of health research, are fully disclosed to the public, litigants, health officials and others. However, there are two significant problems with the provision. It appears that the only existing documents that must be placed in the document depository are those which have been produced, or must be produced, in certain specified legal actions. And, even as to those documents, there is a glaring loophole: for "privileged and trade secret documents." The industry can continue to hide from public view and scrutiny documents in this category, including materials in which companies acknowledge the health risks and hazards of tobacco.

The strong resistance that the industry has demonstrated to producing documents indicates that it is likely to use this category to shield documents containing important research and marketing strategies - the very kind of information that will be most helpful to public health and other leaders trying to fashion anti-smoking programs and messages. Precisely because the tobacco industry has had such success in marketing to women and increasing the number of women smokers, we are very concerned that the "privileged and trade secret documents" loophole will allow industry to continue to hide information that will be especially useful in the effort to reduce smoking among women. Indeed, it may be difficult to undertake a serious and effective anti-tobacco campaign targeted to women without the "inside " information currently in the possession of the tobacco industry. Thus, we urge the Administration to refashion this provision in such a manner that requires the tobacco industry to release documents that provide insight into the health consequences of smoking and the appeal that tobacco has to various groups in the population. These disclosures could be critical to the ultimate efficacy of the public education programs.

Additional Issues

International Tobacco Control

The settlement agreement is silent on obligations which apply outside of the United States. It is unfortunate that international issues are not addressed because the growing number of smokers is a special problem in developing countries where poverty and inadequate health facilities compound the problems of smoking. In these settings, women are a ready-made target for the tobacco companies, because their smoking rates are often much lower than men's, but as they move into positions of greater equality with men, they will be ripe for the same kinds of appeals that the tobacco companies made to women in this country as their status improved.

* * * *

While the agreement would certainly be more comprehensive if some effort had been made to limit the tobacco industry's vigorous marketing and promotional efforts overseas, this omission underscores an important overall observation about this settlement agreement: it is a first step in a critically important process of reducing tobacco consumption and the influence of tobacco products, but warrants re-working and strengthening in several critical areas. When the concerns outlined above are addressed, women can have more confidence that significant reductions in smoking will result and that the smoking-related health hazards that they suffer will decrease dramatically as the provisions of this important settlement agreement are implemented.

Submitted by:

American Medical Women's Association
American Association of University Women
American College of Nurse-Midwives
Center for Women's Policy Studies
National Asian Women's Health Organization
National Black Women's Health Project
National Women's Law Center
Society of Advancement of Women's Health Research
Women's Legal Defense Fund

Tobacco settlement - public health outreach

CAMPAIGN for TOBACCO-FREE Kids

NATIONAL CENTER FOR TOBACCO-FREE KIDS

TO: Bruce Reed, Elena Kagan
456-2878

FROM: Matthew Myers
Executive Vice President and General Counsel

DATE: August 8, 1997

SUBJECT: Two items

Two items :

1) I am heading off on vacation for a couple of weeks. If I can be of help as you move forward on the tobacco agreement in my absence, do not hesitate to contact me. I am enclosing my itinerary while I am gone.

2) Today eleven major public health groups, including the American Medical Association, the American Cancer Society, the American Heart Association, the American College of Preventive Medicine, the Partnership for Prevention, The American Academy of Pediatrics, the American College of Chest Physicians, the American Academy of Family Physicians, The Association of State and Territorial Health Officials, and the National Center for Tobacco Free Kids met.

The good news is that there was broad support and agreement for the position that the tobacco Agreement presents a very important opportunity that must be seized. While no one supports the agreement exactly as written, everyone supported building on the agreement to bring about major public health change. Improving the FDA and penalty sections of the Look Back provision were everyone's top priorities. The group also agreed to work together to urge the White House to move forward and to strengthen the agreement. If this occurs, they agreed to work for its passage.

WH: Office
Myers

ALASKA ITINERARY 1997

Saturday, August 9, 1997
Anchorage: Voyager Hotel 1-800-247-9070
501 K St.
Sunday, August 10, 1997
Homer: Lands End Resort 1-907-235-2500
4786 Homer Spit Road.
Monday, August 11, 1997
Homer: Lands End Resort
Tuesday, August 12, 1997
Cooper Landing: Kenai Princess Lodge 1-800-426-0500
Bean Creek Road.
Wednesday, August 13, 1997
Cooper Landing: Kenai Princess Lodge
Thursday, August 14, 1997
Seward: Best Western Hotel Seward 1-907-224-BEST
221 Fifth Ave.
Friday, August 15, 1997
Seward: Best Western Hotel Seward

**KENAI FJORDS NATIONAL PARK TOUR 1-800-478-8068
Four (4) adults booked for 8.5 hour tour, includes lunch on Fox Island. Leaves Seward at 10 a.m.; Returns at 6:30 p.m.

Saturday, August 16, 1997
Anchorage: Voyager Hotel

**Train to Denali National Park

Sunday, August 17, 1997
Denali Park Entrance: McKinley Chalet Resort 1-800-276-7234
Mile 238.9 George Parks Hwy.
Monday, August 18 through Thursday, August 21, 1997
Camp Denali: Denali National Preserve near Kantishna
1-907-683-2290

**Train to Anchorage

Friday, August 22, 1997
Anchorage: West Coast International Inn 1-800-544-0986
3333 International Airport Rd.

Attendees
Building Consensus Meeting
August 8, 1997

American Academy of Family Physicians

Neil Brooks, MD
President-Elect

Susan Hildebrandt
Assistant Director of WDC Office

Jacqelyn Admire
Assistant Director
Scientific Activities Division

American Academy of Pediatrics

Michael Weitzman, MD
Member, AAP Tobacco Work Group
Chair, AAP Committee on Community Health Services

Elaine Holland
Assistant Director,
Department of Government Liaison

American Cancer Society

Harmon Eyre, MD
Executive Vice-President for Research and Cancer Control

Linda Crawford
National Vice President for State and Federal Government Relations

Susan Polan, PhD
Director of Government Relations

American College of Chest Physicians

Alvin Lever
CEO and Executive Vice President

Lynne Marcus
Vice President of Public Affairs and Membership

Ray Cotton, Esq.
Legislative Counsel

American College of Preventive Medicine

Jonathan Fielding, MD
President

Suzanne Leous
Director of Public Affairs

American Heart Association

Dudley Hafner
Executive Vice President

Brigid McHugh Sanner
Senior Vice President
Communications and Advocacy

Diane Canova
Vice President
Office of Public Advocacy

Richard Hamburg
Legislative Regulatory Representative
Office of Public Advocacy

American Medical Association

Randolph Smoak, MD
Vice-Chairman of the Board of Trustees

Tom Houston, MD
Director, Dept. of Preventive Medicine and Public Health

Margaret Garikes
Asst. Director for Federal Affairs

Mike Chapman
Asst. Director of Congressional Affairs

Mike Ile, Esq.
Counsel

Association of State and Territorial Health Officials

Marty Wasserman, MD, JD
Chair, Prevention Policy Committee
Secretary of Health and Mental Hygiene,
Maryland Department of Health and Mental Hygiene

Jane Moore
Associate Director of Prevention Policy

Campaign for Tobacco-Free Kids

Bill Novelli
President

Matt Myers, Esq.
Executive Vice President and CEO

Patricia Sosa, Esq.
Director, Constituency Relations

Kay Kahler Vose
Director, Communications

Anne Ford, MPH
Manager, Federal Relations

National Association of Country and City Health Officials

Nancy Rawding
Executive Director

Donna Grossman, JD
Director of Government Affairs

Partnership For Prevention

Jonathan Fielding, MD
Vice Chair, Board of Directors

Jordan H. Richland, MPA
Executive Director

Tobacco settlement – public health outreach

ACPM
American College of Preventive Medicine

Leadership in the Science, Policy and Practice of Preventive Medicine

AMERICAN COLLEGE OF PREVENTIVE MEDICINE

Position on the Agreement Between the State Attorneys General and the Tobacco Industry

Introduction

The settlement reached between the state Attorneys General and the tobacco industry on June 20, 1997, contains substantial public health advances, unimaginable even a few years ago. Provisions for public health education, improved health warnings and innovative financial penalties if tobacco use among children doesn't decrease, are of special note. The settlement proposal includes very substantial industry concessions; concerns for weaknesses in the settlement should be seen in the context of considerable progress towards achieving critical public health goals, most especially reducing tobacco use primarily among young people but also in the adult population.

Nonetheless, the public health and prevention community has been chastened by the disappointing results of prior negotiations with the tobacco industry and the industry's voluntary codes in the United States and other countries over tobacco advertising and promotion. It is therefore critical to approach the proposed settlement with caution and healthy skepticism, while, at the same time, remaining cognizant of the substantial gains it represents.

The American College of Preventive Medicine (ACPM), the national medical society of physicians whose primary interest and expertise are in disease prevention and health promotion, believes that the following criteria must be met in any settlement between the state Attorneys General and the tobacco industry:

- Reduction of tobacco use primarily among youth as well as the adult population
- Economic incentives sufficient to change industry behavior to support reduction in youth smoking
- Full jurisdiction over tobacco products by the Food and Drug Administration
- Commitment to international concerns
- Greatly increased advertising and promotion restrictions

Having reviewed the proposed settlement and having participated actively in the Koop-Kessler Advisory Committee on Tobacco Policy and Public Health, the American College of Preventive Medicine supports a modified settlement agreement reflecting adherence to the criteria outlined above. A modified agreement offers an extremely important opportunity to substantially reduce tobacco use. In reaching this position of conditional support, ACPM has carefully examined the key questions of timing and likelihood of the current settlement leading to reduction in tobacco consumption, and has developed a list

of essential modifications. Constructive changes to the proposed settlement strongly increase the likelihood of long-term progressive public health benefits. However, without stronger FDA provisions and increased penalties and without an absolute commitment to address international concerns, ACPM cannot support a settlement.

Timing

ACPM has carefully examined whether or not a delay in reaching the settlement in order to further strengthen an agreement would be beneficial. Further disclosure of serious breach of public confidence is almost certain in the absence or presence of a settlement. However, more disclosures are only beneficial if they lead to a better results from a public health viewpoint.

Victory in the first few Attorney General suits could increase leverage for a "better" settlement that might incorporate other improvements such as a total ban on advertising and promotion and removing the severe constraints to effective FDA regulation of tobacco products.

However, victory in the trials is not assured, and a negative result in one or more of these could increase the bargaining power of the industry. A significant delay will lead to more children becoming addicted than if there is a settlement now that leads to reductions in tobacco use among youth in the near future.

Another potential advantage of waiting is the likelihood that loss of some of the state and class action suits will impair the financial viability of the tobacco companies, perhaps driving them to seek protection under Chapter 11. However, insofar as there are 46 million smokers in the United States addicted to tobacco products, demand will not be eliminated by industry bankruptcy. More important, this scenario will not provide funding for the public health anti-tobacco activities, many of which are of proven effectiveness in reducing tobacco consumption.

Current agreement

Even in the absence of needed changes in the agreement, it appears likely that a significant reduction in tobacco use would be achieved under the current settlement terms:

- The industry will have to significantly raise prices to pay for the settlement, and consumption is sensitive to price increases, with the greatest impact on youth.
- A well-funded enforcement campaign can lead to a reduction in smoking. Experience in California and Massachusetts has shown that a high intensity multi-media anti-tobacco campaign, particularly among adults but also among youth, does just that.
- The more stringent physical barriers to access such as elimination of vending machines and the national licensing of vendors are likely to reduce youth access to some degree.

More difficult to assess is whether the reduction in consumption is likely to continue and ultimately lead to a voluntary non-smoking society, or whether progress will stop and reverse, with the incidence of new smokers rising, as it has in recent years. There is no guarantee of long-term success, however, under any settlement that permits the sale of tobacco products. Perpetual funding by the industry for media anti-tobacco campaigns, for anti-tobacco advocacy organizations, and for federal, state, and local enforcement of FDA regulations increases confidence that progress can be sustained.

Needed Changes

A serious concern for ACPM about the proposed settlement is the asymmetry that the principal tobacco

economic survival will definitely be achieved while attaining the public health goal of ed tobacco consumption is not assured. Reflecting the concern that public health and medicine interests were not fully represented in the negotiations, ACPM recommends that the ng changes and improvements must be sought to further increase public health benefits that can nably be expected from implementation of the settlement.

1. **FDA:** The FDA must have the authority to regulate the manufacture, sale, labeling, distribution, and marketing of tobacco products. The current FDA requirements governing youth access and tobacco marketing are essential minimum components of any public policy initiative. The agency's ability to augment these requirements should not be curtailed. Barriers in the settlement to appropriate FDA rulemaking to reduce the harm of tobacco products should be removed, so that they are in line with authority to regulate other devices or drugs. For example, the FDA should not have to make an *a priori* finding that a proposed reduction or elimination of an ingredient in tobacco products would not lead to an increase in contraband sales to be able to regulate that ingredient.

2. **Accountability:** Tobacco industry performance standards must be established in order to reach quantifiable objectives such as reducing the number of youths who smoke or numbers of new smokers. Strong financial penalties and/or other regulatory sanctions must guarantee the accountability of the tobacco industry's compliance to such objectives. The industry must be held accountable for meeting targets for youth reduction in tobacco use, starting in year 2 and increasing every year thereafter, instead of the settlement which proposes to reach such targets starting in year 5, followed by years 7 and 10.

Penalties for not meeting the reduction targets for youth smoking must be significantly increased and be paid in after-tax dollars. Penalty monies should be used to further reduce youth smoking. The settlement proposes penalties that would offset the future profits based on a teen tobacco user over the lifetime of the individual. The forgiveness provisions for the tobacco industry that could reduce these penalties by up to 75% must be eliminated. Funding should be included, to reimburse not only states for their smoking-related tobacco costs, but also jurisdictions and other municipalities that have filed suit to recover costs for indigent care for tobacco-related illnesses.

3. **Advertising:** Advertising and promotion restrictions must be increased to provide for a total advertising ban covering all tobacco products. The current settlement bans only marketing targeted at youth. A significant concern with the current settlement agreement is to what degree clever and creative advertising and promotion that meet the letter of the settlement agreement could counteract the effectiveness of the other provisions of the settlement designed to reduce youth and adult tobacco use.

4. **International:** The United States cannot put itself in the position of exporting the tobacco problem to the rest of the world, nor can we allow the tobacco industry to simply shift its operations from this country to other countries. A well-funded international compact on tobacco must be developed to better disseminate information regarding the effects of tobacco use and to minimize international tobacco promotion and consumption. Strategies must be developed to assess how multi-national companies can be held to the same standards internationaly as national companies are in the U.S. Some funds from the settlement must be allocated to international tobacco control efforts. The agreement does not address international issues.

5. **Public education and tobacco control:** A well-funded, effective, sustained public education and tobacco control campaign that is protected from political pressure is critical to reducing tobacco use. Only about 20% of the funds made available in the settlement appear to be earmarked for public health tobacco control related initiatives. Tobacco use cessation programs should be made widely available,

and coverage for such programs and services should be required under all health insurance, managed care and employee benefit plans, as well as all Federal health financing programs. The tobacco industry should financially support tobacco use cessation programs and services and research efforts related to the development of such programs and services. A higher proportion of the penalty funds must be allocated for the primary public health goal of progressively reducing tobacco consumption.

6. **Public Disclosure:** While unclear in the proposed settlement, public disclosure must come from the tobacco industry about its knowledge of tobacco's effects on health, addiction, marketing to youth, environmental tobacco smoke and all other areas currently sought under pending litigation. Tobacco companies must be required to disclose to the public the products of combustion as well as the uncombusted products from which they arise.

7. **Environmental tobacco smoke (ETS):** Provisions in the settlement for virtual elimination of smoking in "public places," liberally defined, would help reduce some sources of ETS. A significant exclusion is restaurants (other than fast food restaurants) and that must be remedied. It is further strongly recommended that economic incentives for smoke-free workplaces be developed, that federal health agencies complete a risk assessment of the cardiovascular effects of ETS, and that a comprehensive public education and awareness campaign about the dangers of ETS be funded and implemented at all levels of government.

The American College of Preventive Medicine recommends to the Administration and the Congress that strengthening changes as outlined above be made to the existing proposed tobacco settlement. The Administration is further encouraged to lead a nationwide public education program about the strengths and weaknesses of the settlement in order to generate support among the American people for an improved agreement. An improved agreement, which meets the criteria outlined in this statement will further public health goals and bring this nation closer to achieving substantial reduction in U.S. tobacco consumption and an appropriate leadership role in controlling international tobacco consumption.

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Tobacco - settlement - public health outreach

The Impact of Cigarette Excise Taxes on Smoking Among Children and Adults

Double sided Docs

Summary Report of a National Cancer Institute Expert Panel

August 1993

Cancer Control Science Program
Division of Cancer Prevention and Control

NATIONAL CANCER INSTITUTE

ACKNOWLEDGMENTS

The individuals listed below were members of the expert panel that developed the conclusions of this report. (Affiliations are provided for purposes of identification only.) Their expertise and comments on earlier drafts are gratefully acknowledged. The efforts of Dr. Kenneth Warner, who chaired the expert panel, are especially appreciated.

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The Impact of Cigarette Excise Taxes on Smoking Among Children and Adults

Summary Report of a National Cancer Institute Expert Panel

Introduction

Cigarette smoking is the leading preventable cause of death in the United States and has been called "the most important public health issue of our time."[1] More than 46 million American adults smoke cigarettes, as well as nearly 3 million teenagers and children.[2,3] Eighty-five percent of current smokers began smoking by the age of 21.[4]

The cost in human suffering is extremely high: Each year, more than 434,000 people die because of tobacco use.[5] One-third of all cancer deaths are attributable to smoking. Lung cancer is the leading cause of cancer deaths among both men and women in the United States, and almost 90 percent of these deaths are directly attributable to smoking.[4]

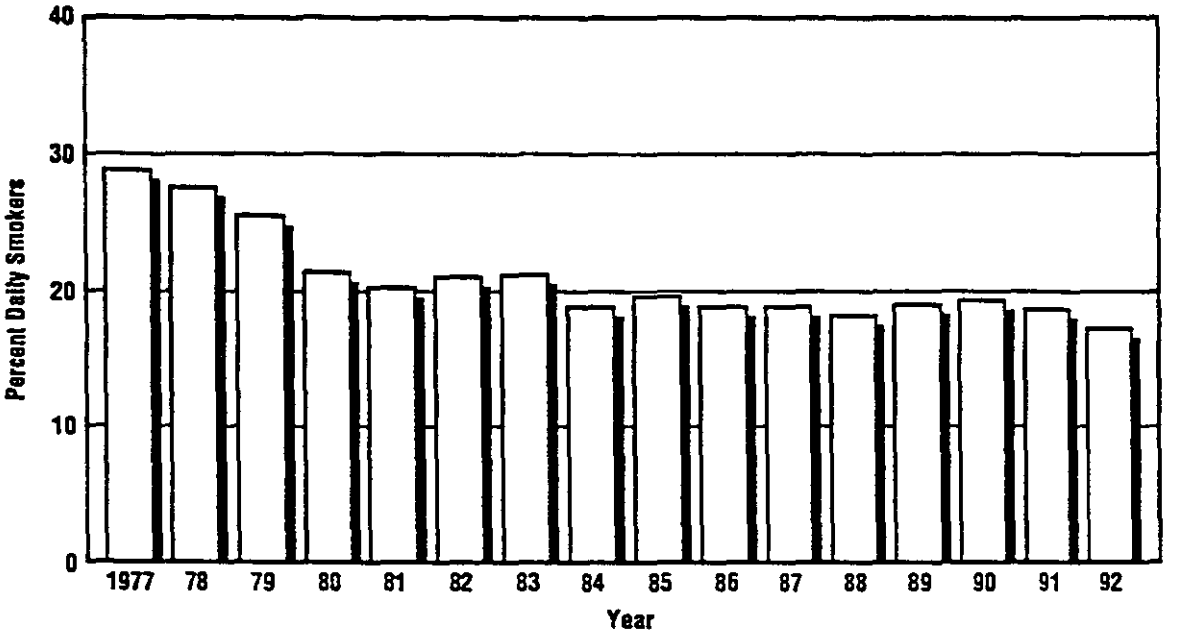
The cost in economic terms is also high: According to recent congressional testimony by the U.S. Office of Technology Assessment, smoking costs this Nation $68 billion annually. Of these costs, $47.2 billion are in lost productivity, and $20.8 billion are increased health care costs.[6] At a time when health care costs are of major concern to governments and businesses alike, these unnecessary and avoidable health care costs have received renewed attention.

Although the prevalence of smoking among adults has been slowly decreasing for many years, the same is not true for children and adolescents. Efforts to reduce tobacco consumption among adults have had and continue to have demonstrable impact. In contrast, programs directed at youth have had less success. For example, among American high school seniors, the prevalence of smoking has remained largely unchanged since 1980 (see figure 1).[7] The use of smokeless tobacco by these same youth has also remained constant in recent years.[7] In spite of more than a decade of public and private health campaigns to reduce tobacco use, more than 3,000 youth start smoking every day.[4]

Efforts to reduce the prevalence of cigarette smoking in the United States have focused both on helping adult smokers to stop and on preventing youth from starting to smoke. Excise taxation, at both the state and Federal levels of government, has been proposed to accomplish both of these goals.

On November 11, 1992, the National Cancer Institute convened an expert panel to review existing research on this topic. Specifically, the panelists reviewed the literature, both domestic and international, on the following topic areas: price elasticity of demand for cigarettes, the effects of price increases on population subgroups (e.g., children and adults, members of various socioeconomic strata), social costs and appropriate tobacco taxation, tying the tax rate to inflation, the comparative effectiveness of taxation as a public health measure, and the effects of taxation on daily consumption and prevalence of tobacco use. A series of consensus statements were formulated to reflect the panel's position on these issues. Finally, the panel identified a number of areas in need of additional research. This report summarizes the major findings of the panel regarding the impact of excise taxes on tobacco consumption. A more detailed report of the panel is also being prepared.

Figure 1. *Daily smoking among high school seniors*



SOURCE: Johnston et al., in press[7]

Background: Historical Trends in Cigarette Excise Taxes

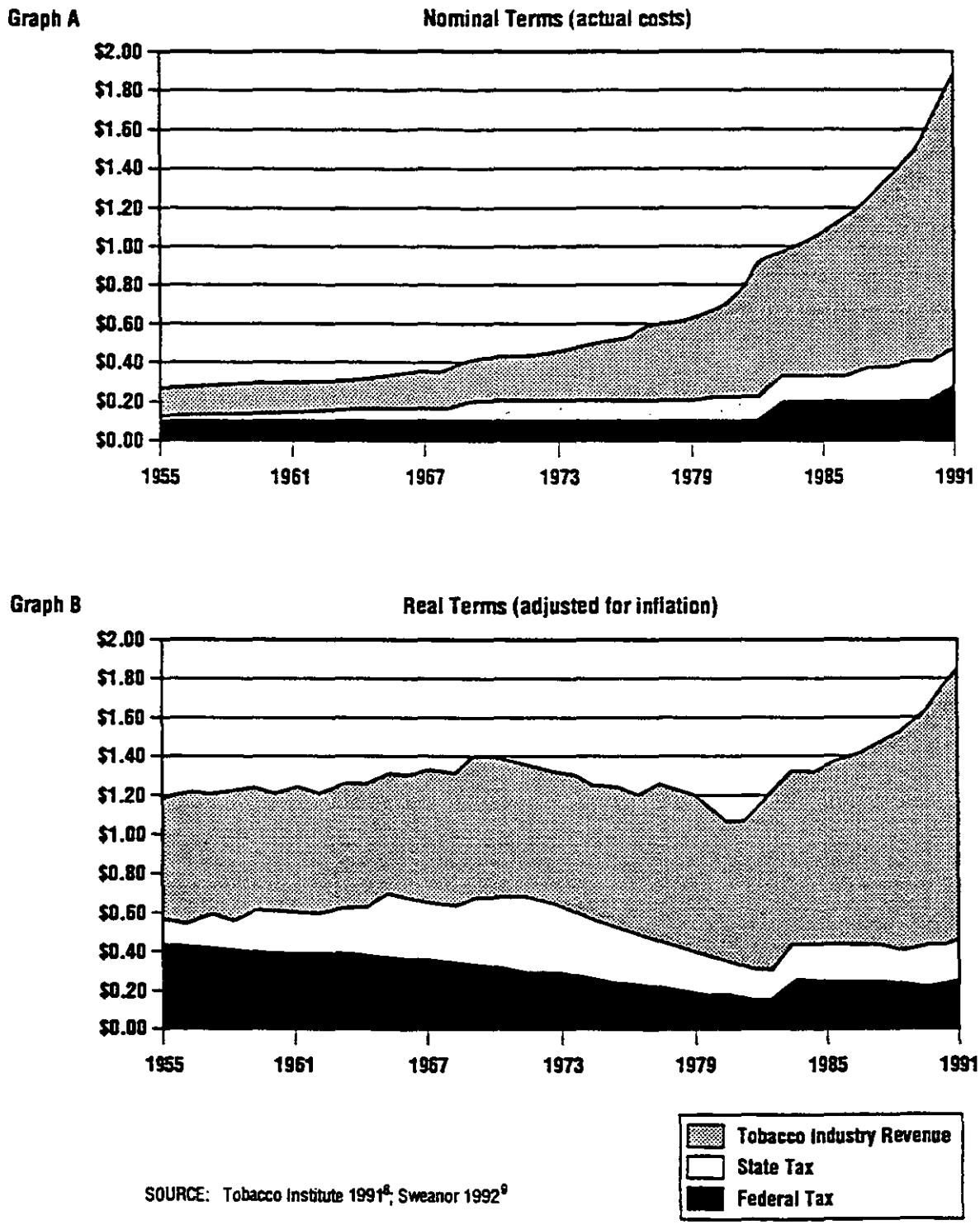
In 1955, the average total price of a pack of cigarettes was 23.2 cents. Of that amount, 3 cents was state tax and 8 cents was Federal tax. This represented a tax incidence—the tax proportion of retail price—of 47.4 percent. In 1991, the average total price of a regular pack of cigarettes was $1.82. Of that amount, 24.5 cents was state tax and 20 cents was Federal tax. In contrast with 1955, when taxes accounted for almost one-half of the purchase price, 1991 taxes represented only 24.4 percent of the cost of a pack of cigarettes.[8]

In other words, although the price of cigarettes has increased since 1955, the increase in taxes has been much smaller than price increases imposed by cigarette manufacturers. This is shown in figure 2, graph A.

The numbers given above do not make adjustments for inflation. When viewed in constant 1991 dollars (see figure 2, graph B), several conclusions are apparent:

- From 1955 to 1971, tobacco prices and taxes rose slightly in real terms. The rise in taxes was accounted for solely by the increase in state taxes. The Federal tax remained unchanged in nominal terms, falling in real terms by almost a third.
- From 1970 to 1981, both pack prices and taxes fell in real terms, pack prices by 24 percent, and total taxes by 54 percent.
- From 1985 to 1991, the nontax component of the pack price increased by 49 percent in real terms. During this same period, the tax component increased by less than 10 percent.[9]

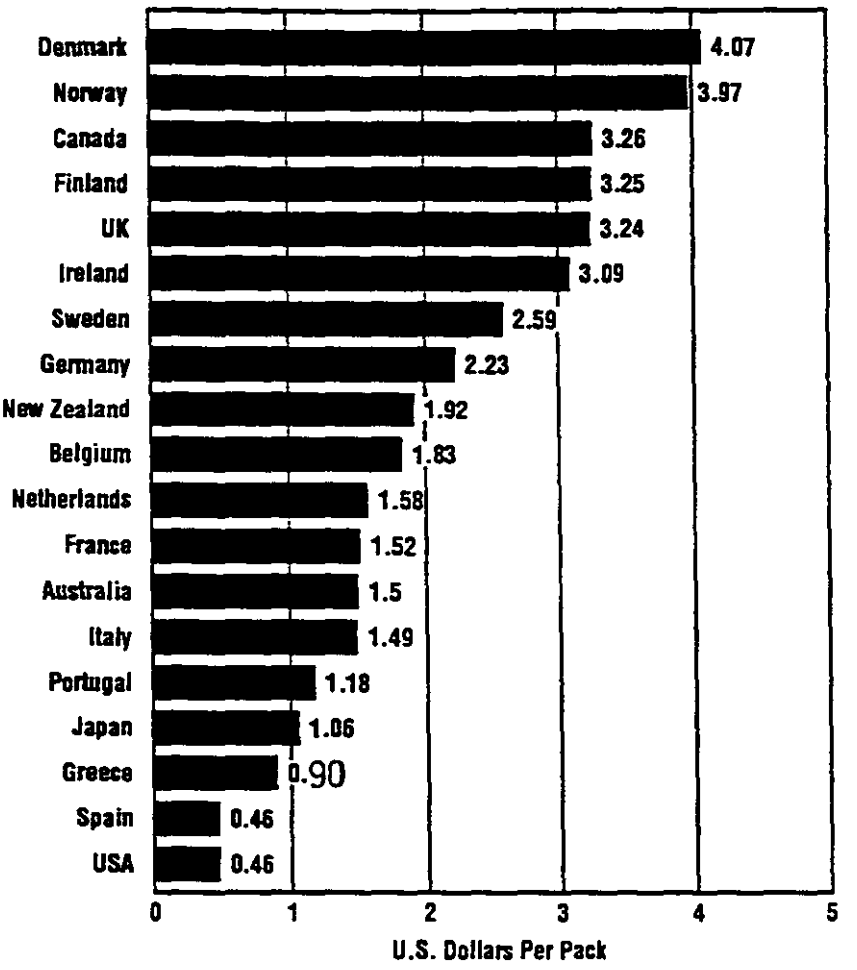
Figure 2. *Cigarette prices and taxes in the United States 1955-1991*



SOURCE: Tobacco Institute 1991[8]; Sweanor 1992[9]

Finally, it is useful to compare cigarette excise taxes in the United States with those in other developed nations. As shown in figure 3, the United States has excise taxes that are significantly lower than all but one of the comparison nations.

Figure 3. *Cigarette taxes in developed nations, data from 1991 and 1992*



SOURCE: Coalition on Smoking OR Health 1993[13]

Expert Panel Conclusions

1. Increases in Tobacco Excise Taxes Will Decrease Tobacco Comsumption by Youth and Adults.

As with almost all other products, the demand for cigarettes decreases as price is increased. A variety of studies have examined the relationship of cigarette prices to consumption and have documented an inverse relationship. The price elasticity of demand for cigarettes has usually been found to be in the range of 0.3 to 0.5 (minus signs deleted here and throughout this report).[10] Defined simply, price elasticity refers to the percentage change in the quantity of cigarettes demanded divided by the percentage change in price. For example, a price elasticity of 0.4 indicates that, when the price of cigarettes is increased by 10 percent, the quantity of cigarettes demanded will fall by about 4 percent (again, recall that the minus sign is being suppressed here).

When the price of cigarettes increases, decreases in consumption occur, both because some people choose not to smoke and because some smokers choose to smoke fewer cigarettes. Approximately two-thirds of the decrease in consumption is estimated to be the result of people choosing not to smoke at all.[11,12] This refers both to current smokers who choose to stop and to nonsmokers (especially children) who choose not to start smoking. The Coalition on Smoking OR Health has calculated that an increase of $2 per pack in cigarette taxes, tied thereafter to inflation, will result in 7.6 million fewer smokers; this, in turn, ultimately will prevent 1.9 million premature deaths.[13]

2. An Excise Tax Increase Reduces Tobacco Comsumption by Children and Teenagers at Least as Much as It Reduces Comsumption by Adults.

An increase in cigarette excise tax may be the most effective single approach to reducing tobacco use by youth. The impact of an increased excise tax can be expected to encourage teenagers to stop smoking, and it may also discourage children from ever starting. Analysis has found that youth consumption of tobacco is influenced by prices at least as much as adult consumption.[12,14] One prominent study concluded that youth consumption may be three times more sensitive to price increases than adult consumption.[14] This may be explained by the fact that children and teenagers are usually less addicted than many adult smokers and, therefore, more able to stop smoking when prices increase.

3. Raising the Excise Tax on Cigarettes Deters Smoking in Lower Income Populations, Who Currently Are Most Harmed by Smoking.

In the United States, the prevalence of smoking is higher among lower socioeconomic populations; in 1991, smoking prevalence was 24.7 percent among persons at or above the poverty level compared with 33.1 percent for persons below the poverty level.[15] The incidence, prevalence, and mortality rates of many cancers caused by smoking are also higher in these poorer groups.[16] Thus, the burden of illness and death caused by smoking is borne disproportionately by those lower income groups that often have the least access to medical care, smoking cessation programs, and information about cessation. Analysis in the United Kingdom documented a greater sensitivity to cigarette prices among people with lower incomes.[17] One analysis in the United States failed to find a statistically significant difference between lower and higher income groups.[12] At a minimum, therefore, the higher prevalence of smoking among lower income groups means they can be expected to reduce consumption at least as much as higher income groups in response to an excise tax increase. A decrease in the disproportionate smoking-related disease and death rates would follow.

4. The Price Elasticity of Demand for Large Price Increases Is Expected to Be at Least as Large as for Small Price Increases.

Most cigarette excise tax increases in the United States have been relatively small, commonly less than 10 cents per pack. Most of the studies of price elasticity have been done by observing the impact on consumption of these small increases and of interstate price differences, reflecting relatively small differences in tax rates. Only recently have some states imposed excise tax increases of more than 20 cents per pack. Other nations, such as Canada, have raised excise taxes much more. In the opinion of this expert panel, based on the empirical experience in these jurisdictions and on theoretical considerations, the price elasticity of demand should be at least as great (in absolute value) for large price increases as for small price increases.

However, accepted estimates of the price elasticity of demand for adults in industrialized nations have been less than 1.0.[10,18] Recent experience in Canada, where the average price of cigarettes now exceeds $4 per pack, has been consistent with a price elasticity of demand of approximately 0.4.[19] This means that the increase in revenues generated by substantial excise tax increases has been far greater than the loss of revenue caused by decreases in cigarette consumption.

5. To Maintain the Public Health Effect of the Tobacco Excise Tax, It Must Be Increased Regularly.

Increasing a tobacco tax by a nominal amount means that the real value of the tax increase, and hence its impact on consumption, will be eroded over time by inflation. In order for the excise tax to maintain reductions in consumption, it must be increased regularly.[20] Policymakers can maintain the real value of the tax by setting it to increase automatically with inflation. Possible indices include the consumer price index, the producer price index for cigarettes, or the consumer price index for tobacco and smoking products. Another option is to establish a policy that increases the cigarette excise tax regularly by a fixed percentage. If this increase is greater than the rate of inflation, this approach would be expected to reduce tobacco consumption more each year. Another means of achieving the same end is to index the excise tax to the rate of inflation plus a specified additional percentage.

6. A Substantial Increase in Tobacco Excise Taxes May Be the Single Most Effective Measure for Decreasing Tobacco Consumption.

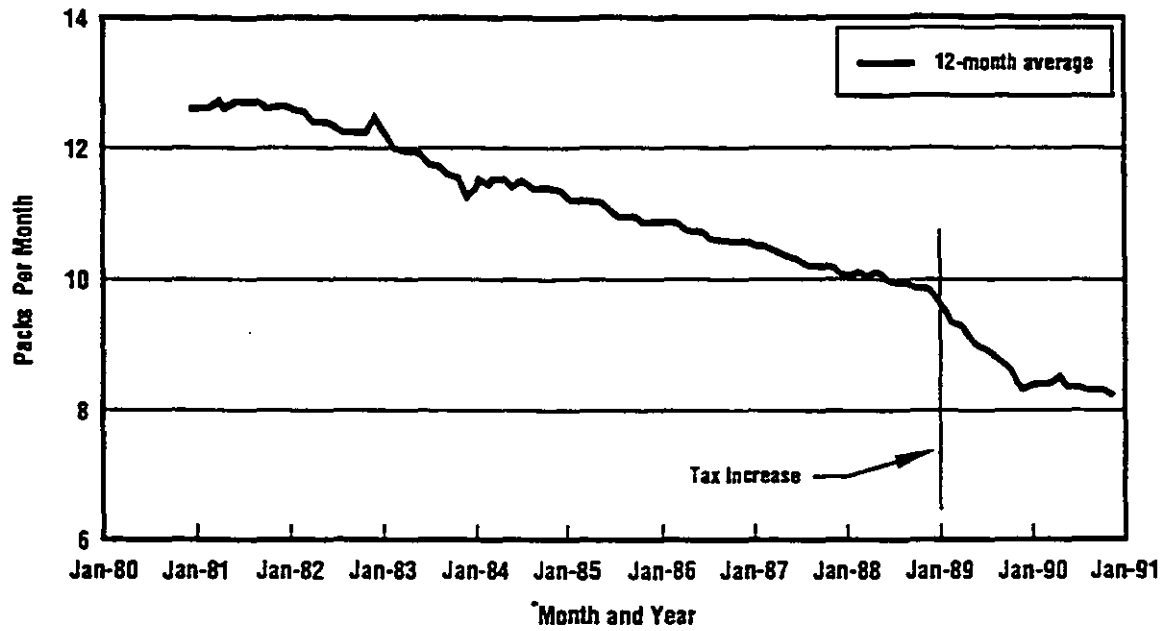
There is widespread agreement within the community of scholars knowledgeable about the effects of interventions on the consumption of tobacco products that few measures exhibit the speed and magnitude of impact achieved by increasing taxation on tobacco products.[20,21,22] To discourage the initiation and continuation of tobacco use, increasing tobacco excise taxes must be considered an essential and primary component of any comprehensive tobacco control program.

7. Cigarette Comsumption Will Decrease When an Excise Tax Increase Is Combined With a Comprehensive Tobacco Control Program That Includes Other Policy Interventions, the Use of Mass Media, Education of Children, and Help for Smokers Who Want to Stop.

Several U.S. states and other nations have made significant increases in their tobacco excise tax. In many cases, the increased revenue generated by these tax increases has been used to fund tobacco control programs. In California, perhaps the best known example of this policy, revenue from an increase in the cigarette tax of 25 cents per pack was earmarked for research and educational intervention programs in tobacco control, as well as a variety of other state projects in health care and other areas. The combination of a tax increase in 1989 and a comprehensive tobacco control program has reduced the prevalence of smoking by 17 percent (see figure 4).[23] This is consistent with other studies that have documented the synergistic effect of multiple components of a comprehensive smoking control program.[24]

A major priority of most tobacco control programs has been children and adolescents. Interventions to prevent smoking among youth have included mass media campaigns, enforcement of laws banning the sale of cigarettes to minors, clean indoor air policies, and school programs to teach youth how to avoid cigarettes.

Figure 4. Per capita consumption of cigarettes in California, 1980 through 1990



SOURCE: Burns and Pierce 1992[23]; Teh-wei Hu, Ph.D.

In addition to targeting youth, comprehensive tobacco control programs have provided assistance to adult smokers who want to stop. A variety of types of assistance have been provided, including self-help programs, assistance from health care providers, and cessation classes. Encouragement to stop smoking has also been provided at the worksite, through community organizations, and at other locations. This kind of comprehensive approach to both the prevention and cessation of tobacco use is currently being implemented in 17 states through the American Stop Smoking Intervention Study, a joint project of the National Cancer Institute and the American Cancer Society.[24]

Through the combined use of the interventions listed above and significant and regular increases in tobacco excise taxes, continued reductions in smoking can be achieved. This, in turn, will result in reductions in the unnecessary disease, deaths, and economic costs caused by smoking.

References

1 U.S. Department of Health and Human Services. *The Health Consequences of Smoking: Cancer. A Report of the Surgeon General.* Rockville, MD; 1982. DHHS Publication No. (PHS)82-50179.

2 Centers for Disease Control and Prevention. Cigarette smoking among adults—United States, 1991. *MMWR.* 42:214-217, 1993.

3 Moss AJ, Allen KF, Giovino GA, Mills SL. Recent trends in adolescent smoking, smoking update correlates, and expectations about the future. *Advance Data From Vital and Health Statistics: No. 221.* Hyattsville, MD: National Center for Health Statistics; 1992. DHHS Publication No. (PHS)93-1250.

[4] U.S. Department of Health and Human Services. *Reducing the Health Consequences of Smoking: 25 Years of Progress. A Report of the Surgeon General*. Rockville, MD; 1989. DHHS Publication No. (CDC)89-8411.

[5] Centers for Disease Control. Smoking-attributable mortality and years of potential life lost—United States, 1988. *MMWR* 40(4):62-63, 69-71, 1991.

[6] Herdman R, Hewitt M, Saschober M. "Smoking-Related Deaths and Financial Costs: Office of Technology Assessment Estimates for 1990." OTA testimony before the Senate Special Committee on Aging; May 6, 1993.

[7] Johnston LD, O'Malley PM, Bachman JG. *National Survey Results on Drug Use From the Monitoring the Future Study, 1975-1992 (Volume I: Secondary School Students)*. Rockville, MD: National Institute on Drug Abuse, DHHS. In press.

[8] Tobacco Institute. *The Tax Burden on Tobacco: Volume 26, 1991*. Washington, DC, 1991.

[9] Sweanor DT. "The Tax Burden on Tobacco?: An Analysis of Tobacco Taxation Policy in the United States." April 1992. Unpublished.

[10] U.S. Department of Health and Human Services. *Smoking and Health in the Americas*. Atlanta, GA; 1992. DHHS Publication No. (CDC)92-8419.

[11] Lewit EM, Coate D. The potential for using excise taxes to reduce smoking. *Journal of Health Economics* 1(2):121-145, 1982.

[12] Wasserman J, Manning WG, Newhouse JP, Winkler, JD. The effects of excise taxes and regulations on cigarette smoking. *Journal of Health Economics* 10:43-64, 1991.

[13] Coalition on Smoking OR Health. *Saving Lives and Raising Revenue: The Case for Major Increases in State and Federal Tobacco Taxes*. Washington, DC: Coalition on Smoking OR Health, January 1993.

[14] Lewit EM, Coate D, Grossman M. The effects of government regulation on teenage smoking. *Journal of Law and Economics* 24:545-569, 1981.

[15] Centers for Disease Control. Cigarette smoking among adults—United States, 1991. *MMWR* 42:230-233, 1993.

[16] Miller BA, Ries LAG, Hankey BF, Kosary CL, Edwards BK (eds.). *Cancer Statistics Review: 1973-1989*. Bethesda, MD; 1992. DHHS Publication No. (NIH)92-2789.

[17] Townsend JL. Cigarette tax, economic welfare and social class patterns of smoking. *Applied Economics* 19:355-365, 1987.

[18] Keeler TE, Hu T, Barnett PG, Manning WG. Taxation, regulation, and addiction: A demand function for cigarettes based on time-series evidence. *Journal of Health Economics* 11:1-18, 1993.

[19] Allen, RC. *The False Dilemma: The Impact of Tobacco Control Policies on Employment in Canada*. Vancouver, B.C.; 1993. University of British Columbia.

[20] Warner KE, Ernster VL, Holbrook JH, Lewit EM, Pertschuk M, Steinfeld JL, Whelan EM. Public policy on smoking and health: Toward a smoke-free generation by the year 2000. *Circulation* 72(2):381A-393A, 1986.

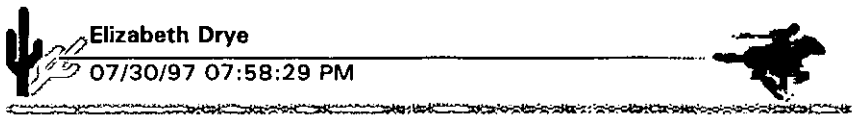
[21] Kaiserman MJ, Rogers B. Tobacco consumption declining faster in Canada than in the US. *American Journal of Public Health* 81(7):902-904, 1991.

[22] Peterson DE, Zeger SL, Remington PL, Anderson HA. The effect of state cigarette tax increases on cigarette sales, 1955 to 1988. *American Journal of Public Health* 82(1):94-96, 1992.

[23] Burns D, Pierce JP. *Tobacco Use in California 1990-1991.* Sacramento, CA: California Department of Health Services, 1992.

[24] National Cancer Institute. *Strategies To Control Tobacco Use in the United States: A Blueprint for Public Health Action in the 1990's.* Rockville, MD; 1991. NIH Publication No. 92-3316.

Tobacco - settlement -
public health outreach



Elizabeth Drye
07/30/97 07:58:29 PM

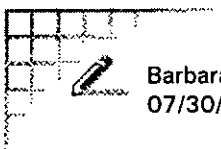
Record Type: Record

To: Bruce N. Reed/OPD/EOP, Elena Kagan/OPD/EOP

cc:
Subject: AMA Press Event - Tobacco

FYI

---------- Forwarded by Elizabeth Drye/OPD/EOP on 07/30/97 07:58 PM ----------



Barbara D. Woolley
07/30/97 07:05:01 PM

Record Type: Record

To: Jerold R. Mande/OSTP/EOP, Elizabeth Drye/OPD/EOP, Barry J. Toiv/WHO/EOP

cc: Mark Hunker/WHO/EOP
Subject: AMA Press Event - Tobacco

On Thursday, the AMA will hold a press conference to issue the release of their statement on the tobacco settlement. It is our understanding the AMA will be in favor of the tobacco settlement, will share concerns of the settlement including FDA regulation reform, see as a positive sign and big opportunity for public health advocates.

Tobacco - settlement - public health outreach

EVK, ED, JRM

NATIONAL SPIT TOBACCO EDUCATION PROGRAM

ORAL HEALTH AMERICA

AMERICA'S FUND FOR DENTAL HEALTH

410 North Michigan Ave., Suite 352
Chicago, Illinois 60611-4211
(312) 836-9900 Fax (312) 836-9986

July 17, 1997

Mr. Brian Reed
White House Domestic Policy Advisor
The White House
1600 Pennsylvania Avenue
Washington, DC 20001

Dear Brian:

Oral Health America very much appreciates being part of the July 11, 1997, meeting to discuss issues related to tobacco control.

Enclosed, our list of recommendations on spit tobacco. I think it's important to recognize that this is a tobacco and not exclusively smoking issue. Just this week U.S. Tobacco has said it will introduce a newer, *cheaper* version of its snuff product. The purpose of the cheaper product is to attract younger users who may not have the money to purchase spit tobacco at current prices. We urge you to include all tobacco products in any settlement with tobacco companies.

Yours very truly,

Robert J. Klaus
President and
Chief Executive Officer

RJK:bpr

NATIONAL SPIT TOBACCO EDUCATION PROGRAM

ORAL HEALTH AMERICA

AMERICA'S FUND FOR DENTAL HEALTH

410 North Michigan Ave., Suite 352
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ORAL HEALTH AMERICA'S PERSPECTIVE ON THE MOST PRESSING ISSUES REGARDING TOBACCO

Oral Health America (OHA) is a non-profit charitable organization that has worked for more that 40 years to improve the oral health of Americans. We address the many barriers to Americans maintaining and improving their oral health that come about because of a lack of knowledge of how to be orally healthy, a lack of access to necessary treatment and preventive services, or exposure to risk factors that increase the potential for disease, disability, or death. Tobacco use is of extreme importance to OHA because its use leads to lesions of the oral cavity, including precancer (leukoplakias, erythroplakias), cancers, periodontal disease, and oral tissue defects. Tobacco and alcohol use have been identified as responsible for 75% of the approximately 30,000 oral and pharyngeal cancers that occur each year in the U.S. Nearly 9,000 Americans die form these cancers each year, and thousands more are permanently disfigured as a result of treatment. Only half of the people diagnosed with oral cancer are still alive five years post diagnosis. And, given the highly addictive nature of tobacco in general and spit tobacco specifically, our concerns are well founded.

We at OHA have been particularly concerned about the epidemic of spit tobacco (smokeless, snuff, chew) use of young people in this county in recent years. Currently, nearly one in four high school senior boys uses spit tobacco. Use among high school, collegiate, and professional baseball players has been reported to be significantly higher. Up to half of the regular users of spit tobacco will have evidence of tissue damage in their mouths. Most regular users of spit tobacco start before they are teenagers, and children as young as kindergarten have been reported to use spit tobacco. With the help of Hall of Fame Broadcaster Joe Garagiola, Major League Baseball, and the Robert Wood Johnson Foundation, OHA has been waging a war against spit tobacco. This past Tuesday at Jacob's Field in Cleveland, the 68th Major League Baseball All-Star Game was played. It was noteworthy for the spectacle of the occasion and athletic feats of the skilled players from the American and National Leagues. But more importantly, thanks to the efforts of the American Baseball Players Association many individual players volunteered to refrain from using spit tobacco during the All-Star Game. And, I am proud that OHA's public service announcements aired on the stadium Jumbotron during the game and also appeared in the official All-Star Program.

While these are positive steps, they are modest relative to the challenge that spit tobacco poses for our nation's youth. I would like to mention several concerns that need to be addressed in a serious and ongoing fashion

if we are to stem the tide of spit tobacco use by young people in their country and prevent an epidemic of oral cancer in the future:

1. Spit tobacco is still too readily available to young people. When sold in stores, it must be placed where it is hard for young people to see and must be impossible for young people to reach or buy it.
2. Spit tobacco must be accurately and understandably labeled on the package for what it is– a highly addictive substance that causes disease and death. "Warning – if you start to use this product you may not be able to stop." The same should be true wherever advertising or promotional items or activities are employed that involve spit tobacco.
3. We must start the educational process as early as first or second grade, given what we know about experimentation with spit tobacco occurring before age 10 by many children. The educational process must continue through high school and college. Education must occur outside of the classroom also – in community settings and in all sporting and recreational activities where spit tobacco use occurs. Bans on spit tobacco are helpful, but are not the final answer. A significant percentage of high school, college, and minor league ballplayers use spit tobacco, even though it has been banned from practices and games.
4. Professional help to assist people get off of spit tobacco is essential. We need many more qualified counselors to work with individuals who want to quit using spit tobacco, but can not stop on their own. This will require documenting effective curricula and techniques and developing a nationwide registry and/or referral service of qualified counselors. From our work with Major League ballplayers, we know that this is a high priority need. We anticipate that the need exists for amateur ballplayers also, given case studies of individuals claiming addition. The tobacco companies should pay the cost of providing this assistance.
5. More prominent role models need to step forward to tell their story about what spit tobacco has done to harm them. Players like Lenny Dykstra, Rod Carew, Curt Schilling, and Pete Harnish have paid a terrible personal price because of spit tobacco use. This has received much publicity.
6. Adequate resources must be made available to conduct a nationwide, comprehensive, ongoing tobacco avoidance program. Spit tobacco must not get second shrift in this. With one in four high school senior boys using spit tobacco, it is not a low-level problem and can not be assumed to be transitory. A well formulated and adequately resourced program to engage employers and major corporations in addressing spit tobacco use by their personnel needs to be undertaken. Again this should be paid for by the tobacco companies.
7. We need 100% of health professionals (including physicians and dentists) talking to their patients about tobacco use, including spit tobacco. Insurance companies and employers should pay health professionals for clinical intervention services designed to get people off of tobacco. These should be required services in approved health plans.
8. Lastly and most importantly, the Food and Drug Administration must be able to closely regulate tobacco products into the future. We know from past experience that the tobacco companies will always be able to pry a crack into a canyon. We must reserve the right to employ whatever legal and regulatory force is needed in the future in the interests of the public's health.

While this list is not exhaustive, I am hopeful that it will be of assistance as you deliberate your course of action. Thank you for the opportunity to share these perspectives.

Robert J. Klaus, Ph.D.
President and CEO
Oral Health America
7/11/97

NEWS

ORAL HEALTH AMERICA
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For Immediate Release:
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Spit Tobacco Dangers Profiled at White House Meeting and Major League Baseball's All-Star Game

Oral Health America, President and CEO Robert Klaus joined representatives from a dozen other national health organizations at a special White House meeting last Friday to advise Secretary Shalala and President Clinton on pending tobacco regulation and control policy.

The meeting was lead by White House Domestic Policy Adviser Brian Reed, and included representatives of the American Cancer Society, the Coalition for Tobacco Free Kids, the American Lung Association, and the American Heart Association.

Dr. Klaus addressed tobacco concerns from an oral health perspective, but additionally pointed out that it was critically important to understand tobacco as a generic issue that included, besides cigarette smoking, spit tobacco, cigars, and pipes. Klaus presented a series of recommendations from Oral Health America on spit tobacco which included explicit warning labels on spit tobacco products as dangerous and addictive and provisions for tobacco companies to pay for extensive spit tobacco education and cessation programs, such as are reflected in Oral Health America's National Spit Tobacco Education Program (NSTEP).

Klaus also urged tobacco control groups to make common cause with organizations outside of health care from both the private and independent sectors. "A broad-based coalition," he said, "especially if it includes members from private industry and business, will make the case for strict tobacco regulation unassailable."

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After the meeting Secretary Shalala, Mr. Reed, and the organizational representatives held a press conference on the White House lawn.

The dangers of spit tobacco were addressed at another high level gathering just days before the White House meeting. Spit tobacco was very much in focus at Major League Baseball's All-Star Game and FanFest last week at Jacobs Field in Cleveland, Ohio. As part of a cooperative effort with Major League Baseball and the Major League Baseball Players Association, Oral Health America's anti-spit tobacco message was reinforced through several multi-media productions. A full page public service announcement appeared in the Official All-Star Program featuring players from all 28 Major League teams. These stars "Agree" that "Chew, Dip, or Snuff Aren't Part of Our Game." Well over 100,000 copies of the Official Program are purchased by attendees at the All Star venues or through other outlets. A video public service announcement was also played on the Jacobs Field Jumbotron screen during the All-Star Game on Tuesday evening.

Hall of Famer Joe Garagiola hosted "Stay in the Game", a morning pre-game clinic for youngsters at the FanFest. Garagiola emphasized not using spit tobacco and other tobacco products as part of a routine that players of all ages must adhere to in order to do their best. Olympic gold medal softball pitcher Michelle Smith, former Major League Baseball star Jay Johnstone, and Los Angeles Dodgers and National League All-Star trainer Charlie Strasser joined Garagiola in reinforcing the message. Clinic attendees received copies of the colorful "We Agree!" pledge card that will be made available to youth around the country who take the pledge to remain tobacco-free.

Oral Health America is in the second year of a planned four-year collaboration with the Robert Wood Johnson Foundation to reduce spit tobacco use in America, particularly among the nation's youth. For more information on the National Spit Tobacco Education Program (NSTEP) and other Oral Health America initiatives or to order materials contact Bryan McGuire at 312-836-9900.

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Settlement – public health outreach

Whistleblowers Mtg 7/18/97

DeNoble – devised safer cigarette. PM wouldn't manufacture bec it would have constituted an admission of liability that current products were dangerous.

Mele – showed addictiveness of nicotine; tiny tolerance for it (more you take, less effect); couldn't demonstrate withdrawal effect.

Disclosure

DeNoble – what are they going to disclose?
ind. has been doing research for 30 yrs.

→ • Partner w/ some people from industry to figure out whether you've really getting everything.

Wigand: Should have to disclose all, incl. non-privileged.

Health labeling claims

Wigand – one Σ: whether "safer" product is safer product (wire cooler)
: hard to get to safer cig if addictive is still there – another just compensates.

Mele: smokeless cig may have some advant – intermed step to quitting / less ETS.

Wigand: Mt per product – still addictive – but much less biological risk.

DeNoble – need to estab syst like w/ other pharmaceuticals – in terms of inspect – etc of research.

~~Wigand~~ -

: safer cigarette could taste quite good.

Wigand - If industry put effort into safer cig, They could do it.

Mele - They could do it if FDA was on their back

Nikki: Cos have manipulated the design of the cig — as a drug deliv device — rather than nicotine per se cig w/ less nic. can give as much nic to smoker bec of way he smokes it.

Nikki - Didn't go to safer bec of fear of lawsuits.

Cig. w/ minimal risk — 6 mos.

~~They~~ Tobacco indus want to get out of situat — where they can't market safer cigs.

→ VP - should rec. a continuing dialogue to Pres w/ scientists etc -
new optics / new cvr
some regularity
absorbing + further developing this sophisticated expertise.

All strongly opposed to Pres cvrt.

Tobacco - settlement - public health outreach

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FOR IMMEDIATE RELEASE **Contact Diane Maple 202-785-3355**

Statement of John R. Garrison
CEO, American Lung Association
June 20, 1997

Global Tobacco Bailout

The American Lung Association believes that this settlement is premature and wrong. We cannot support this settlement. We call on President Clinton, Congress, Governors and the public to carefully and completely review all terms, legislative language, consent decrees and contracts. We are troubled by the actions of some negotiators intent on rushing a deal through what should be a cautious, deliberative process. We fear that the sense of urgency is prompted by terms that will not stand up to intense scrutiny. The American Lung Association will provide this intense scrutiny.

This settlement could grant legitimacy to an industry and its behavior we all find so reprehensible. By vindicating the industry, a deal now will tell the public that all is forgiven and tobacco use is an appropriate and safe behavior. The American Lung Association has worked too hard to educate the public about the dangers of smoking to allow our efforts to be undone by allowing tobacco to purchase an indulgence -- a get out of jail for a fee card -- especially one whose price appears to be far too low.

We know Wall Street loves this deal, look at tobacco stocks. The stock market sees a bright future for tobacco. We fear that same future for our children is very dark -- more addiction, disease and death.

The public health protections are too weak. We cannot compromise on protecting the health of our children.

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- The advertising, marketing, environmental tobacco smoke, youth access and other provisions appear to be inadequate compromises ready for industry exploitation. If this deal is ratified, we could be locked for decades into an agreement that either totally misses the mark or is woefully inadequate.

- The FDA's authority to regulate tobacco is sacrosanct. It is unacceptable that the deal appears to limit FDA authority. No changes to the FDA's current authority or limits on future authority are acceptable.

- We also adamantly opposed to any immunity or limits on the tobacco industry's future liability. Damages should not be capped. No limitations should be imposed on punitive damages. If the tobacco industry cannot be punished, what wrongdoer can?

- We also are concerned about proposed limits on class action lawsuits. The current flight attendants' case on environmental tobacco smoke is an example of why this important legal avenue should not be closed.

Now is not the time to settle with the tobacco industry. Every day brings new revelations about the scope of the industry's conspiracy. For example, hundreds of thousands of documents have yet to be examined in the discovery process of the State of Minnesota's case alone. The American public deserves access to all relevant information before any settlement.

This settlement could leave Americans with the impression that the tobacco issue has been resolved. It cannot and should not be resolved as long as tens of millions of Americans are addicted and nearly half a million people die each year from smoking-related disease and, most importantly, 3,000 American children start smoking every day. And, if the tobacco industry's problems are ameliorated in the U.S., the companies then will be free to continue and expand their efforts to addict millions of children abroad. Promoting the export of tobacco-caused addiction, disease and death is truly unacceptable.

A bailout for the tobacco industry is wrong, we hope the public will join with American Lung Association in our opposition.

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AMERICAN CANCER SOCIETY®

Tobacco - settlement — public health outreach

FOR IMMEDIATE RELEASE

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AMERICAN CANCER SOCIETY REVIEWING TERMS OF TOBACCO SETTLEMENT

June 20, 1997 – Washington DC – The American Cancer Society (ACS) has put into place a three-component process for evaluating the tobacco settlement proposal issued today by 40 states' Attorneys General and the tobacco industry. "We continue to be encoraged by the public health concepts that appear to be contained in the settlement," said John R. Seffrin, American Cancer Society CEO. "However, we will not take a final position until we complete an extensive review of all its elements."

The ACS evaluation process, the preliminary results of which should be ready for public release in a timely fashion, includes (1) a review by ACS's own staff and volunteer executive leadership; (2) a specially-convened panel of outside legal, economic and health policy experts; and (3) participation in the evaluation process by President Clinton's recently- appointed Advisory Committee on Tobacco Policy and Public Health, which is an independent panel chaired jointly by former FDA commissioner David Kessler and former Surgeon General C. Evertt Koop. Seffrin is a member of this panel. "We urge the entire health community to participate in the evaluation of this settlement," Seffrin said.

"We believe it is part of our obligation as public advocates for health that we do all in our power to ensure that this settlement accomplishes extraordinary protection of our kids' health," Seffrin said. "We want a settlement that furthers our mission in bringing cancer under control as a major health problem. Every day in this country, 3,000 kids start smoking for the first time. One element of the settlement outlines goals the tobacco industry would have to meet for the reduction of these youth smoking rates. We have the opportunity to save one million lives with the smoking education and prevention efforts set out in this settlement. -- more American lives than have been lost in all the country's wars combined."

"The settlement proposal now goes to Congress and the President for ratification," Seffrin said. "We intend to monitor this process very closely, and we will work actively to ensure the elements affecting public health are sustained and supported, and this industry controlled."

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