ATTACHMENT 1

Legislative Fiscal Office

Ken Rocco
Legislative Fiscal Officer

Daron Hill
Deputy Legislative Fiscal Officer

900 Court Street NE
H-178 State Capitol
Salem, Oregon 97301
503-986-1828

Budget Information Report

Tobacco Master Settlement Agreement

Master Settlement Agreement (ORS 323.800)

On November 23, 1998, Oregon and 45 other states (the "Settling States"), and the four largest domestic tobacco manufacturers (Philip Morris Incorporated, R.J. Reynolds Tobacco Company, Brown & Williamson Tobacco Corporation, and Lorillard Tobacco Company – referred to as the Original Participating Manufacturers or OPMs) ended a four year legal battle over past, present, and future smoking-related claims made by the states by executing the Tobacco Master Settlement Agreement ("MSA"). Four states had previously settled their lawsuits individually with the tobacco companies ("previously settled states").

The MSA settled state claims filed against the tobacco industry to recover state healthcare costs associated with treating smoking-related illnesses and settled all unlawful trade practices, antitrust, consumer protection, common law, and other relief alleged by the Settling States. In exchange, the OPMs agreed to make annual payments (due each April) to the Settling States in perpetuity beginning with the year 2000 and also voluntarily agreed to the imposition of restrictions on tobacco advertising and marketing. The MSA also allows additional tobacco manufacturers to join the MSA by agreeing to the MSA payment and public health provisions. Tobacco manufacturers who joined after November 1998, of which there are about 40 or so, are referred to as Subsequent Participating Manufacturers. Collectively, OPMs and SPMs are referred to as Participating Manufacturers or "PMs."

Nationwide, the MSA is projected to distribute $5.7 to $6.7 billion annually in payments to the Settling States over the next 30 years. Oregon's share of this total is roughly $75 million annually (+/- 1.3% of the total) or $150 million each biennium. Since December of 1999, Oregon has received $1.4 billion in MSA payments.

MSA payments have two main components: (1) the main payment, which is based on a state's allocable share percentage as set forth in the MSA; and (2) a strategic contribution payment. Unlike the main MSA payment which runs in perpetuity, the PMs are only required to make the strategic contribution payment from April 2008 to April 2017.

The main MSA payment, or allocable share percentage, is based on a formula related to the relative number of smokers in a given state vs. the total number of smokers in the United States. This number was set at the time the MSA was signed and does not change year-to-year. The main MSA payment is subject to a number of upward and downward adjustments. These include, but are not limited to, adjustments for inflation, volume reductions, previously settled states reduction, federal tobacco legislation, and disputed payments. Once all adjustments have been applied, each Settling State receives its allocable share of the total payment from the PMs via the MSA's escrow agent.

The purpose of the strategic contribution payment is to compensate states for their efforts in terms of litigation at the time of the settlement. In 1998, Oregon was next in line after the previously settled

states to litigate the state's case. Therefore, Oregon receives a relatively large strategic payment. Oregon will receive its last strategic contribution payment, in April 2017 for the current 2015-17 biennium.

An annual payment, which is the combination of the annual main MSA payment and the strategic contribution payment, can be reduced by disputed payment withholding amounts, discussed in more detail below.

Limitations of the MSA

MSA payments are based exclusively on sales of cigarettes and roll-your-own tobacco products. The MSA does not cover "Other Tobacco Products" such as cigars or pipe tobacco, smokeless tobacco products, or vapor products; however, there is a Smokeless Tobacco Master Settlement Agreement under which manufacturers of smokeless products have agreed to advertising restrictions and public health provisions similar to the Tobacco MSA, but do not make any payments to the states.

Oregon appellate courts have decided that private party (non-state) litigation related to a cigarette claim fall outside of the MSA. For example, a recent Oregon Supreme Court case affirmed a $25 million lower court judgment against a major tobacco company for a plaintiff's smoking related death. The state's portion this judgment will be paid to the state as punitive damages and deposited into the Criminal Injuries Compensation Account, used to fund crime victims' assistance programs.

The federal government is not a party to the MSA.

Non-Participating Manufacturers (ORS 323.800)

There are a number of mostly smaller tobacco companies that elected not to participate in the MSA. These companies are termed non-participating manufacturers (NPMs). NPMs generally represent 2% or less of Oregon's cigarette market share with the rest comprised of sales by the PMs.

In order to avoid an MSA payment adjustment known as the "NPM Adjustment," the MSA requires Settling States to enact and enforce statutes that require NPMs to make escrow deposits based on their cigarette sales in a given state. After 25 years, any money in an NPM's escrow account that has not been used to either satisfy a court judgment, or settlement, related to past and present smoking-related claims made by a state (or released party under the MSA) will be returned to the NPM.

Since 1998, 39 NPMs have deposited $15.6 million into escrow accounts for the benefit of Oregon. There has been no state claim against NPM escrow funds; however, the Oregon Department of Justice (DOJ) continues to evaluate the potential legal basis for such a claim, which would likely differ in some respects from the legal claim made under the MSA. If Oregon were successful in making a legal claim, any moneys recovered would likely not be deposited to the Tobacco Settlement Funds Account as they would not be part of the original MSA settlement.

In contrast to the MSA, statute places no restriction on NPM advertising or marketing.

PM Disputed Payments and NPM Adjustment

The MSA allows PMs to dispute a portion of the annual MSA payment. Disputed payments may be either withheld (kept with the PMs), paid into a disputed payment account, or paid to states subject to "claw back" by the PMs.

The most significant disputed amount is related to the NPM adjustment. When the PMs have suffered a loss of market share (as defined by the MSA) in a given calendar year, and an economic firm has determined that the MSA was a "significant factor" in that loss, then the PMs can reduce their annual

payment by the NPM Adjustment amount. If a particular state can show that it "diligently enforced" the provisions of its Escrow Statutes during the relevant year, then that state is not subject to the NPM Adjustment.

The MSA requires the arbitration of payment disputes. Whether a state "diligently enforced" its statutes in a given year is therefore determined by an arbitration panel of three retired federal judges.

Some of Oregon's annual payments are currently being withheld by the PMs, a portion of which is in the disputed payment account. The PMs and Settling States are currently in dispute over who receives interest or other earnings from withheld payments. There is a three year lag between the year the cigarettes are sold and a disputed payment based on the NPM Adjustment. For example, the 2016 calendar year payment was reduced by the disputed amount for calendar year 2013. The reason for this lag is for the PM's to evaluate the change in market share.

PMs have disputed each Settling State's annual payment beginning with the first sales year 1999. As a result, the PMs have placed into a disputed payment account a portion of the payments due to Settling States. In 2003, the Settling States and the PMs reached a resolution of the dispute regarding sales years 1999-2002. Oregon's portion of the settlement was $6.2 million, which represents the entire disputed amount for this period. For Oregon, there will be a total of approximately $94 million in annual payments withheld by PMs for the years 2004 through the spring of 2017.

Arbitration of Disputed Payment Amounts and Diligent Enforcement

To determine whether an NPM Adjustment applies to a given payment, the arbitration panel reviews the enforcement efforts of the state at issue, to determine whether that state "diligently enforced" its Escrow Statutes. The term "diligent enforcement" is not defined in the MSA.

There is significant incentive for Settling States to diligently enforce their Escrow Statutes. If a state is found by the arbitration panel to have not diligently enforced it statutes in a given calendar year, then the state's entire annual payment (allocable main payment and the strategic contribution payment) for that year is at risk rather than just the disputed amount for that particular year. Under such a scenario, the state could owe the PMs as much as the difference between the disputed payment and the annual payment for that particular year.

If a state prevails in diligent enforcement arbitration, amounts held in the disputed payment account will be released to the prevailing states. Determining whether a given state "diligently enforced" the state's Escrow Statutes can take years. For example, the 2003 disputed amount, withheld in 2006, was paid in 2014 after a favorable arbitration decision in 2013.

In September 2013, the arbitration panel found that Oregon diligently enforced its Escrow Statutes during calendar year 2003. The decision resulted in the release of $8.9 million in disputed payments back to Oregon. The next arbitration is for the 2004 payment year. This arbitration is just beginning and may not be fully concluded until the fall of 2017. As a result of the dispute, Oregon's annual MSA payment related to 2004 was reduced by approximately $7.7 million. NPM Adjustment arbitrations for sales years after 2003 are a year-by-year process that will involve determining for each of those years whether Oregon "diligently enforced" the state's Escrow Statutes during the year at issue.

Cost of Diligent Enforcement and the Arbitration of Disputed Payments

DOJ undertakes two types of MSA-related activities, which are funded from two different sources: litigation of payment disputes (including the NPM Adjustment arbitrations) and diligent enforcement of NPM statutes.

DOJ spends approximately $3 million General Fund each biennium defending the state's diligent enforcement actions in front of the arbitration panel. This includes costs for expert outside counsel (Special Assistant Attorney General contract with a private law firm), Oregon's share of the cost of the arbitration panel, Oregon's share of the multi-state counsel, expert witnesses, and DOJ staff attorneys. This expense was originally funded as a General Fund allocation from the Emergency Board and has since continued as General Fund.

DOJ expends approximately $1.3 million per biennium in MSA settlement funds for diligent enforcement activities, which include a DOJ lawyer, paralegal, and investigator/auditor. This program certifies manufacturers and maintains a directory of all compliant tobacco products that can be sold in Oregon, monitors quarterly escrow payments by NPMs, coordinates with the Department of Revenue on distributor cigarette sales, and performs other compliance duties directed by statute.

MSA Revenues

Oregon's MSA payments are deposited in the Tobacco Settlement Funds Account (TSFA), which is administered by the Department of Administrative Services (ORS 293.537). After August of 2001, interest earnings on the Account accrues to the General Fund.

MSA revenue estimates come from two sources: the National Association of Attorney Generals and the underwriting community (Global Insight). The most conservative of these estimates is used for budgeting purposes. Actual payments come from the MSA escrow agent (PricewaterhouseCoopers). MSA revenue, as an Other Funds revenue source, is not included in the state's General Fund revenue forecast, with the exception of accrued interest earnings.

The following table details MSA revenues over the 1999-01 through the 2015-17 biennia.

Table A: Master Settlement Agreement Revenue*

#	Biennia	Main Allocable Payment	Strategic Contribution Payment	Disputed Payment Withheld	Disputed Payment Received	Net Revenue	$ Chg.	% Chg.
1	1999-01	$161.6	$--	$--	$--	$161.6	--	--
2	2001-03	174.2	--	--	--	174.2	12.6	+8%
3	2003-05	145.2	--	--	--	145.2	(29.0)	-17%
4	2005-07	137.4	--	--	--	137.4	(7.8)	-5%
5	2007-09	155.1	39.0	(12.0)	6.2	188.4	51.0	+37%
6	2009-11	143.8	36.1	(20.1)	--	159.8	(28.6)	-15%
7	2011-13	142.5	35.8	(20.5)	--	157.8	(2.0)	-1%
8	2013-15	139.9	35.2	(20.4)	8.9	163.7	5.9	+4%
9	2015-17-E	141.0	35.5	(21.0)	--	155.5	(8.2)	-5%
	Total	**$1,340.7**	**$181.6**	**($94.0)**	**$15.1**	**1,443.3**		
	Average	$149.0	$36.3	($18.8)	$7.6	$160.4		

*The figures provided in this table were compiled and summarized by the Legislative Fiscal Office from estimated and actual revenue tracked by the Department of Justice and the Department of Administrative Services. Numbers and percentages may not foot due to rounding.

Since December of 1999, Oregon has received $1.44 billion in MSA revenue. In gross dollars, $1.34 billion, or 93%, of the revenue is attributable to the MSA main or allocable payment and $181.6 million, or 13%, to the strategic contribution payment. These figures are then reduced by approximately $94 million in disputed payments, as of estimates through the spring of 2017. The average main or allocable share payment has been $149 million per biennium and the average strategic payment has been $36.3 million per biennium.

In the early years of the MSA, states received initial payments for the years 1998 through 2003. These initial payments began with the 1999-01 biennium and were comprised of Oregon's main allocable payment plus TSFA investment earnings of $9.5 million during the 1999-01 biennium. The strategic payment began in 2008, but as noted will end in 2017.

MSA payment for the 2017-19 biennium is estimated to be $133.5 million, $21.85 million, or 14%, lower than the 2015-17 biennium due to the phase-out of the final strategic contribution payment for the state. The last such payment will be received in April of 2017 and total approximately $17.4 million before withholding for disputed payment. This forecast is expected to hold through the 2017-19 legislatively adopted budget process as an arbitration panel decision on the 2004 disputed payment account ($7.7 million) is not expected until the fall of 2017.

As noted previously, TSFA revenue is exclusively from the MSA as there is no NPM settlement proceeds deposited in the Account.

MSA Expeditures

The Legislature allocates MSA revenue up to a maximum amount from the TSFA through a budget measure each legislative session or makes adjustments to an MSA allocation with a budget measure. In order for a TSFA allocation to be expended, however, an agency requires Other Funds expenditure limitation.

There are no statutory priorities, restrictions, dedications, or MSA contractual obligations related to MSA revenue. Two consistent priorities for MSA revenue, however, are diligent enforcement and contractual debt service payments, discussed in more detail below.

Oregon voters, in a general election held on November 7, 2000, considered, but failed to approve Ballot Measure 89, which had sought a constitutional dedication of MSA proceeds for health, housing, and transportation programs.

The balance in the TSFA is never fully allocated by the Legislature because a reserve balance is set aside for cash flow purposes in order to pay the next biennium's debt service payment (revenue needed prior to the next scheduled April payment). For the current biennium, the reserve amount is $15.2 million. Any amount above the reserve represents the true carryforward for the Account.

The Legislature has allocated MSA funding for ten purposes, most of which are ongoing, but some were for one-time allocations.

MSA funding has consistently been allocated to support debt service payments and treasury fees on state appropriation bonds and Oregon Health and Science University (OHSU) for the Oregon Opportunity bonds, discussed in more detail below; for the Oregon Health Authority for the Oregon Health Plan; and for the Department of Justice for the Tobacco Enforcement Fund and NPM diligent enforcement activities.

MSA funding has been used somewhat less frequently to fund transfers to the state General Fund for general governmental use; the Oregon Health Authority for Public Health and tobacco prevention and cessation programs; and for the Oregon Department of Education for K-12 physical education grants. MSA funding has been used once for funding in the Oregon Health Authority for the Community Mental Health program and Business Oregon [Oregon Business Development Department] for Oregon Resources and Technology Development.

The following table details the use of tobacco settlement revenues over the period 2001-03 to the current 2015-17 biennium, listed from the largest allocation to the smallest.

Table B: Tobacco Settlement Funds Account Allocation History*

Allocation/Biennia (in millions)	2001-2003	2003-2005	2005-2007	2007-2009	2009-2011	2011-2013	2013-2015	2015-2017	Grand Total	% Total
State Appropriation Bonds Debt Service	--	$41.7	$86.4	$112.0	$138.9	$144.6	$28.8	--	$552.5	39%
Oregon Health Authority - Oregon Health Plan**	$229.0	$42.2	$9.0	--	$6.5	$30.0	116.1	$101.8	$534.6	37%
Oregon Health and Science University - Oregon Opportunity bonds Debt Service	--	$9.7	$31.8	$31.8	$28.5	$31.2	$31.1	$30.9	$195.1	14%
State General Fund	$99.2	--	--	$6.0	--	--	--	--	$105.2	7%
Oregon Health Authority - Community Mental Health	--	--	--	--	--	--	--	$16.0	$16.0	1%
Oregon Health Authority - Public Health	$1.9	--	--	--	--	--	$4.0	$4.1	$10.0	1%
Oregon Department of Education - Physical Education	--	--	--	--	--	--	$4.0	$4.1	$8.1	1%
Department of Justice - Tobacco Enforcement Fund	--	$0.7	$0.7	$0.9	$1.0	$1.2	$1.3	$1.3	$7.1	0.5%
Business Oregon/ Oregon Business Development Department - Oregon Resources and Technology Development	$5.0	--	--	--	--	--	--	--	$5.0	0.3%
State Treasurer - Bond Fees	--	--	--	$0.07	$0.09	$0.02	$0.01	$0.02	$0.21	.01%
Total Biennial Allocation	$335.1	$94.3	$127.9	$150.8	$175.1	$207.0	$185.4	$158.2	$1,433.8	100%

*The figures provided in this table were compiled and summarized from actual expenditures tracked by the Department of Administrative Services - Chief Financial Office. Numbers and percentages may not foot due to rounding.

**Includes a 2001-03 allocation to the Insurance Pool Governing Board in the amount of $17.2 million.

Oregon's Securitization of the MSA Revenue Stream

Since receiving MSA payments, some states have securitized their entire MSA settlement revenue stream in order to receive a lump-sum, up-front payment. Securitization is the process of selling bonds that are backed by settlement payments. The Oregon Legislature has securitized MSA revenue for only two purposes: OHSU for Oregon Opportunity bonds and state appropriation bonds.

The Oregon Opportunity Bonds (Article XI-L of the Oregon Constitution) were issued in 2002 and 2003 (later refinanced at a lower interest rate in 2010 and 2011) to fund the capital costs of the Oregon Opportunity Program of the OHSU. The state originally issued a combined total of $203.2 million in Opportunity bonds. The bonds will be retired in the 2023-25 biennium. The current outstanding balance is $97.9 million, as of July 2016. The Department of Administrative Services - Chief Financial Office provided the following description of how the bond proceeds have been used:

> The Oregon Opportunity Program is a program for research in health care and biotechnology that had five specific goals: (1) bring world-class researchers to OHSU; (2) add state of the art lab space; (3) improve ability to capture the economic value of academic research; (4) distribute the benefits to Oregonians statewide; and (5) more than match the state's contribution. State bond proceeds were used to help the program meet its five goals by successfully recruiting leading researchers, resulting in increased research and grant funding. Successful recruiting also led to the creation and expansion of research centers and programs. To support the expanded research, OHSU constructed new building space, purchased new equipment, made improvements to existing space, and increased its research administration. OHSU also created a physicians practice network and assisted in creating a high-speed communications network.

The 2001 economic recession reduced state General Fund revenues. The state appropriation bonds (technically "appropriation credits" rather than a specific type of constitutionally authorized bonds), authorized by Senate Bill 856 (2003), were issued April 16, 2003 in the amount of $431.6 million to assist the state in balancing its budget for the 2001-03 biennium. Proceeds of the bond sale were credited to the General Fund and were allowed to be used for purposes for which moneys in the General Fund could be expended. The issuance forestalled what otherwise would have been deeper spending cuts in the final months of that biennium. The bonds were completely repaid in September 2013 (2013-15 biennium).

Conclusion

The following conclusions can be drawn from Oregon's MSA history:

- The Legislature has consistently allocated MSA revenue for a narrow list of priorities
- MSA revenue has reduced what otherwise would have been General Fund expenses
- The majority of MSA allocations have funded state health-related investments
- The state has pursued a conservative MSA securitizing (i.e., bonding) strategy
- DOJ's diligent enforcement of NPM statutes has protected the state's MSA revenue stream

The expenditure history of the MSA shows the Legislature has consistently allocated MSA revenue for a relatively narrow list of priorities, even in absence of a constitution or statutory requirement. The majority of MSA allocations have funded state health-related investments totaling over $763.8 million, or 53.3%, of all MSA funding, which includes:

- Oregon Health Authority - Oregon Health Plan ($534.6 million)
- Oregon Health and Science University - Oregon Opportunity bonds Debt Service ($195.1 million)
- Oregon Health Authority - Community Mental Health ($16 million)
- Oregon Health Authority - Public Health ($10 million)
- Oregon Department of Education - Physical Education ($8.1 million)

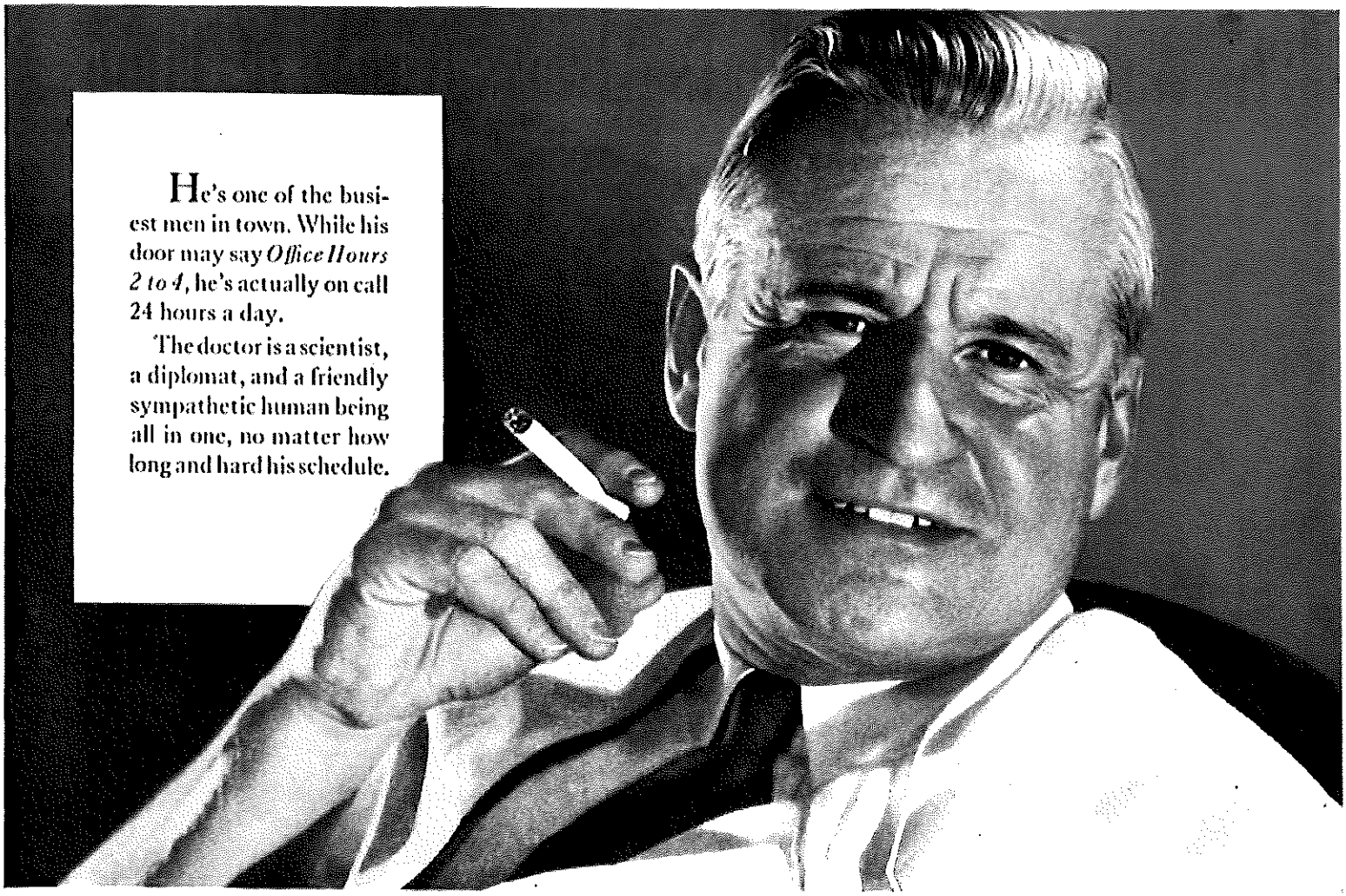
The state has pursued conservative securitization of the MSA revenue stream by only obligating 52% of the available revenue for debt service prior to the repayment of the state appropriation bonds.

Additionally, as an Other Funds source of revenue, MSA funds have been used to reduce what otherwise would have been considered General Fund expenses, with the prime example being allocations supporting the Oregon Health Plan.

The state General Fund has benefited as interest earnings on the TSFA are used to fund general governmental purposes, including the $3 million needed each biennium to defend the state's diligent enforcement actions in front of the arbitration panel.

Oregon's diligent enforcement efforts, coupled with the state's representation at arbitration hearings, have been consistently funded and have protected the state's MSA revenue stream.

ATTACHMENT 2



He's one of the busiest men in town. While his door may say *Office Hours 2 to 4*, he's actually on call 24 hours a day.

The doctor is a scientist, a diplomat, and a friendly sympathetic human being all in one, no matter how long and hard his schedule.

According to a recent Nationwide survey:

MORE DOCTORS SMOKE CAMELS THAN ANY OTHER CIGARETTE

DOCTORS in every branch of medicine—113,597 in all—were queried in this nationwide study of cigarette preference. Three leading research organizations made the survey. The gist of the query was—What cigarette do you smoke, Doctor?

The brand named most was Camel!

The rich, full flavor and cool mildness of Camel's superb blend of costlier tobaccos seem to have the same appeal to the smoking tastes of doctors as to millions of other smokers. If you are a Camel smoker, this preference among doctors will hardly surprise you. If you're not—well, try Camels now.

Your "T-Zone" Will Tell You...

T for Taste . . .
T for Throat . . .
that's your proving ground for any cigarette. See if Camels don't suit your "T-Zone" to a "T."

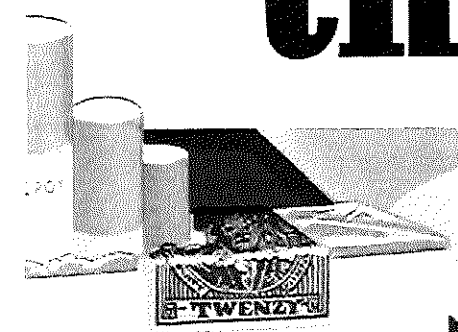
CAMELS *Costlier Tobaccos*

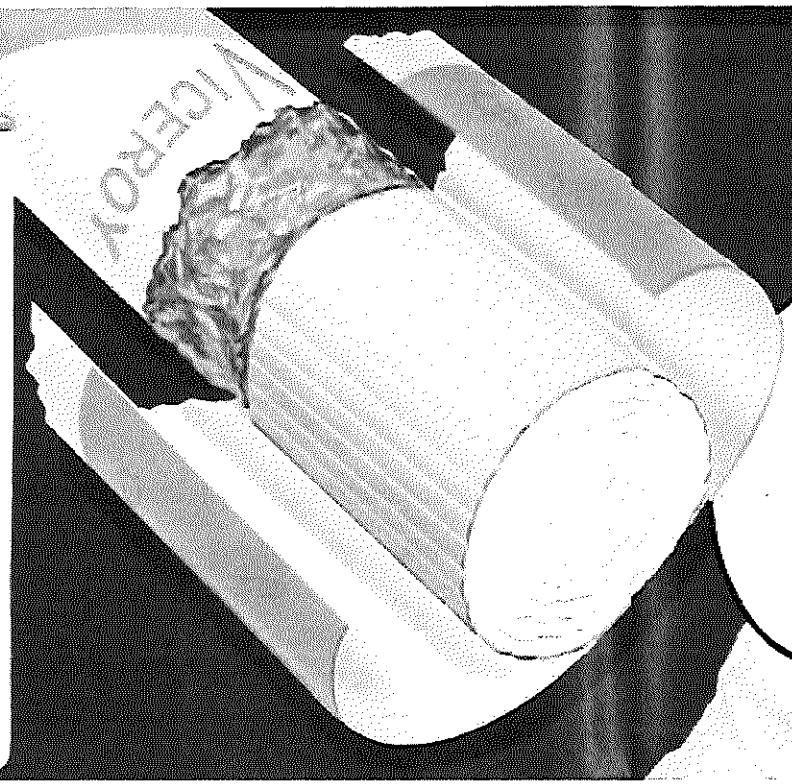
20,679* Physicians say "LUCKIES are *less irritating*"

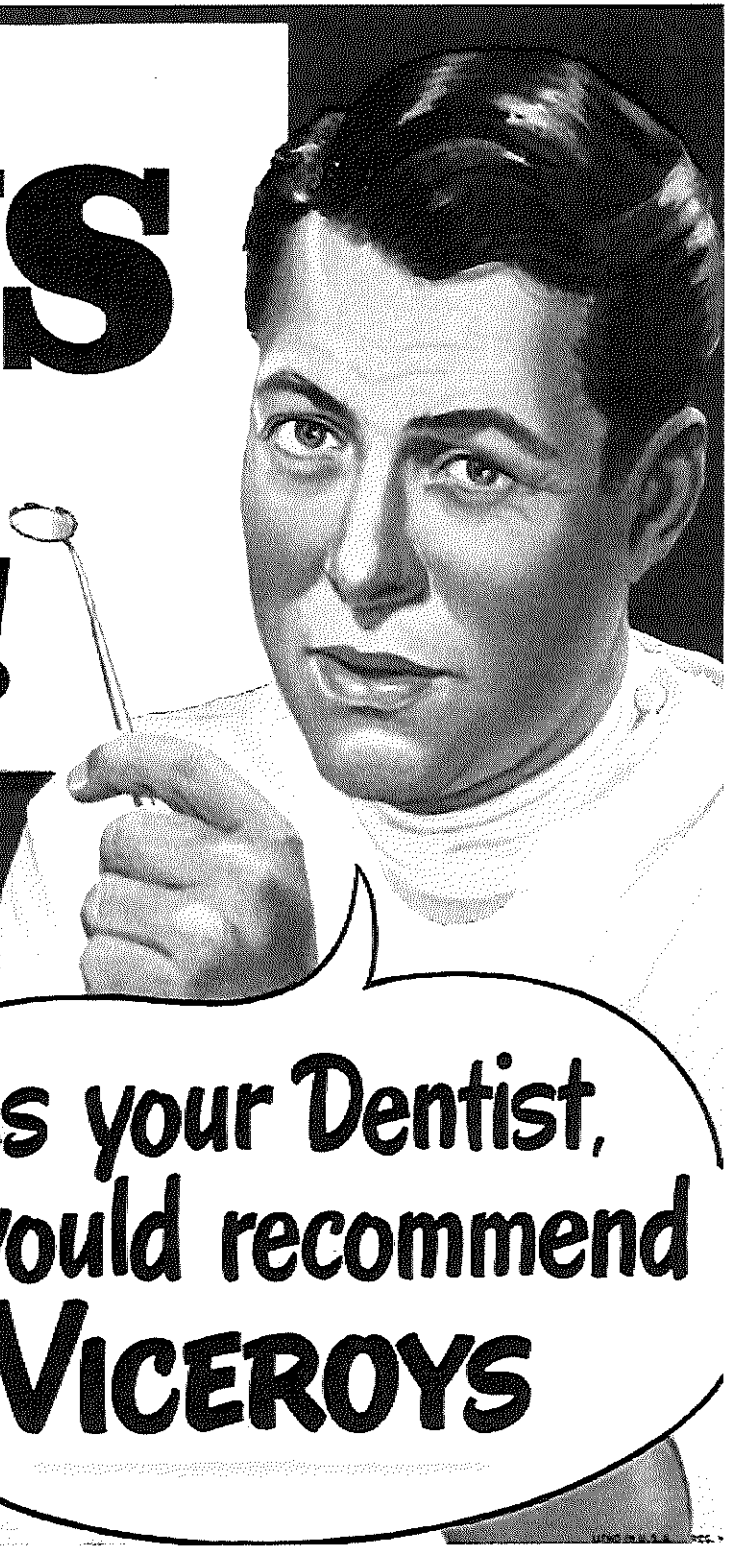
"It's toasted"

Your Throat Protection against irritation against cough

Viceroys FILTER the Smoke!

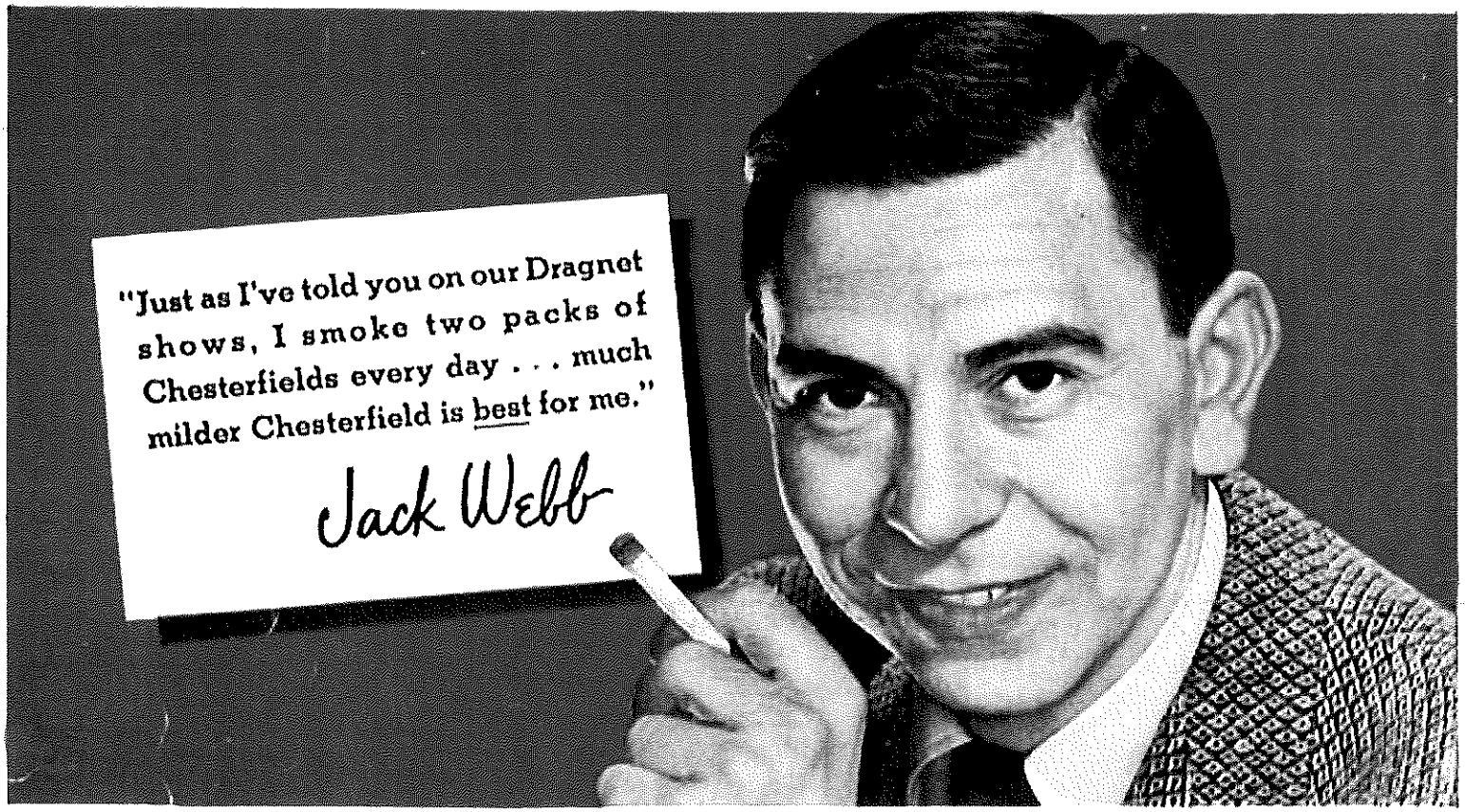






As your Dentist, I would recommend VICEROYS

VICEROY
Filter Tip
CIGARETTES



Chesterfield is Best for YOU!

CHESTERFIELD contains tobaccos of better quality and higher price than any other king-size cigarette . . . the same as regular Chesterfield.

CHESTERFIELD—FIRST CIGARETTE TO OFFER SMOKERS PREMIUM QUALITY IN BOTH REGULAR AND KING-SIZE

WHEN you are asked to try a cigarette you want to know, and you *ought* to know, what that cigarette has meant to people who smoke it all the time.

For a full year now, a medical specialist has given a group of Chesterfield smokers thorough examinations every two months. He reports:

no adverse effects to their nose, throat or sinuses from smoking Chesterfields.

More and more men and women all over the country are finding out every day that Chesterfield is best for them.

Enjoy your Smoking!

Try *Much Milder* Chesterfield with its *extraordinarily* good taste.

An eminent scientist writes the head chemist in our Research Department:

"Chesterfield Cigarettes are just as pure as the water you drink"

THE WATER YOU DRINK is tested from time to time by expert chemists to make sure that it is free from all injurious substances—that it is pure.

So it is in the manufacture of Chesterfield cigarettes. Expert chemists test all the materials that are used in any way in Chesterfield's manufacture, to make sure that everything that goes into Chesterfields is just right.

THE LEAF TOBACCO IS PURE. Long and mild—drying machines of the most modern type—scientifically "dry" and clean and purify the natural tobacco leaves by exact high-temperature treatment.

Then the shreds of cut tobacco, as you see them in your Chesterfields, are again heated, cleaned and purified. From these pure tobaccos the cigarettes are made, and only the purest paper—the best that can be made—is used for Chesterfields.

Cigarettes used to be made in an old-fashioned way, by hand. Now, no hand but yours touches Chesterfields—another purity safeguard.

Chesterfields are made and packed in clean, sanitary factories where even the air is changed every hour and one-half minutes—purity again.

ALL THIS CARE is taken to give you Chesterfields as nearly perfect as cigarettes can be made. Delivered in a moisture-proof, sealed package, they reach you just as good, just as pure as when they leave the factory. Good . . . they've got to be good—they're just as pure as the water you drink!

I'M SENDING CHESTERFIELDS to all my friends.
That's the merriest Christmas any smoker can have—
Chesterfield mildness plus no unpleasant after-taste

Ronald Reagan

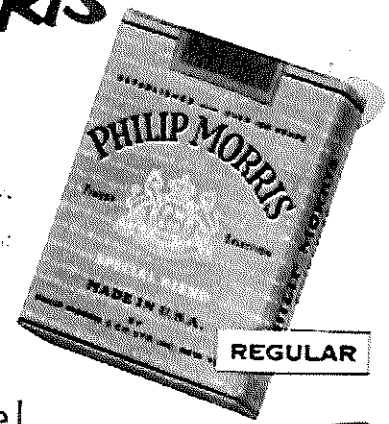
Now Millions Know! ONE

KING SIZE

tops 'em all for TASTE and COMFORT!

Your throat can tell— it's PHILIP MORRIS

No matter what brand of cigarette you are now smoking . . . there's another smoking pleasure waiting for you in the new PHILIP MORRIS King-Size. Millions of smokers have tried them . . . and are buying them over and over again! Once you've tried them, you will, too. Because from the very first puff, your throat can tell that here, at last, is a cigarette not only good to smoke . . . but good to the smoker . . . good to you! So . . . join the millions who now know PHILIP MORRIS King-Size tops 'em all for taste and comfort. Try a carton—you!



America's **Finest** Cigarette!

CALL FOR **PHILIP MORRIS**


CHAMPION
Monte Irvin
CHAMPION
Willie Mays
SMOKE OUR BRAND
CHESTERFIELD
THEY'RE REALLY GOOD TO YOU

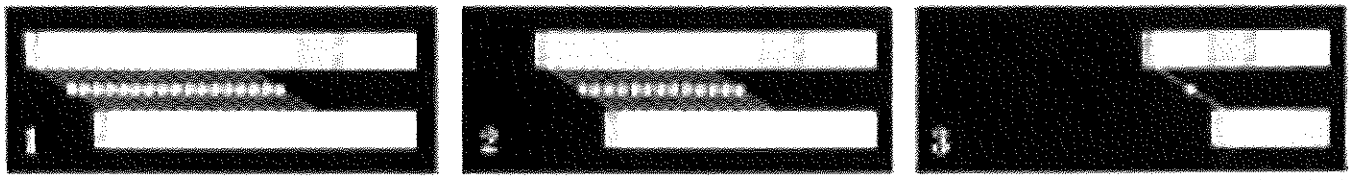
Guard Against Throat-Scratch

enjoy the smooth smoking of fine tobaccos

...smoke PALL MALL
the cigarette whose mildness
you can measure

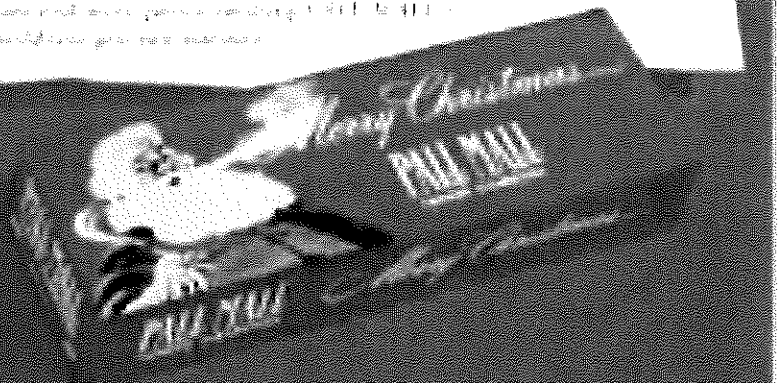
Study This Puff Chart:

PUFF BY PUFF...YOU'RE ALWAYS AHEAD WITH PALL MALL



Outstanding

...and they are mild!



P.S. LET A CARTON OF PALL MALLS SAY "MERRY CHRISTMAS" FOR YOU

IS THIS YOU FIVE YEARS FROM NOW?

When tempted to over-indulge

"Reach for a Lucky instead"

Be moderate—be moderate in all things, even in smoking. Avoid that future shadow* by avoiding over-indulgence, if you would maintain that modern, ever youthful figure. "Reach for a Lucky instead."

Lucky Strike, the finest Cigarette you ever smoked, made of the finest tobacco—The Cream of the Crop—"IT'S TOASTED." **Lucky Strike** has an extra, secret heating process. Everyone knows that heat purifies and so 20,679 physicians say that **Luckies** are less irritating to your throat.

"It's toasted"

Your Throat Protection—against irritation—against cough.

*We do not say smoking **Luckies** reduces flesh. We do say when tempted to over-indulge, "Reach for a **Lucky** instead."

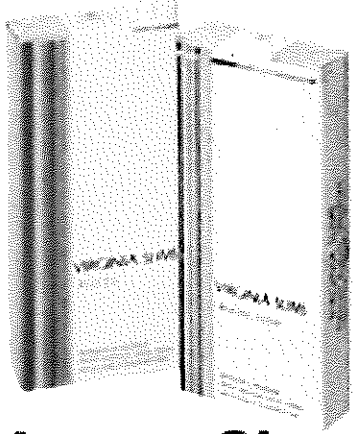
We make Virginia Slims especially for women because they are biologically superior to men.

That's right, *superior*. Women are more resistant to starvation, fatigue, exposure, shock, and illness than men are.

Women have two "X" chromosomes in their sex cells, while men have only one "X" chromosome and a "Y" chromosome...which some experts consider to be the inferior chromosome.

They are also less inclined than men to congenital baldness, Albinism of the eyes, improperly developed sweat glands, color blindness of the red-green type, day blindness, defective hair follicles, defective iris, defective tooth enamel, double eyelashes, skin cysts, shortsightedness, night-blindness, nomadism, retinal detachment, and white occipital locks of hair.

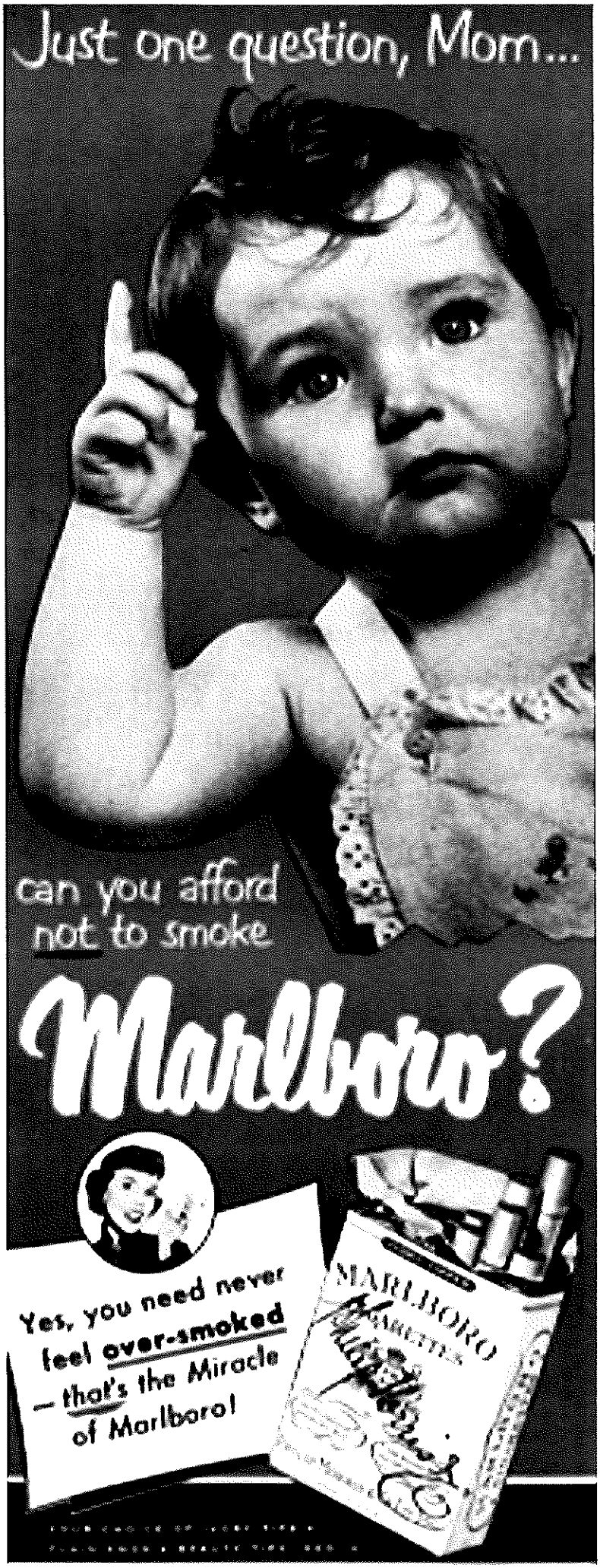
In view of these and other facts, the makers of Virginia Slims feel it highly inappropriate that women continue to use the fat, stubby cigarettes designed for mere men.



Virginia Slims.

Slimmer than the fat cigarettes men smoke.
With which Virginia finds women like.

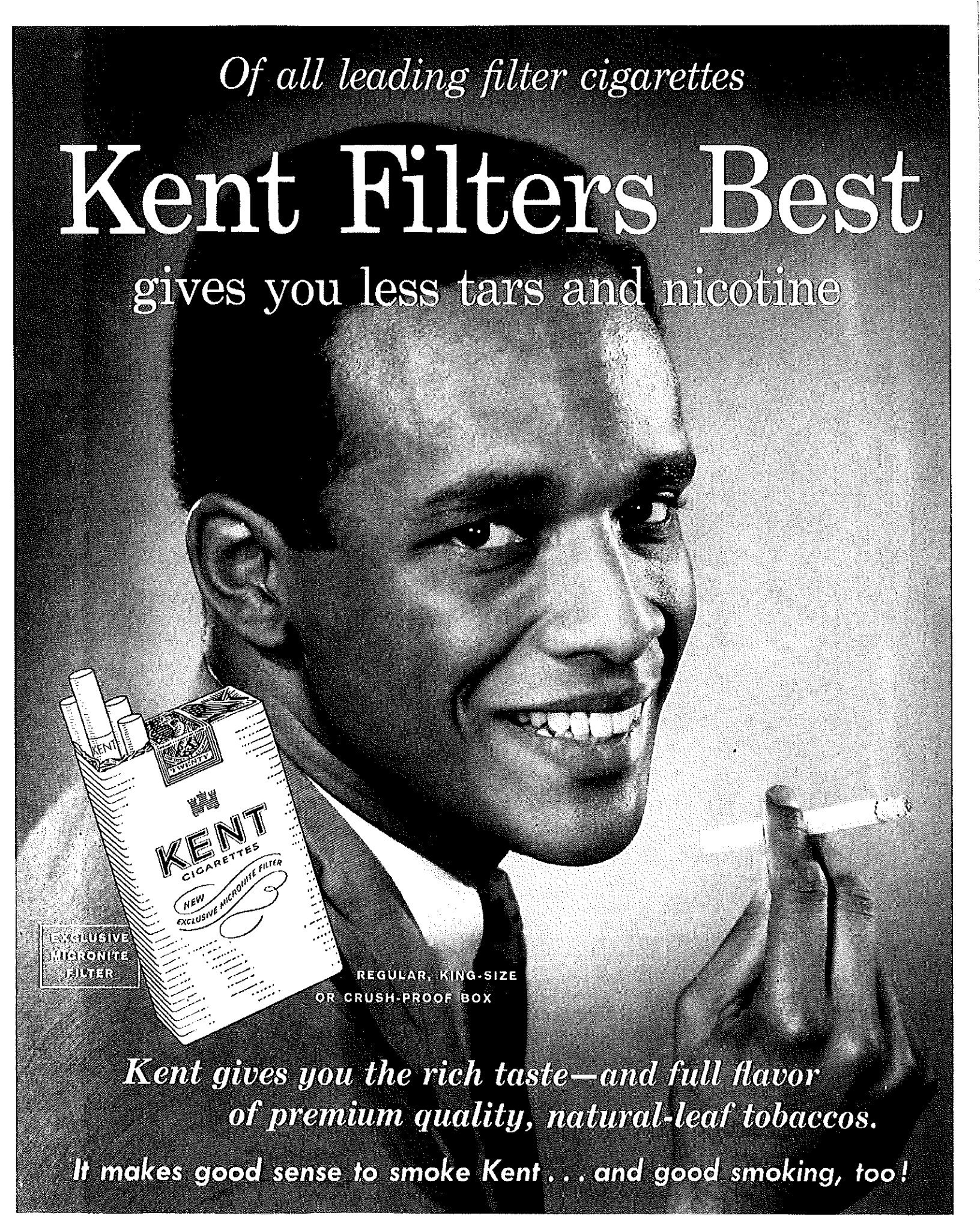
You've come a long way, baby.


Just one question, Mom...
can you afford not to smoke
Marlboro?
Yes, you need never feel over-smoked — that's the Miracle of Marlboro!
MARLBORO

Of all leading filter cigarettes

Kent Filters Best

gives you less tars and nicotine



Kent gives you the rich taste—and full flavor of premium quality, natural-leaf tobaccos.

It makes good sense to smoke Kent . . . and good smoking, too!

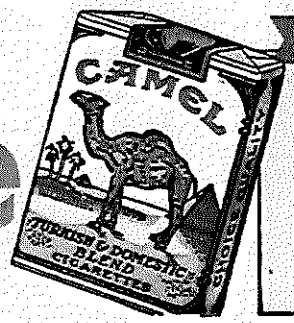
A Product of P. Lorillard Company—First with the finest cigarettes—through Lorillard Research!

R. J. Reynolds Tobacco Company, Winston-Salem, North Carolina

THE *SMOKE* OF SLOWER-BURNING CAMELS CONTAINS

28% Less Nicotine

THAN THE AVERAGE OF THE 4 OTHER LARGEST-SELLING CIGARETTES TESTED—LESS THAN ANY OF THEM—ACCORDING TO INDEPENDENT SCIENTIFIC TESTS OF *THE SMOKE ITSELF!*

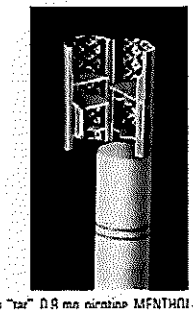


THE CIGARETTE OF COSTLIER TOBACCOS

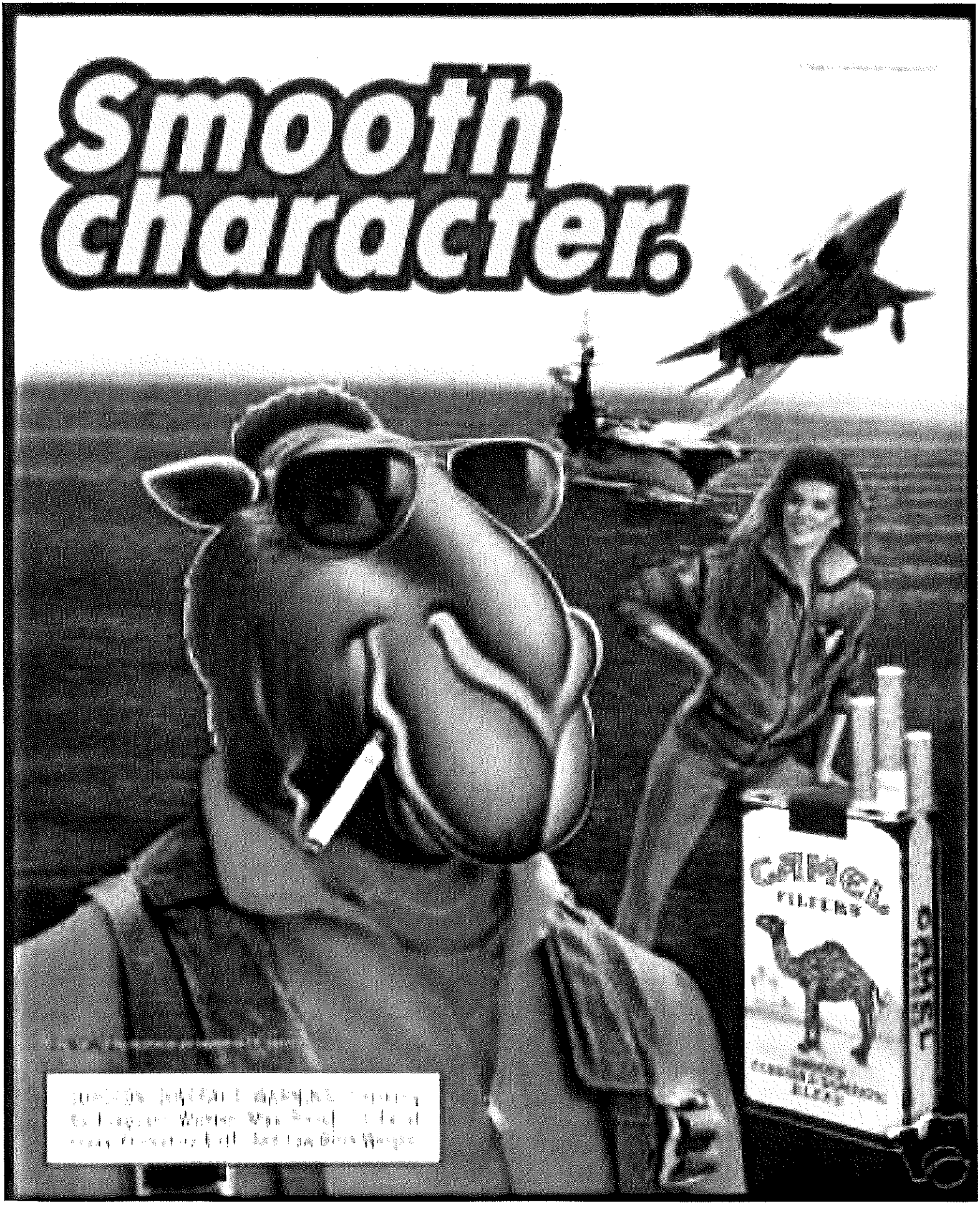
By burning 25% slower than the average of the 4 other largest-selling brands tested—slower than any of them—Camels also give you a smoking *plus* equal, on the average, to

5 EXTRA SMOKES PER PACK!

The filter system you'd need a scientist to explain... but Doral says it in two words, "Taste me"



FILTER: 14 mg "tar" 0.9 mg nicotine. MENTHOL: 13 mg "tar" 1.0 mg. nicotine, av. per cigarette, FTC Report NOV.70.


Smooth character.
CAMEL
FILTERS

ATTACHMENT 3

A Frank Statement to Cigarette Smokers

RECENT REPORTS on experiments with mice have given wide publicity to a theory that cigarette smoking is in some way linked with lung cancer in human beings.

Although conducted by doctors of professional standing, these experiments are not regarded as conclusive in the field of cancer research. However, we do not believe that any serious medical research, even though its results are inconclusive should be disregarded or lightly dismissed.

At the same time, we feel it is in the public interest to call attention to the fact that eminent doctors and research scientists have publicly questioned the claimed significance of these experiments.

Distinguished authorities point out:

1. That medical research of recent years indicates many possible causes of lung cancer.

2. That there is no agreement among the authorities regarding what the cause is.

3. That there is no proof that cigarette smoking is one of the causes.

4. That statistics purporting to link cigarette smoking with the disease could apply with equal force to any one of many other aspects of modern life. Indeed the validity of the statistics themselves is questioned by numerous scientists.

We accept an interest in people's health as a basic responsibility, paramount to every other consideration in our business.

We believe the products we make are not injurious to health.

We always have and always will cooperate closely with those whose task it is to safeguard the public health.

For more than 300 years tobacco has given solace, relaxation, and enjoyment to mankind. At one time or another during those years critics have held it responsible for practically every disease of the human body. One by one these charges have been abandoned for lack of evidence.

Regardless of the record of the past, the fact that cigarette smoking today should even be suspected as a cause of a serious disease is a matter of deep concern to us.

Many people have asked us what we are doing to meet the public's concern aroused by the recent reports. Here is the answer:

1. We are pledging aid and assistance to the research effort into all phases of tobacco use and health. This joint financial aid will of course be in addition to what is already being contributed by individual companies.

2. For this purpose we are establishing a joint industry group consisting initially of the undersigned. This group will be known as TOBACCO INDUSTRY RESEARCH COMMITTEE.

3. In charge of the research activities of the Committee will be a scientist of unimpeachable integrity and national repute. In addition there will be an Advisory Board of scientists disinterested in the cigarette industry. A group of distinguished men from medicine, science, and education will be invited to serve on this Board. These scientists will advise the Committee on its research activities.

This statement is being issued because we believe the people are entitled to know where we stand on this matter and what we intend to do about it.

TOBACCO INDUSTRY RESEARCH COMMITTEE

5400 EMPIRE STATE BUILDING, NEW YORK 1, N. Y.

SPONSORS:

THE AMERICAN TOBACCO COMPANY, INC.
Paul M. Hahn, President

BENSON & HEDGES
Joseph F. Cullman, Jr., President

BRIGHT BELT WAREHOUSE ASSOCIATION
F. S. Royster, President

BROWN & WILLIAMSON TOBACCO CORPORATION
Timothy V. Hartnett, President

BURLEY AUCTION WAREHOUSE ASSOCIATION
Albert Clay, President

BURLEY TOBACCO GROWERS COOPERATIVE ASSOCIATION
John W. Jones, President

LARUS & BROTHER COMPANY, INC.
W. T. Reed, Jr., President

P. LORILLARD COMPANY
Herbert A. Kent, Chairman

MARYLAND TOBACCO GROWERS ASSOCIATION
Samuel C. Linton, General Manager

PHILIP MORRIS & CO., LTD., INC.
O. Parker McComas, President

R. J. REYNOLDS TOBACCO COMPANY
E. A. Darr, President

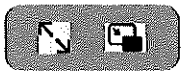
STEPHANO BROTHERS, INC.
C. S. Stephano, D.Sc., Director of Research

TOBACCO ASSOCIATES, INC.
(An organization of flue-cured tobacco growers)
J. R. Hutson, President

UNITED STATES TOBACCO COMPANY
J. W. Peterson, President

ATTACHMENT 4

Tobacco CEO's Statement to Congress 1994 News Clip "Nicotine is not addictive."



April 14, 1994 - Hearing on the Regulation of Tobacco Products House Committee on Energy and Commerce Subcommittee on Health and the Environment

The Subcommittee met, pursuant to notice, at 9:05 a.m., 2123 Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Opening Statement from Chairman Henry A. Waxman

REP. WAXMAN: The meeting of the subcommittee will come to order. I'd like to ask our guests to please take your seats. This is an historic hearing. For the first time ever, the chief executive officers of our Nation's tobacco companies are testifying together before the U.S. Congress. They are here because this subcommittee has legislative jurisdiction over those issues that affect our health. And no health issue is as important as cigarette smoking. It is sometimes easier to invent fiction than to face the truth. The truth is that cigarettes are the single most dangerous consumer product ever sold. Nearly a half million Americans die every year as a result of tobacco. This is an astounding, almost incomprehensible statistic. Imagine our Nation's outrage if two fully loaded jumbo jets crashed each day, killing all aboard. Yet that is the same number of Americans that cigarettes kill every 24 hours. Sadly, this deadly habit begins with our kids. Each day 3,000 children will begin smoking. In many cases they become hooked quickly and develop a life long addiction that is nearly impossible to break. For the past 30 years a series of surgeons general have issued comprehensive reports outlining the dangers these children will eventually face. Lung cancer, heart disease, emphysema, bladder cancer, and stroke are only some of the diseases caused by tobacco causes. And now we know that kids will face a serious health threat even if they don' t smoke. Environmental tobacco smoke is a Class A carcinogen, and it sickens more than 1 million kids every year. In fact, five former surgeons general of

the United States testified before this subcommittee this year, that the most important legislation in disease prevention that we could enact would be restrictions on smoking in public places. This subcommittee will soon act on that legislation, and it will consider other measures as well. This hearing will aid our efforts by presenting an important perspective. But these hearings are important for another reason as well.For decades the tobacco companies have been exempt from the standards of responsibility and accountability that apply to all other American corporations. Companies that sell that sell aspirin, cars, and soda are all held to strict standards when they cause harm. We don't allow those companies to sell goods that recklessly endanger consumers. We don't allow them to suppress evidence of dangers when harm occurs. We don't allow them to ignore science and good sense. And we demand that when problems occur, corporations and their senior executives be accountable to Congress and the public. This hearing marks the beginning of a new relationship between Congress and the tobacco companies. The old rules are out, the standards that apply to every other company are in. We look for- ward to hearing the testimony this morning, and to working with these companies to begin to reduce the extraordinary public health threat that tobacco poses.

An old proverb says that a journey of a thousand miles must begin with a single step. Today is the first step. Many more are to come as we deal with the most serious health problem facing our Nation.

[Tobacco company CEOs declare, under oath, that nicotine is not addictive]

REP. RON WYDEN: Let me begin my questioning on whether or not nicotine is addictive. Let me ask you first, and I'd like to just go down the row, whether each of you believes that nicotine is not addictive. I heard virtually all of you touch on it. Yes or no, do you believe nicotine is not addictive?

MR. WILLIAM CAMPBELL
I believe nicotine is not addictive, yes.

REP. RON WYDEN: Mr. Johnston?

MR. JAMES JOHNSTON
Mr. Congressman, cigarettes and nicotine clearly do not meet the classic definition of addiction. There is no intoxication.

REP. RON WYDEN: We'll take that as a "no." Again, time is short. I think that each of you believe that nicotine is not addictive. We would just like to have this for the record.

MR. JOSEPH TADDEO
I don't believe that nicotine or our products are addictive.

MR. ANDREW TISCH
I believe that nicotine is not addictive.

MR. EDWARD HORRIGAN
I believe that nicotine is not addictive.

MR. THOMAS SANDEFUR
I believe that nicotine is not addictive.

MR. DONALD JOHNSTON
And I, too, believe that nicotine is not addictive.

Witnesses:
William Campbell, President & CEO, Philip Morris, USA
James W. Johnston, Chairman and CEO, R.J. Reynolds Tobacco Company
Joseph Taddeo, President, U.S. Tobacco Company
Andrew H. Tisch, Chairman and CEO, Lorillard Tobacco Company
Edward A. Horrigan, Chairman and CEO, Liggett Group Inc.
Thomas E. Sandefur, Chairman and CEO, Brown and Williamson Tobacco Corp.
Donald S. Johnston, President and CEO, American Tobacco Company
Chaired by: Henry Waxman (D-CA)

Resources:
Ballot on Tobacco Industry Funding Research and Tobacco Documents at UC and UCSF (/tobacco-funding)

ATTACHMENT 5

PHILIP MORRIS: A LONG HISTORY OF DOUBLE TALK

"Lying is as natural to tobacco executives as breathing once was to their customers."

Editorial, "Drug Pushers: Tobacco Products Should Be Regulated,"
Newsday, September 1, 2006

* *

For some time now, Philip Morris has been engaged in an aggressive public relations effort aimed at convincing policy makers and opinion leaders (and potential jurors) that it has finally turned over a new leaf and become a good corporate citizen and that the company actually wants to reduce teen smoking. But a look at the cigarette company's history shows that this media campaign is nothing more than the same old double talk. Since at least the 1960's, Philip Morris has repeatedly made similar claims that it does not market cigarettes to kids. But internal company documents revealed in the tobacco lawsuits show that Philip Morris has regularly done just that. There are many effective actions Philip Morris could take to prevent and reduce smoking among kids, but it has not – and just talking a good game is not enough.

What Philip Morris Says In Public

1965 The cigarette companies' voluntary "Cigarette Advertising Code" goes into effect. Among its standards: *"Cigarette advertising shall not represent that cigarette smoking is essential to social prominence, distinction, success, or sexual attraction."* [Section 1(d)]

1966 Philip Morris President Joseph F. Cullman, III: *"we do not favor smoking by young people. We think smoking should be a custom for adults."*[1]

1969 Philip Morris President Joseph F. Cullman, III: *"It is the intention of the cigarette manufacturers to continue to avoid advertising directed to young persons; to abstain from advertising in school and college publications; not to distribute sample cigarettes or engage in promotional efforts on school and college campuses; not to use testimonials from athletes or other celebrities who might have special appeal to young people; to avoid advertising which represents that cigarette smoking is essential to social prominence, success, or sexual attraction; and to refrain from depicting smokers engaged in sports or other activities requiring stamina or conditioning beyond those required in normal recreation. . ."*[2]

1982 *"On the industry's behalf, The Tobacco Institute began an advertising campaign which was to reach 110 million Americans with the message, 'Do cigarette companies want kids to smoke? No. As a matter of policy. No. As a matter of praetice. No. As a matter of fact. No.'"*[3]

1984 Philip Morris Executive Ellen Merlo: *"I have never in my job been involved with trying to get a non-smoker to smoke. ...I don't think that advertising convinces people to smoke... I have not seen statistics on when people usually begin to smoke."*[4]

1991 Philip Morris Media Affairs Director Sheila Banks: *"Philip Morris strongly believes that young people should not smoke. Smoking is an adult custom. Selling cigarettes to minors is - and should be- illegal, and Philip Morris fully supports these laws."*[5]

1992 Philip Morris Corporate Statement: *"Education and enforcement at the retail level are the only effective means we have of discouraging children from smoking. We want to assure you that Philip Morris remains firmly committed to supporting laws that prohibit unlawful sales to minors. We continue to lend our fullest support to educational programs as well as make very sure that our cigarette advertising is directed exclusively at adults who choose to smoke."*[6]

1400 I Street, NW Suite 1200 Washington, DC 20005
Phone (202) 296-5469 Fax (202) 296-5427 www.tobaccofreekids.org

1995 Philip Morris President James Morgan: *"We at Philip Morris USA have long held the position that minors should not smoke and should not have access to cigarettes, and we have backed that commitment over the years with a series of concrete actions."*[7]

1995 Philip Morris President James Morgan : *"Philip Morris USA believes now, and always has believed, that minors should not smoke nor should they have access to our cigarettes."*[8]

1996 Philip Morris CEO Geoffrey Bible*: "We do not market cigarettes to children. And we do not want children to smoke."*[9]

1998 Philip Morris CEO Geoffrey Bible*: "I'm ashamed at that. I don't like to see something from the company talking about 16-year-olds. We do not market cigarettes to underage people."*[10]

1998 Philip Morris CEO Geoffrey Bible*: "We should not be marketing cigarettes to young people. It is certainly anomalous to the Philip Morris I know."*[11]

1998 Philip Morris CEO Geoffrey Bible*:* Real solutions include a *"willingness to make fundamental changes in our way of doing business."*[12]

1998 Philip Morris CEO Geoffrey Bible*: "In all my years at Philip Morris, I've never heard anyone talk about marketing to youth."*[13]

1998 Philip Morris President Michael E. Szymanczyk*: "We don't want kids to smoke. We're intensifying our efforts that we started a number of years ago by launching this new smoking-intervention initiative, starting with these ads."*[14]

What They Say In Private: Anti-Youth Smoking As A Public Relations Ploy

1979 *It seems to me our objective is . . . a 'media event' which in itself promises a lot but produces little.*[15]

1991 *The youth [anti-smoking] program and its individual parts support The [Tobacco] Institute's objective of discouraging . . . federal, state, and local restrictions on cigarette advertising.*[16]

1992 *[If Philip Morris took] a more progressive position on tobacco, it would enable the company to move onto a higher moral playing field, to neutralize the tobacco issue and to focus attention on other, more appealing products.*[17]

1995 *If we don't do something fast to project the sense of industry responsibility regarding the youth access issue, we are going to be looking at severe marketing restrictions in a very short time.*[18]

What They Say In Private: Marketing to Kids

1975 *Marlboro's phenomenal growth rate in the past has been attributable in large part to our high market penetration among young smokers . . .15 to 19 years old . . . my own data, which includes younger teenagers, shows even higher Marlboro market penetration among 15-17-year-olds.*[19]

1981 *Because of our high share of the market among the youngest smokers, Philip Morris will suffer more than the other companies from the decline in the number of teenage smokers.*[20]

1981 *[T]he success of Marlboro Red during its most rapid growth period was because it became the brand of choice among teenagers who then stuck with it as they grew older.*[21]

1985 [Marlboro must] *continue growth among new, young smokers...While Marlboro continues to attract increasing shares of young smokers, expected declines in the number of young people restrict future volume gains from this source.*[22]

1992 *Thus, the ability to attract new smokers and develop them into a young adult franchise is key to brand development.*[23]

What They Say In Private: Behavioral Research About Kids

1973 A Philip Morris Marketing Research Department document highlights that within a *"probability sample of 452 teen-agers ages 12-17"* 13 percent smoke an average of 10.6 cigarettes per day and that *"the data from the study are consonant with the findings of other such studies, both at Philip Morris and without."*[24]

1974 *We wonder whether such children may not eventually become cigarette smokers in their teenage years as they discover the advantage of self-stimulation via nicotine. We have already collaborated with a local school system in identifying some such children in the third grade. . .* [25]

1981 *It is important to know as much as possible about teenage smoking patterns and attitudes. Today's teenager is tomorrow's potential regular customer, and the overwhelming majority of smokers first begin to smoke while in their teens . . . it is during the teenage years that the initial brand choice is made.*[26]

Dr. Carolyn Levy – Philip Morris' Senior Vice President of Youth Smoking Prevention who is in charge of the company's $100 million anti-youth smoking campaign – previously worked in the Philip Morris research department on studies on nicotine effects and smoking behaviors.[27] Dr. Levy was also one of two Philip Morris researchers who formally approved the previously quoted special report that stated "Today's teenager is tomorrow's potential regular customer."

Campaign for Tobacco-Free Kids, September 1, 2006

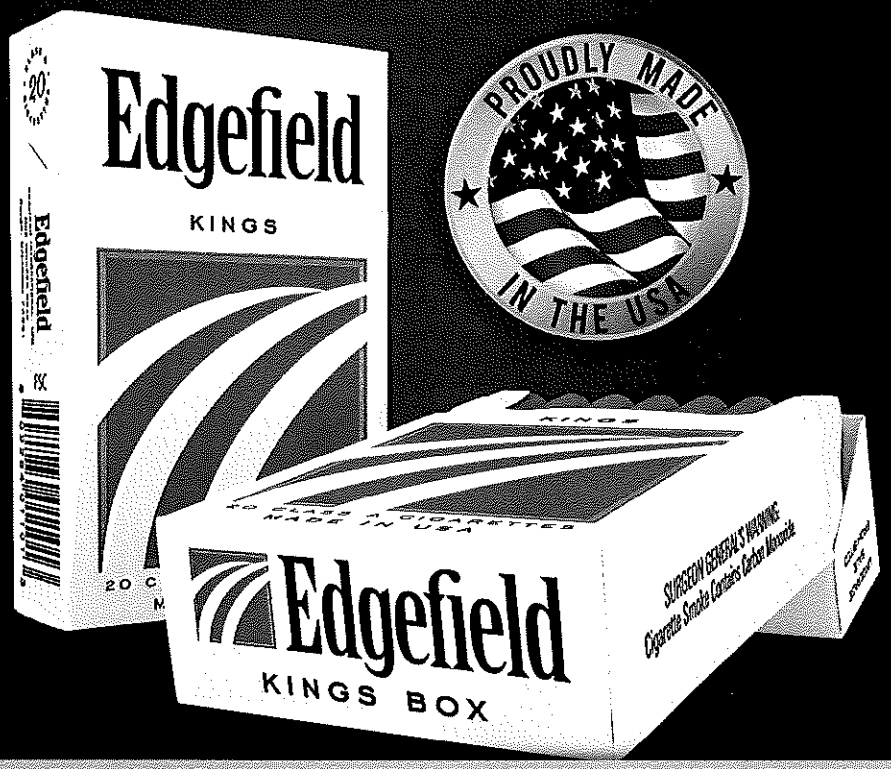
---

[1] Speech to South Carolina Tobacco Warehouse Association, Inc., June 7, 1966, Bates No. 1002600012.
[2] Testimony before US Congress, July 1969.
[3] Philip Morris, *On Youth Smoking*, 1979, Bates No. 2077153116/3117.
[4] Ellen Merlo, June 14, 1984, testimony in *Cipollone v. Liggett.*
[5] Philip Morris Media Affairs Director Sheila Banks, speaking to the Advertising Club of Louisville, February 8, 1991, Bates No. 2025895060/5082.
[6] *Statement of Philip Morris with respect to its marketing practices and policies*, 1992, Bates No. 2500081599/1600.
[7] Morgan, J, *New program to address youth access to our products*, Memo to all Philip Morris USA Employees, June 27, 1995, Bates No. 2060138652/8653.
[8] Philip Morris President James Morgan remarks on the "Action Against Access" program, June 27, 1995, Bates No. 2500050029/0033.
[9] Philip Morris CEO Geoffrey Bible remarks at the 1996 Annual Meeting of Stockholders, April 25, 1996, Bates No. 2500082439/2451.
[10] Testimony of Bible in Minnesota Medicaid suit, March 2, 1998.
[11] Dedman, B, "Tobacco Chief 'Horrified' Over Evidence," The New York Times, March 4, 1998, Bates No. TI13660354.
[12] Philip Morris CEO Geoffrey Bible, testimony before the House Commerce Committee, January 28, 1998, Bates No. 2065112084/2092.
[13] Geoffrey Bible, CEO of Philip Morris, Minneapolis-St. Paul Star Tribune, March 4, 1998.
[14] New York Times, December 3, 1998.
[15] Dryden, F, *August 1 'Pre-Adult Education' Memo*, August 3, 1979, Bates No. TIFL0525654.
[16] Tobacco Institute, *Discussion Paper*, January 29, 1991, Bates No. TIMN0164422/4424.
[17] Hill and Knowlton, *Philip Morris Corporate Affairs Strategic Plan for 1993*, December 3, 1992, Bates No. 2023586677/6725.
[18] Philip Morris, *JJM to PM Invitational – Importance of Youth Issue*, February 9, 1995, Bates No. 2044046017/6022.
[19] Johnston, M, *The Decline in the Rate of Growth of Marlboro Red*, May 21, 1975, Bates No. 1000024921-1000024927.
[20] Johnston, M, *Young Smokers -- Prevalence, Trends, Implications, and Related Demographic Trends*, March 31, 1981, Bates No. 1000390803/0855.
[21] Johnston, M, *Young Smokers -- Prevalence, Trends, Implications, and Related Demographic Trends*, March 31, 1981, Bates No. 1000390803/0855.
[22] Plan Overview, 1985, Bates No. 2043440057/0112, 1985.
[23] PMI Marketing Research, *Worldwide Marlboro Monitor; Five Year Trends, 1988-1992*, 1992, Bates No. 2044895379/5484.
[24] PM USA Marketing Research Department, *Incidence of Smoking Cigarettes*, May 18, 1973, Bates No. 2041761791.
[25] Dunn, WL, *Smoker Psychology*, June 10, 1974, Bates No. 1003288122/8124.
[26] Johnston, M, *Young Smokers -- Prevalence, Trends, Implications, and Related Demographic Trends*, March 31, 1981, Bates No. 1000390803/0855.
[27] See, e.g., Philip Morris Memorandum, "Smoker Psychology" (PM Doc. #1003293097).

ATTACHMENT 6

Edgefield

CIGARETTES



$ 8.88

SURGEON GENERAL'S WARNING: Smoking By Pregnant Women May Result in Fetal Injury, Premature Birth, And Low Birth Weight.

ATTACHMENT 7

Morbidity and Mortality Weekly Report (MMWR)

Cigarette Brand Preference and Pro-Tobacco Advertising Among Middle and High School Students — United States, 2012–2016

Weekly / February 2, 2018 / 67(4);119–124

Siobhan N. Perks[1]; Brian Armour, PhD[2]; Israel T. Agaku, DMD, PhD[2] (VIEW AUTHOR AFFILIATIONS)

View suggested citation

Summary

What is already known about this topic?

Nearly all adult smokers first try cigarettes before age 18 years. Tobacco-advertising activities, among other factors, including peer influence and price, are associated with initiation of smoking and the continued use of tobacco products among youth.

What is added by this report?

Analysis of 2012–2016 National Youth Tobacco Survey data found that Marlboro, Newport, and Camel were the most commonly reported usual brands smoked by middle and high school current (past 30-day) cigarette smokers. In 2016, these three brands accounted for 73.1% and 78.7% of current cigarette smokers in middle and high school, respectively. Ads for these three brands were also the three most commonly identified "favorite cigarette ad" in 2012. Current cigarette smokers who reported exposure to neither e-cigarette ads nor cigarette ads reported significantly lower prevalence of having a usual brand than those who reported exposure to both ads during 2015.

What are the implications for public health practice?

Reducing youth-oriented tobacco marketing, as part of a comprehensive approach in concert with other evidence-based strategies, including comprehensive smoke-free policies, increasing the price of tobacco products, and raising the minimum age of purchase for tobacco products to 21 years, could help reduce the acceptability, affordability, and use of tobacco products among youth.

try cigarettes before age 18 years (*1*), and adolescents can show symptoms of nicotine dependence within days to weeks of the onset of occasional cigarette smoking (*2*). Having a usual cigarette brand among adolescent smokers could reflect exposure and receptivity to pro-tobacco advertising and tobacco product appeal (*1*). To identify usual cigarette brands smoked among U.S. middle and high school students who were current (past 30-day) cigarette smokers, CDC analyzed data from the 2012–2016 National Youth Tobacco Survey (NYTS). Marlboro, Newport, and Camel were the most commonly reported brands smoked during 2012–2016; in 2016, these three were the brands usually smoked for 73.1% and 78.7% of current cigarette smokers in middle and high school, respectively. These three brands also were the three most commonly identified as having a "favorite cigarette ad" in 2012. Efforts to reduce youth exposure to pro-tobacco advertising could help reduce youth smoking (*1*,*3*).

References

Related Materials

[PDF]

NYTS is an annual national survey of U.S. students in grades 6–12.* During 2012–2016, sample sizes ranged from 17,711 (response rate = 63.4%) in 2015 to 24,658 (response rate = 73.6%) in 2012 (*4*). Participants were asked, "During the past 30 days, what brand of cigarettes did you usually smoke?" Response options† were "American Spirit," "Camel," "GPC, Basic, or Doral," "Kool," "Lucky Strike," "Marlboro," "Newport," "Parliament," "Virginia Slims," "I did not smoke a usual brand," "Some other brand not listed here," "I did not smoke a cigarette in the past 30 days," and "Not sure." Responses of "I did not smoke a cigarette in the past 30 days" and "Not sure" were excluded; all other responses were classified as current (past 30-day) cigarette smokers.§ Among current cigarette smokers, any response other than "I did not smoke a usual brand" was classified as having a usual brand.

In the 2012 NYTS only, participants were asked, "What is the name of the cigarette brand of your favorite cigarette ad?" Response options were "American Spirit," "Camel," "GPC, Basic, or Doral," "Kool," "Marlboro," "Newport," "Some other brand not listed here," "I don't have a favorite cigarette ad," and "Not sure." Any response other than "I don't have a favorite cigarette ad" and "Not sure" was classified as having a favorite cigarette ad. In the 2015 NYTS only, exposure to ads for both regular cigarettes and electronic cigarettes (e-cigarettes) over four media categories was assessed (the Internet, newspapers/magazines, retail stores, and TV/movies). An exposure was classified as reporting seeing ads on the assessed medium "Sometimes," "Most of the time," or "Always."¶ The tobacco product exposed to on each advertising medium was classified as 1) neither e-cigarettes nor cigarettes, 2) e-cigarettes only, 3) cigarettes only, and 4) both e-cigarettes and cigarettes.

Among current cigarette smokers, brand-specific prevalence was calculated overall and by school level, sex, grade, race/ethnicity, and smoking frequency within the past 30 days (a response of 20–30 days was considered frequent; a response of 1–19 days was considered infrequent).** Binary logistic regression was used to assess brand-specific linear trends during 2012–2016, adjusting for grade, sex, and race/ethnicity. For 2012 only, agreement between usual brand and favorite cigarette ad was assessed among 1,807 current cigarette smokers with data available for both indicators. For 2015 only, the proportion of current cigarette smokers reporting having a usual brand†† was stratified by amount of reported ad exposure to pro-tobacco advertising across media types. Chi-squared tests and logistic regression were used to determine subgroup differences, with statistical significance set at $p<0.05$. Data were weighted to yield nationally representative estimates.

During 2016, the top three brands usually smoked among current cigarette smokers in all middle school grades combined were Marlboro (38.3%), Newport (21.4%), and Camel (13.4%) (Table). During 2016, 16.5% of middle school current cigarette smokers smoked some other specific brand, and 10.4% had no usual brand. The proportion of current cigarette smokers who smoked Marlboro cigarettes during 2016 was highest among non-Hispanic whites (whites) (54.6%) and lowest among non-Hispanic blacks (blacks) (11.5%; $p<0.05$). Conversely, the proportion who smoked Newport

cigarettes during 2016 was highest among blacks (58.4%) and lowest among whites (7.9%; p<0.05). A higher proportion of female smokers (27.2%) smoked Newport cigarettes than did male smokers (16.6%; p<0.05). Trends during 2012–2016 were not significant for middle school students overall or among subgroups.

Among high school current cigarette smokers, the top three brands usually smoked by students in all grades combined in 2016 also were Marlboro (48.8%), Newport (16.6%), and Camel (13.3%) (Table). During 2016, 15.4% of high school current cigarette smokers smoked other specific brands, and 5.9% reported no usual brand. As was the case among middle school students, Newport was the most prevalent brand among black high school students (47.5% in 2016), and Marlboro was the most prevalent brand among white high school students (59.5% in 2016). During 2016, the proportion of high school current cigarette smokers that smoked Camel cigarettes was highest among Hispanics (18.1%) and lowest among blacks (8.9%). Trend analyses during 2012–2016 indicated an increase in the prevalence of Marlboro smoking for all high school students (38.5% to 48.8%), males (39.4% to 50.0%), females (37.5% to 48.0%), ninth graders (34.3% to 42.9%), 10th graders (37.2% to 45.7%), 12th graders (41.1% to 53.2%), whites (45.8% to 59.5%), and both frequent (42.2% to 59.1%) and infrequent smokers (37.8% to 50.8%) (all p-values for trend <0.05). The prevalence of Newport smoking declined during 2012–2016 among all high school students (23.1% to 16.6%), females (26.0% to 16.8%), and whites (15.4% to 9.5%) (all p-values for trend <0.05). The prevalence of Camel smoking during 2012–2016 declined among all high school students (17.8% to 13.3%), males (17.0% to 12.5%), females (18.6% to 14.2%), 10th graders (19.4% to 14.2%), 12th graders (19.8% to 13.6%), whites (19.6% to 11.9%), and infrequent smokers (19.8% to 12.4%) (all p-values for trend <0.05). The proportion of students who smoked no usual brand increased among all high school students (4.1% to 5.9%), females (2.7% to 6.0%), 10th graders (2.9% to 6.8%), 12th graders (3.3% to 5.1%), and blacks (1.6% to 15.9%) during 2012–2016 (all p-values for trend <0.05).

In 2012, among current cigarette smokers who reported smoking a usual brand, 72.1% identified the same brand as their favorite cigarette ad. The top three favorite cigarette ads were also the top three brands usually smoked (Figure 1).

In 2015, across all advertising media, current cigarette smokers who reported exposure to neither e-cigarette ads nor cigarette ads reported significantly lower prevalence of having a usual brand than those who reported exposure to both ads (Figure 2). By specific advertising media, among those exposed to neither e-cigarette nor cigarette ads versus both ads, the proportion who reported having a usual brand was as follows: for movies/TV (neither ad = 80.5%; both ads = 94.2%), for retail stores (neither = 69.8%; both = 94.8%), for Internet (neither = 79.4%; both = 94.5%), and for magazines/newspapers (neither = 88.0%; both = 94.6%) (all p-values <0.05).

Top

Discussion

During 2012–2016, the top three brands usually smoked by U.S. middle and high school current cigarette smokers were Marlboro, Newport, and Camel; these brands also were the top three favorite cigarette ads reported by current cigarette smokers in middle and high school in 2012. Market data also indicated that these three brands accounted for the largest share (62%) of the U.S. cigarette market during 2016; the percentage shares of retail volume for Marlboro, Newport, and Camel during 2016 were 40.2%, 13.8%, and 8.0% respectively (*5*). Cigarette ads use youth-oriented themes, including those highlighting independence, rebellion, and perceived social acceptability of cigarette smoking (*3*). Previous epidemiologic studies have demonstrated an association between amount of reported ad exposure and most frequently smoked brands among adolescents (*6*); efforts to reduce youth exposure to pro-tobacco advertising might help reduce smoking initiation among U.S. youth (*1*).

Targeted marketing of tobacco products to certain groups can explain differences in brand preferences among subgroups (*1*,*7*,*8*). Whereas Marlboro smoking was more prevalent among whites, Newport, a predominantly menthol brand, was more often smoked by blacks, which is consistent with previous reports that have documented that menthol

cigarettes are marketed to specific demographic groups, including blacks (*7,8*). Among high school students overall, as well as among females, blacks, and 10th and 12th graders, significant increases were observed in the proportion of smokers reporting no usual brand. Having no usual brand might be an indicator of nonspecific cigarette access patterns, including from social sources such as friends (*1*).

The findings in this report are subject to at least four limitations. First, self-reported cigarette smoking is subject to social desirability bias and might be underreported among youth. Second, both brand preferences and pro-tobacco ad exposure were measured at the same time in this cross-sectional study; the data therefore did not permit assessment of temporality. Exposure to ads could increase brand use or brand use could lead to a favorable impression of tobacco ads. Third, these findings might not be generalizable to youth who are not enrolled in traditional schools, (e.g., dropouts [approximately 6.4% among high school students][§§] and those home-schooled [approximately 3.4% of school-aged children]).[¶¶] Finally, the relationships between "favorite cigarette ad" and cigarette brand preferences as assessed in 2012 NYTS might have limited comparability with subsequent years.

In 2014, U.S. cigarette manufacturers spent approximately $8.5 billion, or approximately $1 million per hour, to advertise and promote cigarettes (*9*). Information on cigarette brand usually smoked can help guide efforts to reduce cigarette smoking among the approximately 1.6 million U.S. middle and high school cigarette smokers (*10*). Reducing youth-oriented tobacco marketing, as part of a comprehensive approach in concert with other evidence-based strategies could help reduce the acceptability, affordability, and use of tobacco products among youth (*1*). Such strategies include comprehensive smoke-free policies, increasing the prices of tobacco products, and raising the minimum age of purchase for tobacco products to 21 years (*1*).

Top

Conflict of Interest

No conflicts of interest were reported.

Top

Corresponding author: Israel T. Agaku, iagaku@cdc.gov, 404-580-3276.

Top

---

[1]Rollins School of Public Health, Emory University, Atlanta, Georgia; [2]Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Top

* The study period was restricted to 2012–2016 because the questions assessing cigarette brand usually smoked had different response options in preceding NYTS survey years.

† Because of small sample sizes, "GPC, Basic, or Doral," "Kool," "Lucky Strike," "Parliament," and "Virginia Slims" were collapsed together into one category ("Other specific brand").

§ Final analytical sample for each year (past 30-day cigarette smokers) was as follows: 2012 (n = 3,292), 2013 (n = 2,377), 2014 (n = 2,386), 2015 (n = 1,823), and 2016 (n = 1,739).

¶ For each specific advertising medium assessed, participants could select any one of the following response options that best described their frequency of exposure: "Never," "Rarely," "Sometimes," "Most of the time," or "Always." Participants could also indicate if they did not use the medium assessed (e.g., "I do not use the Internet"). Participants who answered

"Never" or "Rarely," or who indicated they did not use the assessed medium, were classified as nonexposed to that medium; all other responses were classified as exposed.

** Frequency of cigarette smoking was ascertained with the question "During the past 30 days, on how many days did you smoke cigarettes?" Categorical response options were "0 days," "1 or 2 days," "3 to 5 days," "6 to 9 days," "10 to 19 days," "20 to 29 days," and "All 30 days." A response of "0 days" was classified as being a current nonsmoker and was excluded. The remaining response options were dichotomized as infrequent (1–19 days) and frequent (≥20 days) cigarette smokers.

†† Outcome was dichotomized as 0 or 1. Persons who reported having a specific brand they usually smoked ("American Spirit," "Camel," "GPC, Basic, or Doral," "Kool," "Lucky Strike," "Marlboro," "Newport," "Parliament," "Virginia Slims," or "Some other brand not listed here") were treated as a positive response. Those who responded, "I did not smoke a usual brand" were treated as not having a brand usually smoked. Responses of "Not sure" or "I did not smoke a cigarette in the past 30 days" were excluded.

§§ https://www.census.gov/newsroom/press-releases/2016/cb16-tps142.html .

¶¶ https://nces.ed.gov/programs/digest/d15/tables/dt15_206.10.asp?current=yes .

Top

References

1. US Department of Health and Human Services. Preventing tobacco use among youth and young adults: a report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services, CDC; 2012. https://www.surgeongeneral.gov/library/reports/preventing-youth-tobacco-use/full-report.pdf
2. DiFranza JR, Rigotti NA, McNeill AD, et al. Initial symptoms of nicotine dependence in adolescents. Tob Control 2000;9:313–9. CrossRef PubMed
3. National Cancer Institute. The role of the media in promoting and reducing tobacco use. Tobacco control monograph no. 19. Rockville, MD: US Department of Health and Human Services, National Cancer Institute; 2008. https://cancercontrol.cancer.gov/brp/tcrb/monographs/19/m19_complete.pdf
4. CDC. National Youth Tobacco Survey (NYTS). Atlanta, GA: US Department of Health and Human Services, CDC; 2016. https://www.cdc.gov/tobacco/data_statistics/surveys/nyts/index.htm
5. Euromonitor International. Cigarettes in the US. London, United Kingdom: Euromonitor International; 2017. http://www.euromonitor.com/cigarettes-in-the-us/report
6. Substance Abuse and Mental Health Services Administration. Cigarette brand preferences in 2005. Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration; 2007. https://archive.samhsa.gov/data/2k7/cigBrands/cigBrands.pdf
7. Anderson SJ. Marketing of menthol cigarettes and consumer perceptions: a review of tobacco industry documents. Tob Control 2011;20(Suppl 2):ii20–8. PubMed
8. Gittelsohn J, McCormick LK, Allen P, Grieser M, Crawford M, Davis S. Inter-ethnic differences in youth tobacco language and cigarette brand preferences. Ethn Health 1999;4:285–303. CrossRef PubMed
9. Federal Trade Commission. Federal Trade Commission cigarette report for 2014. Washington, DC: Federal Trade Commission; 2017. https://www.ftc.gov/system/files/documents/reports/federal-trade-commission-cigarette-report-2014-federal-trade-commission-smokeless-tobacco-report/ftc_cigarette_report_2014.pdf
10. Singh T, Arrazola RA, Corey CG, et al. Tobacco use among middle and high school students—United States, 2011–

2015. MMWR Morb Mortal Wkly Rep 2016;65:361–7. CrossRef PubMed

Top

TABLE. Brand of cigarettes usually smoked by current (past 30-day)* cigarette smokers in middle and high school, by selected characteristics — National Youth Tobacco Survey, United States, 2012–2016†

Return

Characteristic	Marlboro		Newport		Camel		Other specific brand§		No usual brand	
	2012 % (SE)	2016 % (SE)	2012 % (SE)	2016 % (SE)	2012 % (SE)	2016 % (SE)	2012 % (SE)	2016 % (SE)	2012 % (SE)	2016 % (SE)
Middle school										
Total	37.0 (3.5)	38.3 (4.1)	17.1 (2.4)	21.4 (3.5)	17.8 (2.8)	13.4 (2.4)	17.5 (2.2)	16.5 (2.4)	10.5 (1.6)	10.4 (1.8)
Sex										
Male	38.0 (4.5)	38.9 (6.0)	14.6 (2.7)	16.6 (3.8)	19.7 (3.8)	14.5 (3.5)	18.0 (2.7)	17.3 (3.9)	9.7 (1.9)	12.6 (2.7)
Female	35.7 (3.9)	37.2 (4.6)	20.5 (3.2)	27.2 (4.3)	15.4 (2.7)	12.3 (2.9)	16.9 (3.0)	15.6 (3.6)	11.6 (2.1)	7.6 (2.4)
Grade										
6	33.8 (4.9)	40.6 (6.3)	19.7 (4.0)	17.4 (4.6)	15.8 (2.8)	13.4 (4.4)	20.7 (4.5)	18.7 (4.6)	10.1 (2.8)	9.9 (3.6)
7	38.4 (5.9)	33.2 (4.8)	16.3 (3.6)	22.5 (4.6)	16.7 (4.1)	15.8 (3.4)	17.8 (3.7)	13.4 (3.3)	10.8 (2.2)	15.1 (3.5)
8	37.6 (3.8)	41.4 (6.2)	16.5 (2.3)	22.4 (4.7)	19.6 (3.8)	11.5 (3.0)	15.8 (3.2)	17.9 (3.6)	10.6 (2.2)	6.9 (1.9)
Race/Ethnicity										
White, non-Hispanic	44.3 (4.8)	54.6 (5.1)	8.5 (2.1)	7.9 (2.8)	20.3 (5.0)	16.1 (3.5)	17.5 (3.3)	9.4 (3.2)	9.4 (2.3)	12.1 (3.6)
Black, non-Hispanic	28.4 (6.9)	11.5 (5.1)	42.7 (6.6)	58.4 (5.6)	3.8 (0.9)	8.6 (4.3)	16.7 (4.8)	15.5 (5.4)	8.4 (3.7)	6.0 (2.8)

Hispanic	33.2 (4.2)	26.5 (4.2)	14.9 (2.6)	21.3 (5.9)	20.8 (5.5)	18.5 (4.4)	18.8 (4.6)	23.8 (5.2)	12.4 (3.0)	9.9 (3.2)
No. of days smoked in past 30 days[¶]										
Frequent (≥20 days)	44.8 (9.2)	47.5 (11.0)	14.8 (4.0)	9.1 (4.8)	17.8 (6.5)	14.7 (7.9)	19.5 (6.8)	26.6 (9.4)	3.0 (2.2)	2.0 (2.0)
Infrequent (1–19 days)	41.6 (4.8)	40.3 (7.6)	19.0 (3.7)	18.6 (5.3)	16.1 (4.1)	17.3 (4.0)	18.5 (3.1)	14.0 (4.5)	4.8 (1.2)	9.9 (4.1)
High school										
Total	38.5 (1.8)	48.8 (2.4)**	23.1 (2.1)	16.6 (1.8)**	17.8 (1.4)	13.3 (1.3)**	16.4 (1.5)	15.4 (1.6)	4.1 (0.4)	5.9 (0.9)**
Sex										
Male	39.4 (2.1)	50.0 (2.8)**	21.0 (2.0)	16.0 (2.2)	17.0 (1.5)	12.5 (1.7)**	17.4 (1.8)	15.6 (2.1)	5.1 (0.7)	5.8 (1.2)
Female	37.5 (2.3)	48.0 (3.5)**	26.0 (2.7)	16.8 (2.4)**	18.6 (2.1)	14.2 (1.9)**	15.2 (1.7)	15.0 (1.9)	2.7 (0.5)	6.0 (1.2)**
Grade										
9	34.3 (2.6)	42.9 (3.7)**	25.1 (2.7)	18.4 (2.8)	17.4 (2.2)	15.9 (3.6)	16.2 (1.5)	17.4 (3.1)	6.9 (1.4)	5.4 (1.5)
10	37.2 (2.4)	45.7 (3.7)**	25.5 (3.1)	19.5 (3.0)	19.4 (2.3)	14.2 (3.9)**	14.9 (1.8)	13.9 (1.7)	2.9 (0.7)	6.8 (2.3)**
11	40.3 (2.7)	50.8 (4.4)	22.5 (2.7)	17.2 (3.1)	14.5 (1.6)	10.0 (1.9)	19.0 (2.2)	15.6 (1.5)	3.8 (0.8)	6.4 (1.5)
12	41.1 (2.5)	53.2 (3.7)**	20.3 (2.4)	12.7 (2.0)	19.8 (2.5)	13.6 (1.8)**	15.5 (2.9)	15.3 (2.6)	3.3 (0.6)	5.1 (1.2)**
Race/Ethnicity										
White, non-Hispanic	45.8 (2.1)	59.5 (3.1)**	15.4 (1.8)	9.5 (1.6)**	19.6 (1.9)	11.9 (1.9)**	15.4 (2.0)	14.1 (2.1)	3.7 (0.6)	5.0 (1.4)
Black, non-Hispanic	10.3 (2.7)	11.0 (3.6)	67.0 (4.3)	47.5 (7.6)	4.2 (1.7)	8.9 (3.0)	16.9 (2.7)	16.7 (5.6)	1.6 (0.7)	15.9 (2.5)**

Hispanic	36.6 (2.6)	40.5 (3.2)	20.5 (3.0)	20.2 (3.3)	20.7 (2.3)	18.1 (2.1)	17.8 (2.3)	16.5 (2.0)	4.4 (1.3)	4.7 (1.4)
No. of days smoked in past 30 days[¶]										
Frequent (≥20 days)	42.2 (2.8)	59.1 (5.1)**	25.6 (2.9)	12.5 (3.4)	18.2 (2.3)	14.0 (2.7)	12.7 (1.9)	11.5 (2.7)	1.3 (0.4)	2.9 (1.3)
Infrequent (1–19 days)	37.8 (2.4)	50.8 (3.5)**	21.6 (2.3)	17.1 (2.5)	19.8 (2.3)	12.4 (2.2)**	18.0 (2.2)	16.6 (2.2)	2.8 (0.6)	3.1 (1.1)

Abbreviation: SE = standard error.

* Assessed with the question: "During the past 30 days, what brand of cigarettes did you usually smoke?" Response options were "American Spirit," "Camel," "GPC, Basic, or Doral," "Kool," "Lucky Strike," "Marlboro," "Newport," "Parliament," "Virginia Slims," "I did not smoke a usual brand," "Some other brand not listed here," "I did not smoke a cigarette in the past 30 days," and "Not sure." Any response other than "I did not smoke a cigarette in the past 30 days" or "Not sure" was treated as being a current (past 30-day) cigarette smoker.

† Trend analyses include data for 2012, 2013, 2014, 2015, and 2016. Prevalence estimates are presented only for 2012 and 2016.

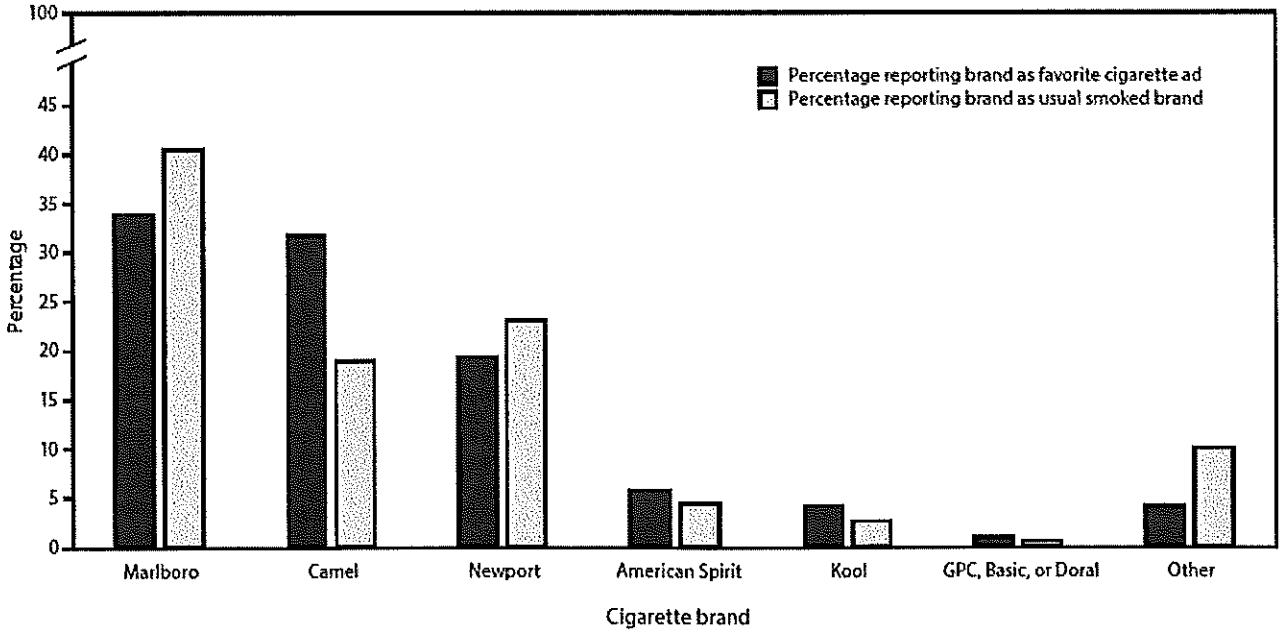
§ Because of small sample sizes, the responses "GPC, Basic, or Doral," "Kool," "Lucky Strike," "Parliament," and "Virginia Slims" were combined together as one category ("Other specific brand").

¶ Assessed with the question "During the past 30 days, on how many days did you smoke cigarettes?" Response options included "0 days," "1 or 2 days," "3 to 5 days," "6 to 9 days," "10 to 19 days," "20 to 29 days," and "All 30 days." Responses of "0 days" were excluded. All other responses were dichotomized as frequent (≥20 days) or infrequent (1–19 days).

** Statistically significant linear trend during 2012–2016 (p-trend<0.05).

Top Return

FIGURE 1. Agreement* between brand of cigarettes usually smoked† and favorite cigarette brand ad§ among middle and high school current (past 30-day) cigarette smokers — National Youth Tobacco Survey, United States, 2012



* Restricted to students who smoked cigarettes during the past 30 days and reported having both a favorite cigarette ad and a cigarette brand usually smoked (n = 1,807). The question on favorite cigarette ad was asked only in 2012.

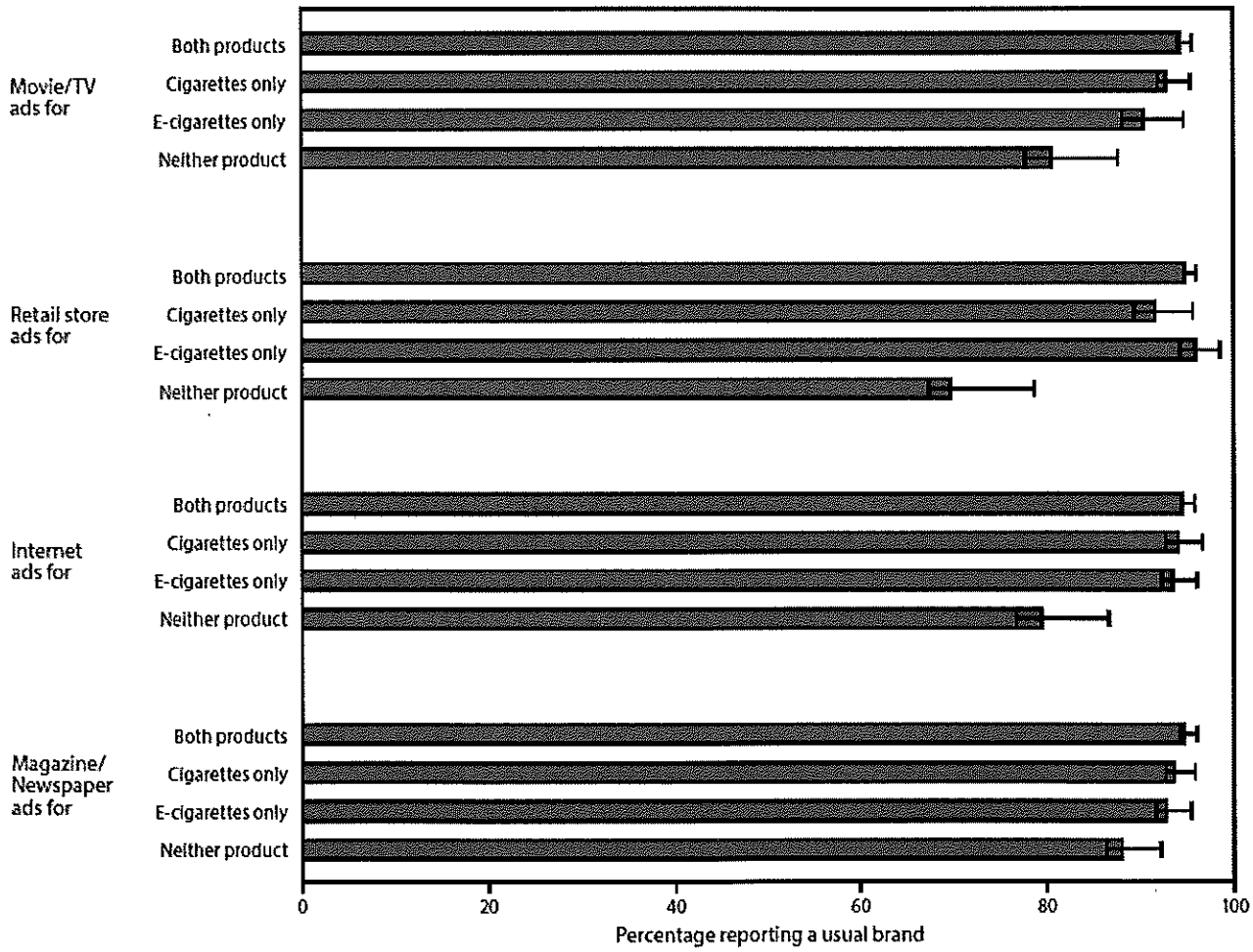
† Assessed with the question: "During the past 30 days, what brand of cigarettes did you usually smoke?" Responses classified as having a brand usually smoked among past 30-day smokers included "American Spirit," "Camel," "GPC, Basic, or Doral," "Kool," "Lucky Strike," "Marlboro," "Newport," "Parliament," "Virginia Slims," and "Some other brand not listed here."

§ Assessed with the question: "What is the name of the cigarette brand of your favorite cigarette ad?" Responses classified as having a favorite cigarette ad were "American Spirit," "Camel," "GPC, Basic, or Doral," "Kool," "Marlboro," "Newport," and "Some other brand not listed here."

The figure is a bar chart showing agreement between brand of cigarettes usually smoked and favorite brand ad among middle and high school current (within the past 30 days) cigarette smokers in 2012.

Top Return

FIGURE 2. Proportion of middle and high school current (past 30-day) cigarette smokers reporting a usual cigarette brand,* by advertising medium and status of exposure to cigarette and/or electronic cigarette ads† — National Youth Tobacco Survey, United States, 2015§



* Outcome was dichotomized as 0 or 1. Persons who reported having a specific brand they usually smoked ("American Spirit," "Camel," "GPC, Basic, or Doral," "Kool," "Lucky Strike," "Marlboro," "Newport," "Parliament," "Virginia Slims," or "Some other brand not listed here") were coded as 1. Those who responded, "I did not smoke a usual brand" were coded

as 0. Responses of "Not sure" or "I did not smoke a cigarette in the past 30 days" were excluded.

† Separate questions were asked for electronic cigarettes and regular cigarettes in relation to exposure to pro-tobacco ads on the different media sources (Internet, newspapers/magazines, retail stores, and TV/movies). For both electronic cigarettes and regular cigarettes, respondents' ad exposure status was coded on each medium as either: 1 = exposed (responses of "Sometimes," "Most of the time," and "Always") or 0 = nonexposed ("Never," "Rarely," or those who indicated not using the assessed medium).

§ The questions on exposure to both electronic cigarette and regular cigarette ads were asked only in 2015.

The figure is a bar chart showing the proportion of middle and high school current (within the past 30 days) cigarette smokers reporting a usual brand by advertising medium and status of exposure to cigarette and/or electronic cigarette ads.

Top

Suggested citation for this article: Perks SN, Armour B, Agaku IT. Cigarette Brand Preference and Pro-Tobacco Advertising Among Middle and High School Students — United States, 2012–2016. MMWR Morb Mortal Wkly Rep 2018;67:119–124. DOI: http://dx.doi.org/10.15585/mmwr.mm6704a3 .

ATTACHMENT 8

Tobacco Brand Preferences

Cigarettes

Market Share Information

- According to 2017 sales data, Marlboro is the most popular cigarette brand in the United States, with sales greater than the next seven leading competitors combined.[1]
- The three most heavily advertised brands—Marlboro, Newport, and Camel—continue to be the preferred brands of cigarettes smoked by young people.[2]

2017 Market Shares for Leading Cigarette Brands[1]

Brand	Market %
Marlboro	40%
Newport	14%
Camel (filter only)	8%
Pall Mall Box	7%
Maverick	2%
Santa Fe	2%
Winston	2%
Kool	2%

NOTE: Market share—or market percentage—is defined as the percentage of total sales in the United States.

Industry Marketing Practices

Tobacco industry marketing practices can influence the brands that certain groups prefer. For example:[2]

- The packaging and design of certain cigarette brands appeal to adolescents and young adults.
- Historically, menthol cigarettes have been targeted heavily toward certain racial/ethnic groups, especially African Americans.
  - Among African American adult, adolescent, and young adult cigarette smokers, the most popular brands are all mentholated.
- Cigarettes with brand names containing words such as "thins" and "slims" have been manufactured to be longer and slimmer than traditional cigarettes to appeal directly to women—e.g., Virginia Slims and Capri brands.

Brand Characteristics

- Of all the cigarettes sold in the United States in 2018—[3]

  99.7% were filtered

  36.0% were mentholated brands

- Use of mentholated brands varies widely by race/ethnicity. The percentage of current smokers aged 12 years or older who reported using mentholated brands in 2012-2014 was:[4]

  84.6% Non-Hispanic black

  46.9% Hispanic

  38.0% Non-Hispanic Asian

  28.9% Non-Hispanic White

- Before 2010, manufacturers were allowed to label cigarettes as "light" or "ultra light" if they delivered less than 15 mg of tar when measured by an automated smoking machine.[5]
  - Such labeling allowed tobacco companies to deliberately misrepresent "light" cigarettes as being less harmful and an acceptable alternative to quitting smoking.[6]
  - The 2009 Family Smoking Prevention and Tobacco Control Act, however, prohibits use of terms like "light," "low," and "mild" on tobacco product labels.[7]

Other Tobacco Products

Cigars

According to 2015 sales data, Swisher Little is the most popular brand of cigars in the United States, with sales substantially greater than any little cigar competitor and the leading large cigars and cigarillos competitors.[8]

2015 Market Shares for Leading Cigar Brands[8]

Brand	Category	Market %
Swisher Little	Little cigars	60%
Swisher Sweets	Large cigars and cigarillos	16%
Black & Mild	Large cigars and cigarillos	11%
Garcia y Vega	Large cigars and cigarillos	5%
White Owl	Large cigars and cigarillos	5%

NOTE: Market share—or market percentage—is defined as the percentage of total sales in the United States.

Smokeless Tobacco

The five major U.S. smokeless tobacco companies experienced decreased sales from 2018 to 2019, from 128.4 million pounds to about 126 million pounds.[9] Smokeless tobacco products include dry snuff, moist snuff, plug/twist, loose-leaf chewing tobacco, snus, and dissolvable products.

2011 Market Shares for Leading Smokeless Tobacco Brands[9]

Brand	Category	Market %
Levi Garrett Plug	Moist plug tobacco	52%
Day's Work	Plug tobacco	45%
Red Man Plug	Moist plug tobacco	36%
Grizzly	Moist snuff and fine cut tobacco	26%
Copenhagen	Moist snuff and fine cut tobacco	25%
Garrett	Dry snuff	24%
Skoal	Moist snuff and fine cut tobacco	24%
Red Man	Loose leaf tobacco	18%

NOTE: Market share—or market percentage—is defined as the percentage of total sales in the United States.

References

1. Maxwell JC. The Maxwell Report: Year End & Fourth Quarter 2017 Cigarette Industry. Richmond (VA): John C. Maxwell, Jr., 2018 [cited 2018 Jul 26].
2. U.S. Department of Health and Human Services. Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2012 [accessed 2017 Nov 3].
3. U.S. Federal Trade Commission (FTC). Cigarette Report for 2018 [PDF – 281 KB] . Washington: Federal Trade Commission 2019 [accessed 2020 Apr 16].
4. Villanti AC, Mowery PD, Delnevo CD, et al. Changes in the prevalence and correlates of menthol cigarette use in the USA, 2004–2014 . Tobacco Control 2016;25:ii14-ii20 [accessed 2020 Apr 16].
5. National Cancer Institute. Risks Associated with Smoking Cigarettes with Low Machine-Measured Yields of Tar and Nicotine . Smoking and Tobacco Control Monograph 13. Bethesda (MD): U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute, 2001 [accessed 2017 Nov 3].
6. U.S. Department of Health and Human Services.The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed 2017 Nov 3].
7. Food and Drug Administration. Tobacco Control Act . Washington: U.S. Department of Health and Human Services, Food and Drug Administration 2015 [accessed 2017 Nov 3].
8. Maxwell JC. The Maxwell Report: Cigar Industry in 2015. Richmond (VA): John C. Maxwell, Jr., 2016 [cited 2018 Jul 26].
9. U.S. Federal Trade Commission (FTC). Federal Trade Smokeless Tobacco Report for 2019 [PDF – 1 MB] . Washington: Federal Trade Commission, 2021 [accessed 2021 Apr 27].

Page last reviewed: May 14, 2021
Content source: Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion

ATTACHMENT 9

Tobacco Prevention

Health Promotion and Chronic Disease Prevention
(/oha/PH/PREVENTIONWELLNESS/TOBACCOPREVENTION)

Oregon Tobacco Facts

Get Help Quitting (/oha/PH/PREVENTIONWELLI

Tobacco Prevention and Education (/oha/PH/PREVENTIONWELLI

Tobacco Prevention: Retail Environment (/oha/PH/PREVENTIONWELLI

Tobacco Retail Licensing and Sales (/oha/PH/PREVENTIONWELLI

State Rules and Statutes (/oha/PH/PREVENTIONWELLNI rules-and-statutes.aspx)

Retailers (/oha/PH/PREVENTIONWELLNI

Community Members (/oha/PH/PREVENTIONWELLNI members.aspx)

Local Public Health Authorities (/oha/PH/PREVENTIONWELLNI -public-health-authorities.aspx)

Data and Reports (/oha/PH/PREVENTIONWELLNI and-reports.aspx)

Indoor Clean Air Act (/oha/PH/PREVENTIONWELLI

About the Law (/oha/PH/PREVENTIONWELLNI

For Businesses (/oha/PH/PREVENTIONWELLNI

About Oregon Tobacco Facts

One of the primary responsibilities of the Oregon Tobacco Prevention and Education Program is to collect and report data about tobacco use and related topics among Oregon adults and youth.

The Oregon Tobacco Facts publication is a collection of this data. It includes tables, graphs and maps that describe tobacco use, economic burden, related diseases, and retail marketing in Oregon.

Fact sheets for each county can be found in **Oregon County Tobacco Facts** (/oha/PH/PREVENTIONWELLNESS/TOBACCOPREVENTION/Pages/Oregon-County-Tobacco-Facts.aspx).

Oregon Tobacco Facts Table of Contents

The Oregon Tobacco Facts report includes the following sections.

Suggested citation: Oregon Health Authority Public Health Division, Health Promotion and Chronic Disease Prevention Section. Oregon tobacco facts. Available at https://www.oregon.gov/oha/ph/preventionwellness/tobaccoprevention/pages/oregon-tobacco-facts.aspx.

Enclosed Areas (/oha/PH/PREVENTIONWELLNI areas.aspx)

Complaint of Violation (/oha/PH/PREVENTIONWELLNI

Smoke Shop and Cigar Bar Certification (/oha/PH/PREVENTIONWELLNI

E-Cigarettes (/oha/PH/PREVENTIONWELLNI cigarettes.aspx)

Data and Publications (/oha/PH/PREVENTIONWELLI

Materials for Download (/oha/PH/PREVENTIONWELLI

Contact Us (/oha/PH/PREVENTIONWELLI Information.aspx)

Oregon County Tobacco Facts (/oha/PH/PREVENTIONWELLI County-Tobacco-Facts.aspx)

Section 1: Executive summary

The Oregon Tobacco Prevention and Education Program (TPEP) is a comprehensive program that works to decrease tobacco use across the state.

Together with partners, TPEP works to improve policies and environments that prevent youth use, help adults quit and counter the tobacco industry's targeting of stressed communities. Although communities have taken great strides toward decreasing tobacco use, some Oregonians have benefited more from these changes than others. To find out more about the work that Oregon's TPEP is doing visit https://www.oregon.gov/oha/ph/preventionwellness/tobaccoprevention/pages/index.aspx (/oha/PH/PREVENTIONWELLNESS/TOBACCOPREVENTION/pages/index.aspx).

Since TPEP began in 1997, cigarette sales in Oregon have declined by about two-thirds (Figure 4.1). However, tobacco use remains the number one cause of preventable death and disease in Oregon. It kills approximately 8,000 people each year (Table 2.2). Tobacco use costs Oregonians an estimated $5.7 billion a year in medical expenses and lost productivity (Table 4.2).

This website describes current tobacco use, tobacco-related diseases, disparities and issues impacting you tobacco use throughout Oregon. Some key findings on this site are:

- Youth (Figure 5.1) and adult (Table 4.2) cigarette smoking has decreased from 1997 to 2020 However, use of non-cigarette products is on the rise (Table 4.3; Figure 5.1).
- Data show that more than half of youth and young adults who use tobacco are using flavored tobacco or vaping products (Figure 5.4).
- In 2020, the tobacco industry spent over $8 billion in marketing, price discounts and promotional allowances for cigarettes and smokeless tobacco (1,2,3). This is about $23 million per day or almost $1 million an hour.
- On March 17, 2022, the Federal Trade Commission (FTC) published their first report on e-cigarettes. The data show, similar to cigarettes and smokeless tobacco, the retail setting is where e-cigarette companies are spending most of their money (4).
- Almost 80% of the tobacco industry's total marketing expenditures for cigarettes and smokeless tobacco products (3) and 61% of e-cigarette products (4) are in the retail environment including convenience stores, pharmacies and grocery stores.
- The tobacco industry spends more than $100 million every year to advertise and promote its products in Oregon's stores (Figure 7.1).
- The tobacco industry targets people who have faced racism and other discrimination, people with lower incomes and people who are stressed or struggling. For example, about one in three Oregonians with a household income of less than $20,000 a year smoke compared to less than one in 10 Oregonians with a household income of more than $50,000 a year smoke (Table 6.1).

While some American Indian tribes use traditional tobacco and other plants for medicinal, ceremonial or religious purposes, when OHA refers to tobacco in this report, it is in reference to commercial tobacco and not the sacred and traditional tobacco used by some American Indian communities.

Back to Table of Contents

Section 2: Health and economic burden of tobacco

Tobacco use affects all Oregonians. Tobacco use is the number-one cause of preventable death and disease in Oregon. Each year, tobacco use kills over 8,000 Oregonians (Table 2.1) and costs almost $5.7 billion in medical expenses and lost productivity (Table 2.4).

The burden of tobacco is not distributed equally. People living with lower incomes, less education, and marginalized social groups smoke at higher rates than other social groups. Consequently, they suffer a disproportionate burden of tobacco-related illness and death. They are also the most exploited victims of predatory marketing practices that capitalize on their lack of education and other vulnerabilities. Additionally, many of these marginalized social groups do not receive adequate access to treatment or protection through general public health policy interventions.

Table 2.1 Leading causes of preventable death, Oregon, 2020

Cause of preventable death	Estimated number of deaths
Tobacco use	8,200
Obesity, poor diet and physical inactivity	2,600
Alcohol use	2,200
Illicit drug use	1,000
Motor vehicles*	500
Firearms	600
Influenza & pneumonia	400

* Includes alcohol-related crashes.
Source: Oregon Center for Health Statistics, Death data. Unpublished data.

Table 2.2 Underlying causes of tobacco-related deaths, Oregon, 2020

Cause of death	Number of deaths	Tobacco-related deaths (%)
Cancers	2,197	27
Cardiovascular diseases	2,096	26
Respiratory diseases	1,530	18
Other	2,391	29
Total tobacco-related deaths	**8,214**	**100**

Source: Oregon Center for Health Statistics, Death data. Unpublished data.

Table 2.3 Tobacco-related death rates per 100,000 population by county, Oregon

Select a year range

2017 - 2020

	Number of deaths	Rate
Oregon State		
Baker		
Benton		
Clackamas		
Clatsop		
Columbia		
Coos		
Crook		
Curry		
Deschutes		
Douglas		
Gilliam		
Grant		
Harney		
Hood River		
Jackson		
Jefferson		

Microsoft Power BI

Source: Oregon Center for Health Statistics, Death data. Unpublished data.
Note: Rates are per 100,000 population and are age-adjusted to the 2000 standard population.

Table 2.4 Estimated costs of tobacco-related medical treatment and lost productivity (in millions of dollars), Oregon, 2021

	Total costs	Cost of lost productivity	Medical costs
Oregon	**5,691.7**	**5,453.0**	**238.5**
Baker	17.8	16.9	0.9
Benton	35.9	32.9	3.0
Clackamas	245.0	232.5	12.5
Clatsop	46.2	41.6	4.6
Columbia	49.0	43.7	5.3
Coos	114.2	103.8	10.4
Crook	30.3	25.3	5.0
Curry	34.6	30.9	3.7
Deschutes	103.3	94.0	9.3
Douglas	172.0	161.0	11.0
Gilliam	1.9	1.8	0.1
Grant	8.6	7.4	1.2
Harney	5.3	4.6	0.7
Hood River	12.3	10.9	1.4
Jackson	213.4	200.6	12.8

Jefferson	20.9	18.1	2.8
Josephine	113.9	105.6	8.3
Klamath	90.5	82.7	7.8
Lake	8.5	6.9	1.6
Lane	310.3	295.3	15.0
Lincoln	75.0	67.9	7.1
Linn	135.6	126.0	9.6
Malheur	20.8	20.1	0.7
Marion	243.1	228.8	14.3
Morrow	8.3	8.0	0.3
Multnomah	531.3	505.8	25.5
Polk	52.3	48.3	4.0
Sherman	1.5	1.2	0.3
Tillamook	38.5	33.8	4.7
Umatilla	48.0	44.4	3.6
Union	19.6	18.6	1.0
Wallowa	4.7	4.3	0.4
Wasco	32.6	28.8	3.8
Washington	227.8	215.9	11.9
Wheeler	1.5	1.2	0.3
Yamhill	85.5	77.5	8.0

Source: Oregon Health Authority. Economic Costs of Tobacco Use in Oregon. Calculations Based on Oregon Population Data 2015-2019 and the Department of Health and Human Services (US) Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC) data, 2021. Unpublished data.

*State and county estimates are calculated on different measures.

Back to Table of Contents

Section 3: Tobacco-related diseases

Tobacco use is a major risk factor for developing chronic diseases such as cancer, cardiovascular disease, diabetes and asthma (5). Oregonians who smoke are about 35% more likely to have one or more chronic diseases compared to nonsmokers - i.e. 64% vs 47% (6).

When people experience severe or long-lasting forms of stress, health problems like high blood pressure, elevated heart rate, and anxiety develop. People who are part of marginalized social groups experience prejudice and discrimination which can lead using tobacco as a way to relieve the stress. Additionally, under the pressure of this stress, it is harder for people to quit using tobacco.

About one out of five Oregonians with a chronic disease smoke cigarettes (Table 3.1). Using tobacco worsens outcomes for people living with chronic diseases. Quitting tobacco use and reducing exposure to secondhand smoke decreases the risk of developing certain chronic diseases and improves the health outcomes of those already living with chronic diseases. To advance better health for communities facing disadvantage, tobacco cessation efforts must be tailored to communities that might not be reached by general efforts.

Table 3.1 Percentage of adults with chronic diseases who smoke cigarettes, Oregon, 2020

	Percent (%)
One or more chronic diseases (1)	18.8
Arthritis	22.6
Asthma	19.4
Cancer	19.5
Cardiovascular disease (2)	27.4
Chronic obstructive pulmonary disease (COPD)	44.0
Depression	23.4
Diabetes	16.0

(1) One or more chronic disease includes arthritis, asthma, diabetes, cancer, cardiovascular disease, depression or chronic obstructive pulmonary disorder.
(2) Cardiovascular disease includes coronary heart disease, angina, heart attack or stroke.

Source: Oregon Behavioral Risk Factor Surveillance System. Unpublished data.; Note: Estimates are age-adjusted to the 2000 standard population.

Table 3.2 Rate of lung and bronchus cancer diagnoses and death

Table 3.2 Rate of lung and bronchus cancer diagnoses and death per 100,000 population by county, Oregon, 2015–2019

	Rate of new diagnoses	Death rate
Oregon	**51.1**	**34.7**
Baker	37.6	40.1
Benton	31.7	24.0
Clackamas	50.4	30.7
Clatsop	61.8	40.1
Columbia	66.2	47.7
Coos	64.6	48.4
Crook	65.3	39.1
Curry	55.8	45.0
Deschutes	39.4	24.4
Douglas	58.2	46.9
Gilliam	--	--
Grant	31.9	26.2
Harney	32.9	27.6
Hood River	40.2	32.0
Jackson	55.0	36.2
Jefferson	60.2	42.4
Josephine	61.7	44.7
Klamath	56.1	37.1
Lake	54.3	36.4
Lane	45.7	33.9
Lincoln	53.8	42.9
Linn	57.1	44.0
Malheur	40.3	32.6
Marion	59.6	37.5
Morrow	45.0	22.9
Multnomah	53.8	35.2
Polk	50.8	35.4
Sherman	--	--
Tillamook	57.4	44.4
Umatilla	48.0	35.9
Union	37.2	31.0
Wallowa	26.1	19.8
Wasco	64.7	40.6
Washington	42.7	26.0
Wheeler	--	--
Yamhill	51.0	35.5

Source: Diagnosis data from Oregon State Cancer Registry, death data from Oregon Center for Health Statistics. Unpublished data.
Note: Rates are per 100,000 population and age-adjusted to the 2000 standard population.

Back to Table of Contents

Section 4: Adult cigarette smoking

Tobacco prevention and education programs across Oregon began in 1997 and have increased access to tobacco free environments and evidence-based quitting support. Since 1996 (the year prior to the inception of TPEP), the percentage of Oregon adults who smoke cigarettes has declined by 42% (Table 4.2). The decline in adult smoking corresponds with a 61% decrease in per capita cigarette sales since 1996 (Table 4.1). Oregonians are smoking less or quitting entirely. Over half of adult cigarette smokers say they have tried to quit in the past year, and 65% say they want to quit (Table 4.6).
Despite progress, smoking affects some communities more than others.

- About one in three Oregonians with a household income of less than $20,000 a year smoke. In comparison, less than one in 10 Oregonians with a household income of more than $50,000 a year smoke (Table 6.1).
- Race and ethnicity are also important factors. Twenty-seven percent of American Indians in Oregon smoke compared to 17% of non-Hispanic whites (Figure 6.1).

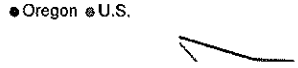
The environments and systems that have contributed to these disparities must be addressed to reduce tobacco use and tobacco-related diseases. To learn more about smoking disparities, see section six of this website.

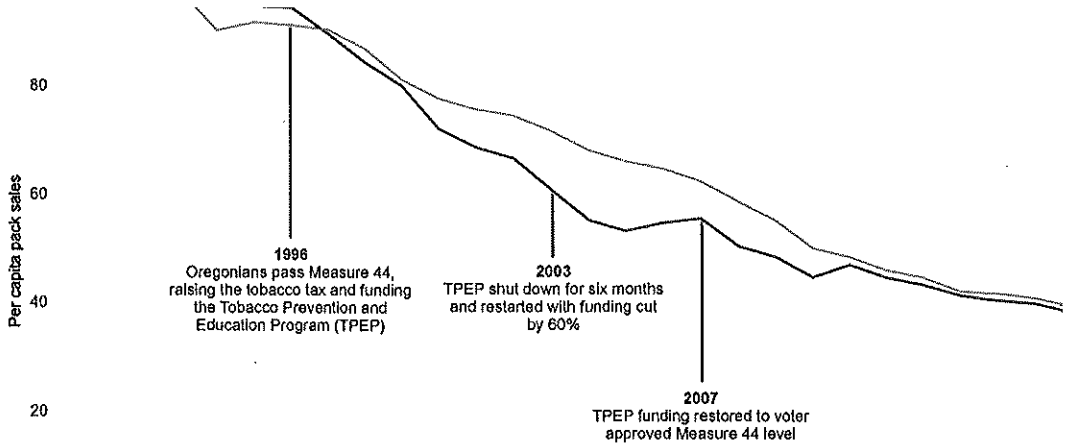
Table 4.1: Per capita cigarette pack sales, Oregon and the United States, 1993–2021

	Oregon	U.S.
1993	98.7	97.5
1994	96.6	90.1
1995	94.6	91.6
1996	94.3	91.0
1997	89.5	90.2
1998	84.2	86.8
1999	79.9	81.1
2000	72.0	77.6
2001	68.6	75.6
2002	66.6	74.5
2003	60.9	71.7
2004	55.2	68.1
2005	53.2	66.0
2006	54.7	64.7
2007	55.5	62.4
2008	50.4	58.6
2009	48.4	55.1
2010	44.7	50.1
2011	47.0	48.5
2012	44.7	46.0
2013	43.3	44.7
2014	41.4	42.1
2015	40.5	41.8
2016	40.0	41.0
2017	38.3	39.4
2018	37.2	36.7
2019	35.0	35.1
2020	33.6	34.2
2021	29.6	33.5

Orzechowski and Walker, The Tax Burden on tobacco. Historical compilation. Fairfax and Richmond, Virginia.

Figure 4.1: Per capita cigarette pack sales, Oregon and the United States, 1993–2021





Microsoft Power BI

Source: Orzechowski and Walker, The Tax Burden on tobacco. Historical compilation. Fairfax and Richmond, Virginia.

Table 4.2. Percentage of adult cigarette smoking by sex and total, Oregon, 1996–2020

Percent (%)

Year	Total	Male	Female
1996	23.7	24.2	23.1
1997	20.9	22.0	19.7
1998	22.0	22.9	21.1
1999	21.4	22.0	20.9
2000	21.0	22.3	19.8
2001	20.9	21.9	19.8
2002	21.4	22.6	20.1
2003	21.1	23.2	18.8
2004	20.1	21.4	18.7
2005	18.8	20.6	17.0
2006	18.6	20.1	17.2
2007	17.0	18.8	15.3
2008	15.7	16.1	15.4
2009	17.5	18.5	16.4
2010	20.7	22.3	19.1
2011	20.5	22.6	18.4
2012	18.5	19.9	17.2
2013	17.8	18.6	17.0
2014	16.9	18.2	15.7
2015	17.7	18.9	16.5
2016	17.1	19.4	14.9
2017	17.0	19.0	15.0
2018	16.3	16.0	16.7
2019	15.1	15.9	14.3
2020	14.1	15.2	13.0

Source: Adult Tobacco Use: Oregon Behavioral Risk Factor Surveillance System. Available from: https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/CHRONICDISEASE/DATAREPORTS/Pages/Substance-use.aspx (/oha/PH/DISEASESCONDITIONS/CHRONICDISEASE/DATAREPORTS/Pages/Substance-use.aspx).
Note: Estimates are age-adjusted to the 2000 standard population. Data collection and weighting methods changed in 2010. Estimates beginning in 2010 should not be compared to those from earlier years.

Table 4.3: Percentage of adult tobacco use, by product type, Oregon, 2014-20

Percent (%)

Year	Cigarettes	E-cigarettes	Smokeless tobacco	Any tobacco product (1)
2014	16.9	8.1	3.8	24.3
2015	17.7	6.5	4.1	25.7
2016	17.1	4.4	4.6	24.5

2017	17.0	4.9	4.0	26.4
2018	16.3	6.0	4.6	25.4
2019	15.1	6.6	3.9	24.6
2020	14.1	5.3	4.1	23.0

(1) Any tobacco product includes cigarette, e-cigarette, smokeless tobacco, large or small cigars or hookah.
Source: Adult Tobacco Use: Oregon Behavioral Risk Factor Surveillance System. Available from: https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/CHRONICDISEASE/DATAREPORTS/Pages/Substance-use.aspx (/oha/PH/DISEASESCONDITIONS/CHRONICDISEASE/DATAREPORTS/Pages/Substance-use.aspx).
Note: Estimates are age-adjusted to the 2000 standard population.

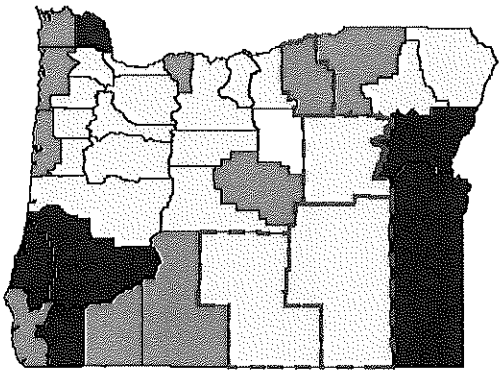
Table 4.4 Percentage of adult tobacco use by age and sex, Oregon, 2020

Percent (%)

Age group	Cigarette smoking			E-cigarettes			Other tobacco product(1)			Any tobacco product(2)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
18–24	14.0	9.4	11.8	17.9	12.3	15.2	16.5	5.5	11.3	31.7	21.5	26.8
25–34	17.2	14.7	15.9	7.8	5.5	6.6	15.0	4.8	9.8	31.8	21.1	26.4
35–44	16.5	13.7	15.1	6.5	3.9	5.2	12.9	3.8	8.4	29.1	19.4	24.3
45–54	18.7	14.5	16.6	4.0	3.4	3.7	16.8	2.0	9.3	33.9	18.5	26.1
55–64	13.4	17.1	15.3	1.3^	3.0	2.2	10.5	2.2	6.2	22.9	20.7	21.7
65–74	11.1	12.2	11.7	0.8^	1.4^	1.1	7.2	1.9	4.4	17.8	14.1	15.8
75+	5.9^	3.6	4.6	--	--	--	6.8	1.2^	3.6	11.7	4.5	7.5

^ indicates the estimate may be statistically unreliable and should be interpreted with caution.
-- this number is suppressed because it is statistically unreliable.
(1) Other tobacco products include smokeless tobacco, large or small cigars or hookah.
(2) Any tobacco product includes cigarette, e-cigarette, smokeless tobacco, large or small cigars or hookah.
Source: Oregon Behavioral Risk Factor Surveillance System. Unpublished data.
Note: Estimates are age-adjusted to the 2000 standard population.

Figure 4.2 Percentage of adult cigarette smoking, by county, Oregon, 2016-2019



Red dashed counties indicates the estimate may be statistically unreliable and should be interpreted with caution.
Counties filled in white are suppressed because they have statistically unreliable data.
(1) North Central Public Health District includes Gilliam, Sherman and Wasco counties.
Source: Oregon Behavioral Risk Factor Surveillance System County Combined dataset, 2016 –2019. Unpublished data.
Note: Estimates are age-adjusted to the 2000 standard population

Note: Estimates are age-adjusted to the 2000 standard population.

Table 4.5 Percentage of adult cigarette smoking, by county, Oregon, 2016-2019

	Percent (%)
Oregon	**16.5**
Baker	24.9
Benton	9.6
Clackamas	15.5
Clatsop	19.3
Columbia	26.2
Coos	27.6
Crook	17.9
Curry	21.9
Deschutes	14.6
Douglas	22.3
Grant	14.9^
Harney	16.0^
Hood River	18.6
Jackson	21.7
Jefferson	15.7
Josephine	25.7
Klamath	20.5
Lake	8.5^
Lane	16.6
Lincoln	21.7
Linn	15.6
Malheur	22.5
Marion	15.9
Morrow	20.4^
Multnomah	15.2
North Central (1)	14.8
Polk	15.1
Tillamook	18.5
Umatilla	18.8
Union	16.1
Wallowa	12.9^
Washington	11.5
Wheeler	--
Yamhill	16.7

^ indicates the estimate may be statistically unreliable and should be interpreted with caution.
-- this number is suppressed because it is statistically unreliable.
(1) North Central Public Health District includes Gilliam, Sherman and Wasco counties.
Source: Oregon Behavioral Risk Factor Surveillance System County Combined dataset, 2016 –2019. Unpublished data.
Note: Estimates are age-adjusted to the 2000 standard population.

Table 4.6 Percentage of adult smokers by quit status and county, Oregon, 2016–2019

	Wants to quit cigarette smoking (%)	Attempted to quit cigarette smoking during previous year (%)
Oregon	**63.2**	**54.1**
Baker	--	46.1
Benton	55.9	51.9
Clackamas	56.9	55.0
Clatsop	--	49.2
Columbia	61.5	52.1
Coos	49.2	48.3
Crook	--	50.1
Curry	--	63.9
Deschutes	69.8	57.1
Douglas	64.6	54.9
Grant	--	--
Harney	--	--
Hood River	--	--
Jackson	59.9	52.9
Jefferson	--	--

Josephine	58.1	50.1
Klamath	69.9	46.3
Lake	--	--
Lane	66.6	56.1
Lincoln	53.2	57.8
Linn	59.5	51.0
Malheur	--	64.6
Marion	58.5	54.5
Morrow	--	--
Multnomah	65.0	55.5
North Central (1)	--	44.6
Polk	62.9	60.8
Tillamook	--	42.8
Umatilla	61.8	64.0
Union	--	57.9
Wallowa	--	--
Washington	71.1	53.4
Wheeler	--	--
Yamhill	47.3	50.1

-- this number is suppressed because it is statistically unreliable.

(1) North Central Public Health District includes Gilliam, Sherman and Wasco counties.

Source: Oregon Behavioral Risk Factor Surveillance System County Combined dataset, 2016 –2019. Unpublished data.

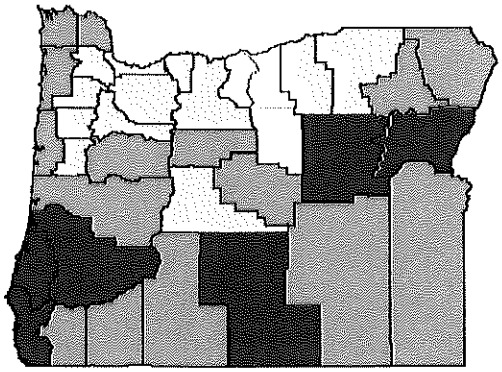
Note: Estimates are age-adjusted to the 2000 standard population.

Table 4.7 Percentage of births to mothers who smoke cigarettes during pregnancy, Oregon and the United States, 1993–2020

	Percent (%)	
Year	U.S.	Oregon
1993	15.8	18.9
1994	14.6	18.2
1995	13.9	17.9
1996	13.6	17.8
1997	13.2	16.2
1998	12.9	15.2
1999	12.6	14.5
2000	12.2	13.5
2001	12.0	12.8
2002	11.4	12.6
2003	10.7	12.0
2004	10.2	12.6
2005	10.7	12.4
2006	10.0	12.3
2007	10.4	11.7
2008	9.7	11.8
2009	9.3	11.3
2010	9.2	11.3
2011	8.9	10.7
2012	8.7	10.6
2013	8.5	10.2
2014	8.4	10.4
2015	7.7	10.0
2016	7.2	9.6
2017	6.9	9.0
2018	6.5	8.4
2019	5.9	7.5
2020	5.5	6.8

Sources: Oregon Center for Health Statistics; National Center for Health Statistics. Unpublished data.

Figure 4.3 Percentage of births to mothers who smoke cigarettes during pregnancy by county, Oregon, 2018–2020



Counties filled in white are suppressed because they have statistically unreliable data.
Source: Source: Oregon Center for Health Statistics, Birth data. Unpublished data.

Table 4.8 Percentage of births to mothers who smoke cigarettes during pregnancy by county, Oregon, 2018–2020

	Percent (%)
Oregon	**7.6**
Baker	19.4
Benton	5.8
Clackamas	5.2
Clatsop	13.4
Columbia	10.8
Coos	17.1
Crook	14.5
Curry	16.6
Deschutes	6.5
Douglas	18.7
Gilliam	--
Grant	15.8
Harney	12.0
Hood River	3.1
Jackson	10.3
Jefferson	10.8
Josephine	13.0
Klamath	13.1
Lake	16.1
Lane	10.3
Lincoln	15.0
Linn	13.4
Malheur	11.8
Marion	7.3
Morrow	7.0
Multnomah	4.9
Polk	7.8
Sherman	--
Tillamook	12.3
Umatilla	9.4
Union	11.7
Wallowa	10.1
Wasco	8.9
Washington	2.3
Wheeler	--
Yamhill	8.7

-- this number is suppressed because it is statistically unreliable.
Source: Source: Oregon Center for Health Statistics, Birth data. Unpublished data.

Back to Table of Contents

Section 5: Youth tobacco use

Most addiction to tobacco starts in adolescence. In fact, nine of 10 adults who smoke report that they started smoking before turning 18 (7). Studies show that the younger someone is when they start smoking, the harder it is to quit (8,9). Teenager's developing brains are vulnerable to the highly addictive nicotine in tobacco products (10).

The truth is, where you see a young person, tobacco companies see a replacement smoker (11). Data show that the industry has increased nicotine concentrations by about 60% between 2015 and 2018 (4).

- From 1996 to 2020, cigarette smoking among 11th-graders decreased more than 89% and among eighth graders by more than 94% (Table 5.1).
- Despite these decreases in youth smoking, many young people still smoke. Many of them will continue to smoke into adulthood.

Non-cigarette use

The rise in use of other tobacco products, such as little cigars, e-cigarettes and hookah, is also a concern.

- In Oregon from 2013 to 2019, e-cigarette use among 11th graders increased over four-fold from 5% to 23% (Table 5.1). 2020 marked the first year that we saw a decrease in e-cigarette use among 11th graders (12%).
- About 70% of 8th and 11th graders who have ever used tobacco report e-cigarettes as the first product used (Figure 5.2).

Less regulation

Non-cigarette tobacco products such as little cigars, electronic cigarettes and hookah are less regulated than cigarettes. Laws in the United States limit flavors, labeling and marketing of cigarettes. Cigarettes can no longer contain flavors other than menthol. Accordingly, cigarette use has declined. Non-cigarette tobacco products by comparison are cheap, available in flavors and come in packaging that appeals to young people. Non-cigarette tobacco products are heavily promoted in convenience stores and other locations accessible to youth.

Flavor appeal

Products with flavors such as electronic cigarettes, little cigars and hookah are more popular among youth and young adults compared to older adults (Table 5.6). Two thirds of Oregon youth tobacco users use flavored tobacco compared to about 26% of older adult tobacco users (Figure 5.4). Flavors appear to be a key component for youth to start using tobacco (12).

Widely available

Over 93% of stores in Oregon that sell tobacco sell flavored tobacco products (Table 7.2). Almost half of Oregon eighth graders (43%) and 11th-graders (40%) report visiting a convenience store at least once a week (Table 7.4).

Cheap

Flavored non-cigarette tobacco products are cheap. Retailers can sell these products in single units, which reduces the price. Nearly 57% of tobacco stores advertised single little cigars for under $1 many of which are flavored (Table 7.2). Low prices make these products more affordable for young people.

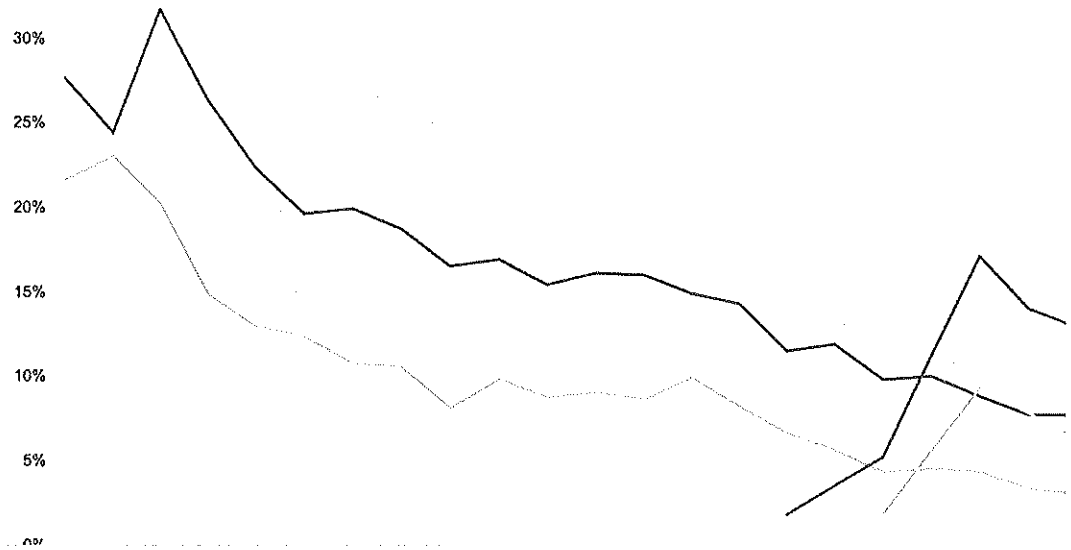
Table 5.1 Percentage of youth cigarette smoking and e-cigarette use, Oregon, 1996–2020

	Cigarettes (%)		E-cigarettes (%)	
Year	8th grade	11th grade	8th grade	11th grade
1996	21.6	27.6		
1997	23.0	24.4		
1998	20.2	31.7		
1999	14.8	26.3		
2000	12.9	22.3		
2001	12.3	19.6		
2002	10.7	19.9		
2003	10.5	18.7		
2004	8.1	16.5		
2005	9.8	16.9		
2006	8.7	15.4		
2007	9.0	16.1		
2008	8.6	16.0		
2009	9.9	14.9		

2010	8.2	14.3		
2011	6.6	11.5	1.3	1.8
2012	5.6	11.9		
2013	4.3	9.8	1.8	5.2
2014	4.5	10.0		
2015	4.3	8.8	9.3	17.1
2016	3.3	7.7		14.0
2017	3.0	7.7	6.3	12.9
2018	2.8	5.8		20.8
2019	2.6	4.9	11.8	23.4
2020	1.2	2.9	5.1	11.9

Source: Student Drug Use Survey (1996, 1998, 2000); Youth Risk Behavior Survey (1997, 1999); Oregon Healthy Teens (2001-2009, 2011, 2013, 2015,2017,2019); Student Wellness Survey (2012, 2014, 2016,2018); Student Health Survey (2020). Unpublished data.

Figure 5.1 Percentage of youth cigarette smoking and e-cigarette use, Oregon, 1996–2020



Source: Student Drug Use Survey (1996, 1998, 2000); Youth Risk Behavior Survey (1997, 1999); Oregon Healthy Teens (2001-2009, 2011, 2013, 2015,2017,2019); Student Wellness Survey (2012, 2014, 2016,2018); Student Health Survey (2020). Unpublished data.

Table 5.2 Percentage of youth exposed to tobacco, Oregon, 2019

	8th graders (%)	11th graders (%)
Saw someone smoking or vaping on school property (current school year)	42.7	70.0
Secondhand smoke or vape exposure in the home	9.1	8.6

Source: Oregon Healthy Teens; https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/CHRONICDISEASE/DATAREPORTS/Documents/datatables/ORAnnual(/oha/PH/DISEASESCONDITIONS/CHRONICDISEASE/DATAREPORTS/Documents/datatables/ORAnnualOHT_Tobacco.pdf).

Table 5.3 Percentage of youth tobacco use by product type, Oregon, 2020

	6th graders (%)	8th graders (%)	11th graders (%)
Any tobacco product (1)		5.7	13.3
E-cigarettes (2)	1.7	5.1	11.9
Cigarettes	0.4	1.2	2.9
Smokeless tobacco		0.6	1.3

Little cigars			1.4
Large cigars			0.5
Hookah			1.0
Little cigars, hookah, and large cigars		0.3	

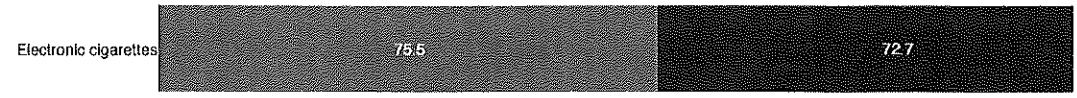
(1) Any tobacco product includes cigarettes, large or little cigars, hookah tobacco, smokeless tobacco or electronic cigarettes or other vaping products.
(2) E-cigarettes includes those shaped like USB flash drives and Juul.
Source: Student Health Survey, unpublished data.

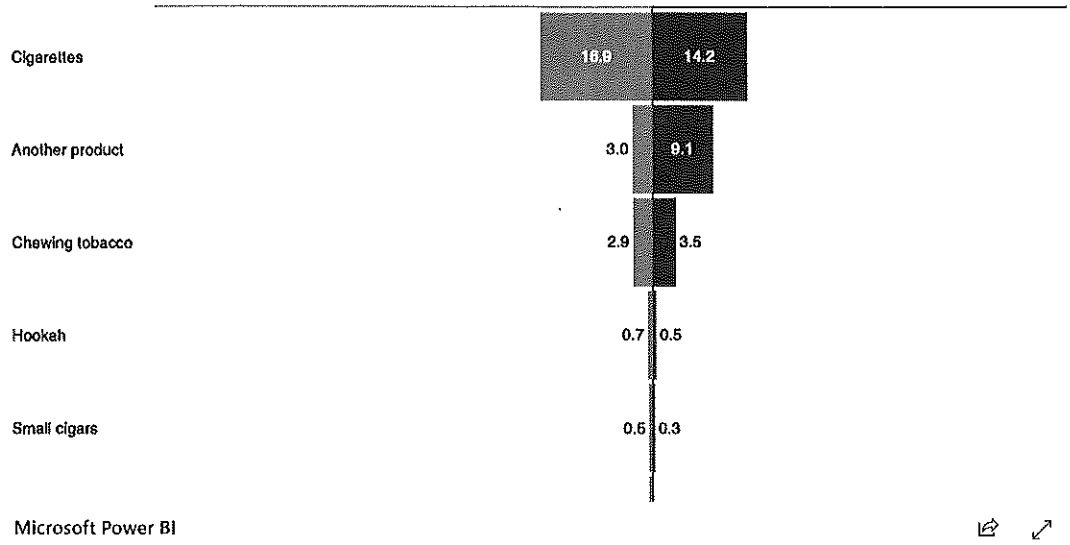
Table 5.4 Percentage of youth tobacco product type use by grade and county, Oregon, 2020

	8th Grade			11th Grade		
	Any tobacco product* (%)	Cigarette smoking (%)	E-cigarette (1) (%)	Any tobacco product* (%)	Cigarette smoking (%)	E-cigarettes (2) (%)
Oregon	**5.7**	**1.2**	**5.1**	**13.3**	**2.9**	**11.9**
Baker	--	--	--	16.6	==	12.9
Benton	10.7	4.3	9.1	15.1	--	14.5
Clackamas	4.2	1.3^	3.5	9.4	3.0	7.6
Clatsop	15.5	4.0	14.5	12.5^	--	9.7^
Columbia	4.0^	3.9^	2.9^	16.8	--	16.8
Coos	3.0	--	--	22.0	--	22.0
Crook	16.8	7.5	14.3	29.4	6.0	27.9
Curry	--	--	--	21.6	--	21.6
Deschutes	4.7^	0.7^	4.5^	26.1^	8.4^	22.4^
Douglas	17.5	--	15.6	23.0	--	21.2
Grant	No data collected			No data collected		
Harney	--	-	--	--	--	--
Hood River	3.9	--	3.9	14.9	--	11.8
Jackson	8.8	1.8	8.1	17.3	3.2	15.3
Jefferson	4.7^	--	3.6^	14.0	--	12.0
Josephine	8.2^	--	8.1^	18.4	2.6^	16.9
Klamath	--	1.4^	--	12.4^	--	12.2^
Lake	20.5	7.7	20.5	35.9	12.8	30.8
Lane	4.8	0.7^	4.5	19.0	--	18.2
Lincoln	7.4^	3.2^	6.6^	9.8^	--	9.3^
Linn	6.0	2.3^	4.9	13.4^	--	11.1^0
Malheur	8.8^	1.5	8.0	9.8^	--	9.7^
Marion	3.2^	--	2.1^	9.6	2.8	8.9
Morrow	--	--	--	--	--	--
Multnomah	2.2^	--	2.0^	10.5	4.4^	8.1
Polk	6.7	--	5.5^	9.1	1.6^	9.1
Sherman	--	--	--	--	--	--
Tillamook	3.9	--	3.9	12.3^	--	12.3^
Umatilla	7.0	1.6^	6.7	12.8	--	11.4
Union	8.8	1.8	8.7	27.0	3.9^	25.0
Wallowa	No data collected			No data collected		
Wasco	4.6	--	3.8	25.9	--	25.9
Washington	2.7	0.4^	2.3	7.3	1.1^	6.8
Wheeler	No data collected			No data collected		
Yamhill	19.9	--	18.0	20.3	--	20.3

(1) Any tobacco product includes cigarettes, large or little cigars, hookah tobacco, smokeless tobacco or electronic cigarettes or other vaping products.
(2) E-cigarettes includes those shaped like USB flash drives and Juul.
(3) North Central Public Health District includes Gilliam, Sherman and Wasco counties.
^ indicates the estimate may be statistically unreliable and should be interpreted with caution.
-- this number is suppressed because it is statistically unreliable.
Source: Oregon Student Health Survey, unpublished data.

Figure 5.2 Percentage of first tobacco product type used among youth who have ever used tobacco, Oregon, 2020





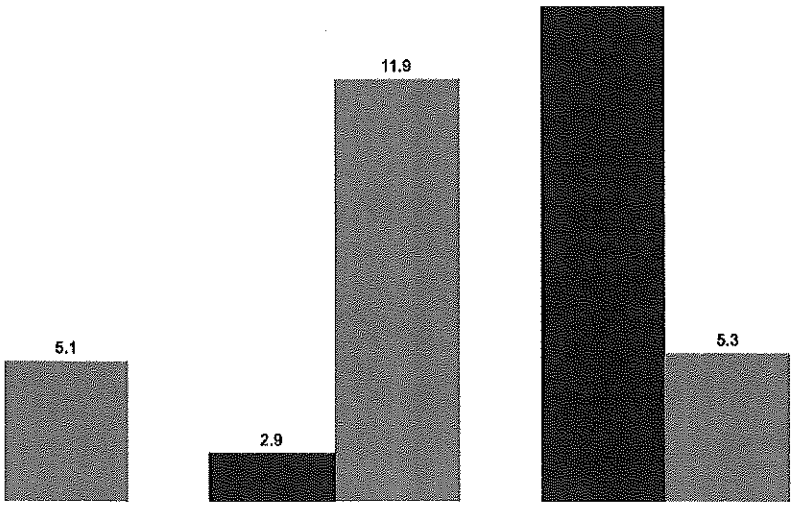
^ indicates the estimate may be statistically unreliable and should be interpreted with caution.
Source: Oregon Student Health Survey, unpublished data.

Table 5.5 Percentage and number of sources of tobacco products among youth who have ever used tobacco, Oregon, 2019

	8th grade (%)	Estimated number of students	11th grade (%)	Estimated number of students
Social sources (1)	81.2	4,700	78.5	8,500
Friends under 21 years of age	56.8	3,300	57.9	6,300
Friends 21 years old or older	18.1	1,000	29.1	3,100
A family member	17.1	1,000	9.9	1,100
Took from home without permission	11.1	600	3.1	300
A store or gas station	4.2	200	13.0	1,400
The Internet	6.1	300	8.8	1,000
Some other source	20.5	1,200	20.4	2,200

(1) Social sources include friends under 21, friends 21 or older or a family member.
Source: Oregon Healthy Teens, unpublished data.

Figure 5.3 Percentage of cigarette and e-cigarettes use among Oregon youth and adults, 2020



Sources: Oregon Student Health Survey; Behavioral Risk Factors Surveillance System. Unpublished data.
Notes: Adult data are age-adjusted to the 2000 standard population.

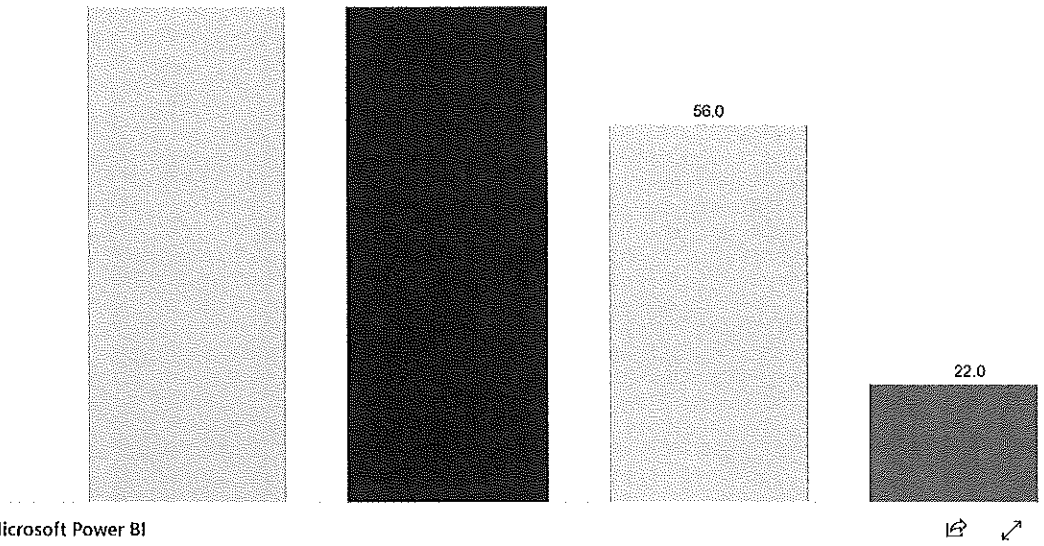
Table 5.6 Percentage of current tobacco product use by type and selected age groups, Oregon, 2020

Percent (%)

	8th graders	11th graders	Young adults (18-24)	Older adults (25+)
Cigarettes	1.2	2.9	11.8	13.9
Electronic cigarettes	5.1	11.9	15.2	3.4
Large cigars		0.5	3.2	1.6
Small cigars		1.4	4.5	1.3
Hookah		1.0	3.6	1.1
Smokeless tobacco	0.6	1.3	4.0	3.7

Sources: Oregon Student Health Survey; Behavioral Risk Factors Surveillance System. Unpublished data.
Note: Estimates for older adults are age-adjusted to the 2000 standard population.

Figure 5.4 Percentage of flavored tobacco or vaping product use among current tobacco users by selected age groups, Oregon, 2020



Sources: Oregon Student Health Survey; Behavioral Risk Factors Surveillance System. Unpublished data.

Back to Table of Contents

Section 6: Targeted Communities

Tobacco use and its resulting health problems are not spread equally throughout Oregon's communities. The tobacco industry has intentionally targeted people facing systemic racism and other discrimination, people with lower incomes and people who are stressed or struggling. Unfortunately, many of these same populations have not received adequate access to treatment or adequate protection through policy interventions that help shape a healthier environment. This has lead to large disparities in smoking rates among certain communities.

Targeting

Adding menthol flavoring to cigarettes is a common industry practice to make cigarettes seems less harsh. For decades, the tobacco industry worked to create a product preference for menthol cigarettes among minority populations (13, 14). For example, the industry linked menthol cigarettes to themes of African American empowerment and identity, targeting retail stores and neighborhoods and media, music and magazines(14). Studies show that neighborhoods with higher proportions of African American residents have greater numbers of tobacco advertisements, a larger presence of menthol cigarette advertising and lower prices for menthol cigarettes (13). Unfortunately, people who use menthol cigarettes also have less success in quitting and could be at greater risk of lung cancer (13, 14).

- African American people and American Indian Alaska Natives smoke at higher rates than white people in Oregon (Figure 6.1).
- 51% of African American Oregonians who smoke use menthol cigarettes compared to only 16% of white, non-Latino cigarette smokers (Table 6.4).

The tobacco industry has also targeted people with mental illnesses and addictions. They provided cigarettes to psychiatric facilities, sponsored research to show that nicotine alleviates negative mood and blocked smoke-free property policies in mental health and substance use treatment settings (13). People with mental illnesses live 25 fewer years, on average, than the general population, largely because of tobacco-related health conditions (13).

- Among people who report experiencing poor mental health approximately one in four (24%) smoke while only about one in seven (12%) of people who report not experiencing poor mental health smoke (Table 6.1).

Policy Protection and Access to Care

As policies that help people quit or prevent youth from starting tobacco use have expanded, communities with higher incomes have benefited more and decreased tobacco use more rapidly relative to communities with lower incomes. For example, while smoke-free homes and housing policies have expanded, people who rent

are still more often exposed to secondhand smoke (Table 6.6). In turn, secondhand smoke exposure can cause health problems even among people who don't use tobacco and can make it harder to quit for people who are addicted to quit.

- About one in three Oregonians with a household income of less than $20,000 a year smoke. In

comparison, about one in 10 Oregonians with a household income of more than $50,000 a year smoke (Table 6.1).
- In addition, 22% of people who rent are exposed to secondhand smoke compared to only 15% of people who own their home (Table 6.6).

While 65% of people in Oregon who smoke express that they want to quit (Table 4.6), many do not have access to the environments, medication or counseling that are critical to sustaining a successful quit attempt. Smoking cessation support such as receiving advice to quit from a health professional, counseling through phone or internet-based services and medications like Nicotine Replacement Therapy (NRT) are all effective at helping people quit and stay quit, especially when used in combination.

While access to cessation support has expanded throughout Oregon, disparities in access to and use of these resources still exist.

- People who are ethnic or racial minorities are more likely to report experiencing discrimination when interacting with doctors or the health care system (13) and thus may be hesitant to seek out counseling or medications that could assist with quitting.
- People who are ethnic or racial minorities or those who are low income are less likely to receive advice to quit from a health care provider, including counseling on how to use cessation medications like NRT (13,16).
- Oregonians who have no health insurance are offered recommendations and support from health care providers on how to quit tobacco at a much lower rate (42%) than people who have insurance through the Oregon Health Plan (55%) (Figure 6.2)

The persistence of this inequity in the health care system is likely due to many factors including physician bias, lack of resources or a focus on treating other conditions perceived as more urgent.

Communities Leading Change

The commercial tobacco industry has harmed tribes and Native communities in Oregon for decades by stealing cultural imagery and misrepresenting sacred traditions to sell commercial tobacco products (17, 18).

- 27% of American Indian and Alaska Native adults smoke cigarettes while only 17% of white, non-Latino adults smoke cigarettes (Figure 6.1)

Investing in culturally specific practices and services is a way to improve access to treatment and counter industry targeting. For example, native-led organizations and Oregon's nine federally recognized tribes are using their tribal culture to treat commercial tobacco use and fight tobacco industry tactics through the Native Quitline. This service was created in partnership with these tribal communities to offer culturally specific help to American Indian and Alaska Native peoples to quit commercial tobacco. It is one way that Native peoples in Oregon can quit commercial tobacco using Indigenous values, supported by a quit coach trained to work with Native peoples.

Table 6.1: Percentage of adult cigarette smoking, by select demographic groups, Oregon

	Percent (%)
Annual household income (2020)	
Less than $20,000	28.5
$20,000– $49,999	17.9
$50,000 or more	8.9
Education (2020)	
Less than high school graduate	27.5
High school graduate or GED	19.2
Some college	14.2
College graduate	5.8
Insurance (2020)	
No health insurance	21.8
Have health insurance (1)	13.4
Reporting mental health not good for seven or more days in the past 30 days (2020)	
Experiencing poor mental health	23.6
Not experiencing poor mental health	11.6
Served in the U.S. military (2020)	
Current or former member of the armed forces	20.2
Never a member of the armed forces	13.6
Socio-economic status (SES; 2) (2020)	
Low SES	26.0
Higher SES	11.6
Urban or rural residency (3) (2016-2019)	
Rural	21.9
Urban	14.9

(1) Includes Oregon Health Plan members

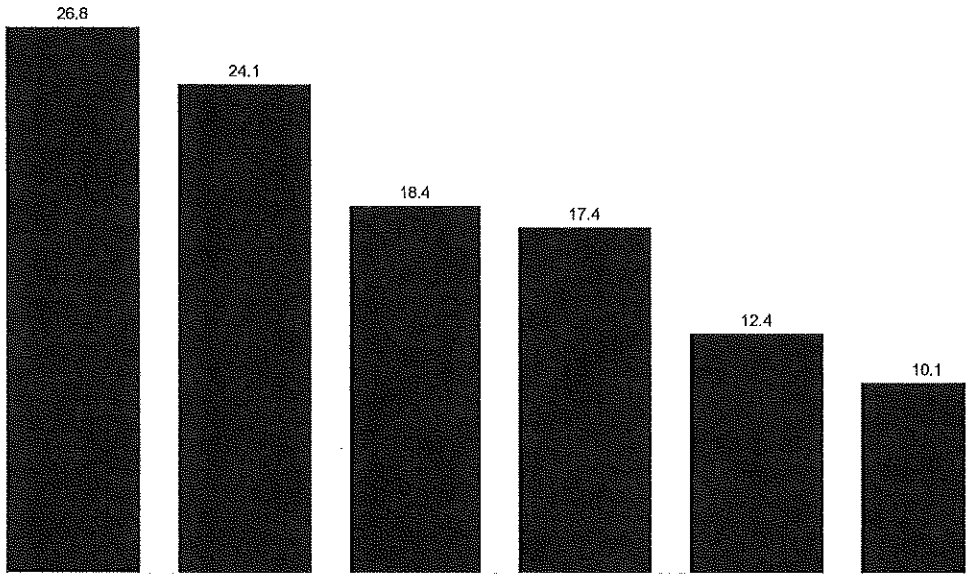
(2) Low socio-economic status includes having less than a high school education or being at 100% or less of the federal poverty level.
(3) Urban or rural residency was designated using ZIP code level rural-urban commuting area (RUCA) codes. For more information on RUCA codes see http://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx (http://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx).
Source: Oregon Behavioral Risk Factor Surveillance System. Unpublished data.
Notes: Estimates are age-adjusted to the 2000 standard population.

Table 6.2: Percentage of adult cigarette smoking, by sexual orientation, Oregon, 2016-2019

	Percent (%)
Women	
Lesbian women	18.4
Bisexual women	26.9
Heterosexual women	14.6
Men	
Gay men	19.5
Bisexual men	22.3
Heterosexual men	17.5

Source: Oregon Behavioral Risk Factor Surveillance System. Unpublished data.
Notes: Estimates are age-adjusted to the 2000 standard population.

Figure 6.1 Percentage of adult cigarette smoking by race and ethnicity, Oregon, 2016-2019



Source: Oregon Behavioral Risk Factor Surveillance System. Unpublished data.
Note: Estimates are age-adjusted to the 2000 standard population.

Table 6.3 Percentage of adult tobacco use[1] among Oregon Health Plan members, by race and ethnicity, Oregon, 2016-2019

Race/Ethnicity	Percent (%)
African American, non-Latino	44.0
American Indian and Alaska Native, non-Latino	51.3
Asian or Pacific Islander, non-Latino	--
Hispanic/Latino	22.0
White, non-Latino	40.5

(1) Any tobacco product includes cigarette, e-cigarette, smokeless tobacco, large or small cigars or hookah.
Source: Oregon Behavioral Risk Factor Surveillance System. Unpublished data.

Table 6.4. Percentage of adult menthol cigarette use among cigarette smokers, by race, Oregon, 2016-2019

Race/Ethnicity	Percent (%)
African American, non-Latino	51.3
American Indian and Alaska Native, non-Latino Asian or Pacific Islander, non-Latino	20.2
Asian or Pacific Islander, non-Latino	31.2
Hispanic/Latino	27.0
White, non-Latino	15.7

Source: Oregon Behavioral Risk Factor Surveillance System. Unpublished data.
Note: Estimates for adults are age-adjusted to the 2000 standard population.

Table 6.5. Percentage of menthol cigarette use among cigarette smokers, by age group, Oregon

	Percent (%)
Adults	21.3
11th grade	44.6
8th grade	43.0

Sources: Oregon Healthy Teens (2019); Oregon Behavioral Risk Factor Surveillance System (2020). Unpublished data.
Note: Estimates for adults are age-adjusted to the 2000 standard population.

Table 6.6: Percentage of adult exposure to any secondhand smoke indoors in a typical week, by demographic groups, Oregon, 2018

	Percent (%)
Annual household income	
Less than $20,000	28.1
$20,000– $49,999	22.7
$50,000 or more	10.0
Employment status	
Employed or self-employed	16.7
Unemployed	32.4
Not in workforce	9.8
Housing status	
Rent	21.9
Own	15.0
Urban or rural residency (1)	
Rural	22.7
Urban	16.2

(1) Urban or rural residency was designated using ZIP code level rural-urban commuting area (RUCA) codes. For more information on RUCA codes see http://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx (http://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx).
Source: Oregon Behavioral Risk Factor Surveillance System. Unpublished data.
Notes: Estimates are age-adjusted to the 2000 standard population.

Back to Table of Contents

Section 7: Retail tobacco environment and marketing

The tobacco industry spends more than one million per hour promoting its products in the United States. (19) The tobacco industry spends more than $100 million on marketing every year in Oregon (Figure 7.1). Almost 80% of the tobacco industry's total marketing expenditures for cigarettes and smokeless tobacco products (20)

(/oha/PH/PREVENTIONWELLNESS/TOBACCOPREVENTION/Pages/oregon-tobacco-facts.aspx#c20) and 61% for e-cigarette products (4) (/oha/PH/PREVENTIONWELLNESS/TOBACCOPREVENTION/Pages/c4) are is in the retail environment including convenience stores, pharmacies and grocery stores.

In 2021, the average cost of a pack of cigarettes in Oregon was approximately $6.82 (Table 7.1). However, the

price of a pack is often less than that to the buyer, because the tobacco industry provides discounts to offset the price. To offer these discounts to consumers, retailers must follow tobacco company requirements on product placement and advertising in their stores. This increases exposure to promotional advertising and product displays (21). Approximately three out of every five tobacco retailers advertise sales, discounts or other price promotions on tobacco products (Table 7.2).

Appeal to Kids

Tobacco products are often marketed to appeal to kids. They often have candy-like packaging, come in sweet flavors and are advertised or placed in areas where youth are likely to see them (Table 7.3). Three of four youth reported seeing tobacco product ads at a store within the last month, and almost half visited a convenience store in the past week (Table 7.4).

Among stores that sell tobacco in Oregon:

- Nearly one in five display toys, candy or gum within 12 inches of tobacco products (Table 7.2).
- More thank one in five place advertisements for tobacco products within three feet of the floor (Table 7.2).
- Over nine in 10 stores sell flavored tobacco (Table 7.2)., which makes them appealing to young people (22).

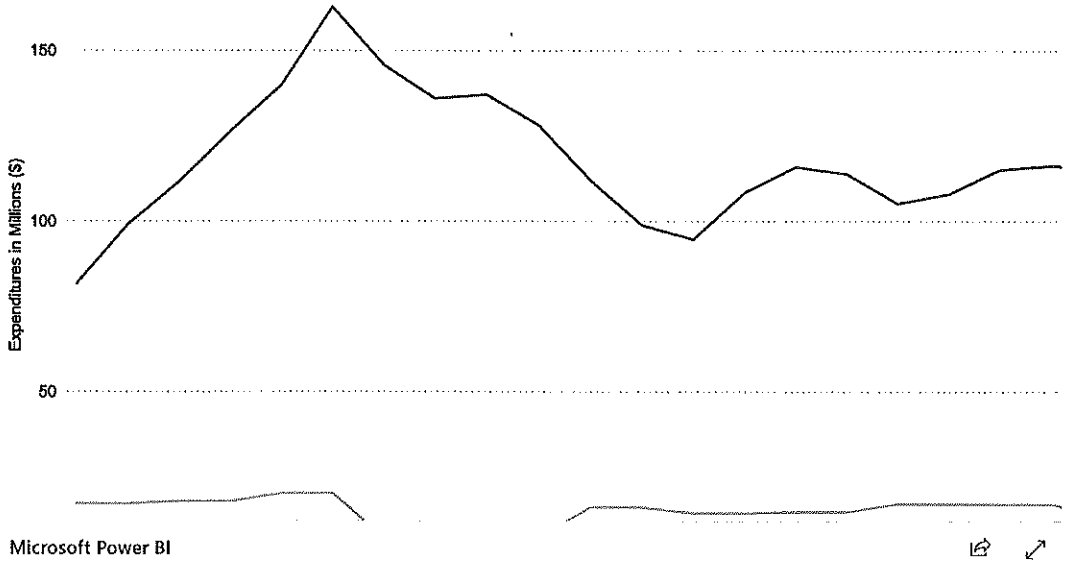
Youth Access to Tobacco

Most youth who use tobacco get tobacco from friends, family members or from their home (Table 7.5), whereas over half of adults purchase their cigarettes at convenience stores or gas stations (Table 7.6).

In 2018, Oregon made it illegal to sell tobacco to people under the age of 21. Prior to 2018, it was illegal to sell to those under 18.

- Among tobacco retailers inspected in 2019, over 15% illegally sold tobacco to underage Oregonians.
- Small cigars/cigarillos and e-cigarettes are illegally sold to underage youth more frequently than cigarettes (Figure 7.3).
- Retail sales to underage Oregonians was highest in tobacco shops, followed by small markets and mini marts that also sold gas (Table 7.8).

Figure 7.1 Annual tobacco industry marketing expenditures and Oregon Tobacco Prevention and Education Program funding (in millions of dollars), Oregon, 1998–2019



Source: Expenditures in Oregon: Campaign for Tobacco-Free Kids. "The Toll of Tobacco in Oregon," 2020. https://www.tobaccofreekids.org/problem/toll-us/oregon (https://www.tobaccofreekids.org/problem/toll-us/oregon); Oregon TPEP Funding: Unpublished data.
Note: Oregon Tobacco Prevention and Education program funding is per biennium.

Table 7.1 Average cigarette pack price in Oregon, Washington and California (1), 1990-2021

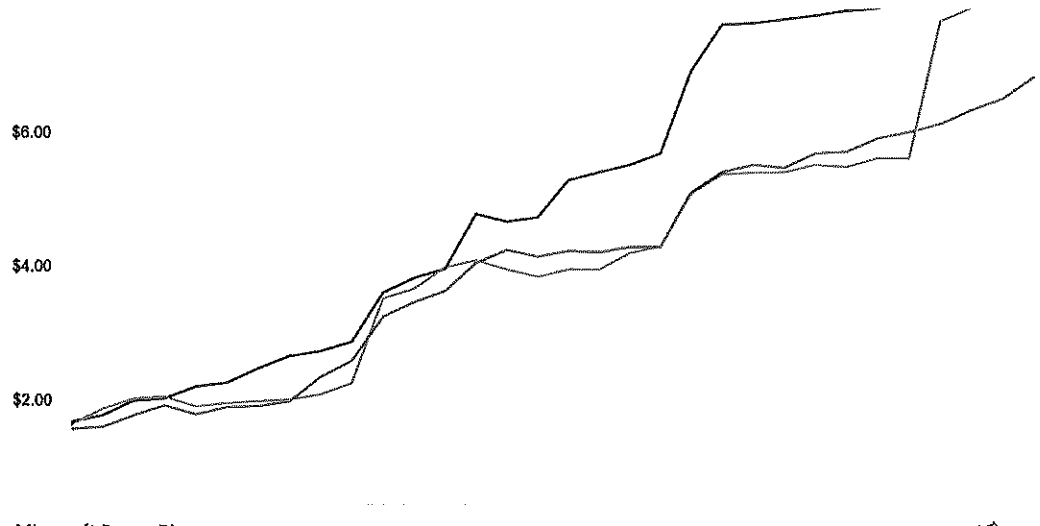
	Oregon	Washington	California
1990	$1.57	$1.68	$1.64
1991	$1.60	$1.77	$1.87
1992	$1.77	$1.99	$2.02
1993	$1.92	$2.02	$2.05
1994	$1.78	$2.20	$1.90
1995	$1.90	$2.26	$1.95
1996	$1.91	$2.47	$1.98
1997	$1.98	$2.65	$2.00
1998	$2.34	$2.73	$2.08
1999	$2.58	$2.87	$2.25
2000	$3.24	$3.60	$3.51
2001	$3.46	$3.82	$3.66
2002	$3.62	$3.95	$3.98
2003	$4.05	$4.77	$4.08
2004	$4.24	$4.66	$3.95
2005	$4.14	$4.73	$3.84
2006	$4.23	$5.28	$3.95
2007	$4.21	$5.40	$3.95
2008	$4.29	$5.51	$4.20
2009	$4.29	$5.69	$4.29
2010	$5.10	$6.92	$5.09
2011	$5.41	$7.61	$5.37
2012	$5.52	$7.64	$5.40
2013	$5.47	$7.69	$5.40
2014	$5.68	$7.75	$5.51
2015	$5.71	$7.82	$5.48
2016	$5.91	$7.85	$5.61
2017	$6.00	$7.99	$5.61
2018	$6.12	$8.18	$7.66
2019	$6.33	$8.32	$7.86
2020	$6.50	$8.57	$8.14
2021	$6.82	$8.94	$8.41

(1) Price includes generic brand

Source: Orzechowski and Walker, The Tax Burden on tobacco. Historical compilation. Fairfax and Richmond, Virginia.

Figure 7.2 Average cigarette pack price in Oregon, Washington and California(1), 1990-2021

$8.00



(1) Price includes generic brands.
Source: Orzechowski and Walker, The Tax Burden on tobacco. Historical compilation. Fairfax and Richmond, Virginia.

Table 7.2 Percentage of Oregon retailers with tobacco product marketing, 2018

Total number of tobacco retailers(1)	**3145**
Among tobacco retailers	**(%)**
Advertised little cigars for under $1	56.6
Any tobacco product or advertisement that is displayed in a manner that appeals to youth	33.0
Tobacco advertisements displayed within 3 ft. of the floor	21.4
Tobacco products displayed within 12 inches of candy or toys	19.7
Price promotions displayed for any tobacco product (discounts, 2 for 1, etc.)	63.9
Sell flavored tobacco	93.2

(1) Number of stores that sell tobacco or vaping products that are accessible to unaccompanied people under 21 (excludes liquor stores, bars, etc.). Oregon does not require tobacco retailers to be licensed, so this number is likely an underestimate.
Source: Oregon Tobacco and Alcohol Retail Assessment, 2018. Unpublished data.

Table 7.3 Percentage and number of Oregon retailers with tobacco product marketing by county, 2018

	Any tobacco product or advertisement that is placed in a manner that appeals to youth (%)	**Tobacco advertisements within 3 ft. of the floor (%)**	**Tobacco products 12 inches from toys (%)**	**Any tobacco price promotion (%)**	**Flavored tobacco available (%)**	**Total number of retailers (1)**
Oregon	**33.0**	**21.4**	**19.7**	**63.9**	**93.2**	**3145**
Baker	9.1	4.6	9.1	68.2	95.5	24
Benton	26.3	18.4	13.2	84.2	94.7	45
Clackamas	15.4	4.4	12.3	39.0	93.4	240
Clatsop	18.4	10.5	13.2	39.5	89.5	49
Columbia	25.0	11.1	16.7	86.1	97.2	40
Coos	21.9	9.4	17.2	67.2	98.4	71
Crook	39.1	34.8	17.4	60.9	91.3	24
Curry	35.0	15.0	25.0	65.0	100.0	24
Deschutes	40.5	21.6	32.4	73.0	91.9	109
Douglas	27.3	20.5	13.6	65.9	97.7	146
Grant	8.3	NA	8.3	58.3	83.3	18
Harney	80.0	60.0	50.0	100.0	70.0	16
Hood River	20.8	16.7	8.3	70.8	100.0	23
Jackson	53.3	44.4	11.1	82.2	95.6	172
Jefferson	22.2	16.7	5.6	11.1	100.0	27
Josephine	37.0	26.1	17.4	84.8	97.8	87
Klamath	26.6	22.8	8.9	60.8	87.3	84
Lake	14.3	14.3	NA	42.9	85.7	14

Lane	28.1	15.8	18.7	74.8	97.1	323
Lincoln	13.6	2.3	11.4	40.9	93.2	60
Linn	28.3	19.6	19.6	54.4	90.2	103
Malheur	8.3	4.2	8.3	25.0	87.5	24
Marion	64.7	45.1	43.1	27.5	94.1	224
Morrow	40.0	20.0	20.0	70.0	100.0	10
Multnomah	30.8	16.6	19.8	73.1	93.7	608
North Central (2)	29.3	22.0	12.2	73.2	82.9	49
Polk	46.5	32.6	37.2	90.7	95.4	47
Tillamook	44.8	37.9	17.2	82.8	82.8	33
Umatilla	37.0	34.8	13.0	73.9	95.7	73
Union	7.7	NA	7.7	73.1	100.0	28
Wallowa	20.0	20.0	NA	90.0	40.0	10
Washington	36.4	21.9	30.7	53.5	88.2	265
Wheeler	NA	NA	NA	100.0	50.0	3
Yamhill	27.3	21.2	10.6	84.9	90.9	72

(1) Number of stores that sell tobacco or vaping products that are accessible to unaccompanied people under 21 (excludes liquor stores, bars, etc.). Oregon does not require tobacco retailers to be licensed, so this number is likely an underestimate.

(2) North Central Public Health District includes Gilliam, Sherman and Wasco counties.

NA = Not applicable.

Source: Oregon Tobacco and Alcohol Retail Assessment, 2018. Oregon Tobacco Retailer Database, 2020. Unpublished data.

Table 7.4 Percentage of youths exposed to tobacco advertising, Oregon, 2019

	8th graders (%)	11th graders (%)
Saw a tobacco advertisement on a storefront or in a store in past 30 days	75.0	75.5
Visited a convenience store one or more times in the past week	46.2	48.0

Source: Oregon Healthy Teens. Unpublished data.

Table 7.5 Percentage of sources of tobacco products and ease of access among youth, Oregon, 2020

	8th grade (%)	11th grade (%)
Source of tobacco (1)		
A store or gas station	4.5	13.4
A social source[2]	62.3	67.5
The internet	13.6	4.6
Some other source	35.1	27.7
Ease of access (2)		
Easy to get cigarettes	20.5	31.6
Easy to get e-cigarettes	22.7	47.9

(1) Youth that had used tobacco or vaping products in the past 30 days were asked where they had gotten their products. Responses do not add to 100% because respondents could select more than one source.

(2) Social sources include friends, family members or from their home.

(3) Among all respondents, regardless of whether current tobacco users, percent indicating it would be very easy or sort of easy to get the tobacco product.

Source: Oregon Student Health Survey, unpublished data.

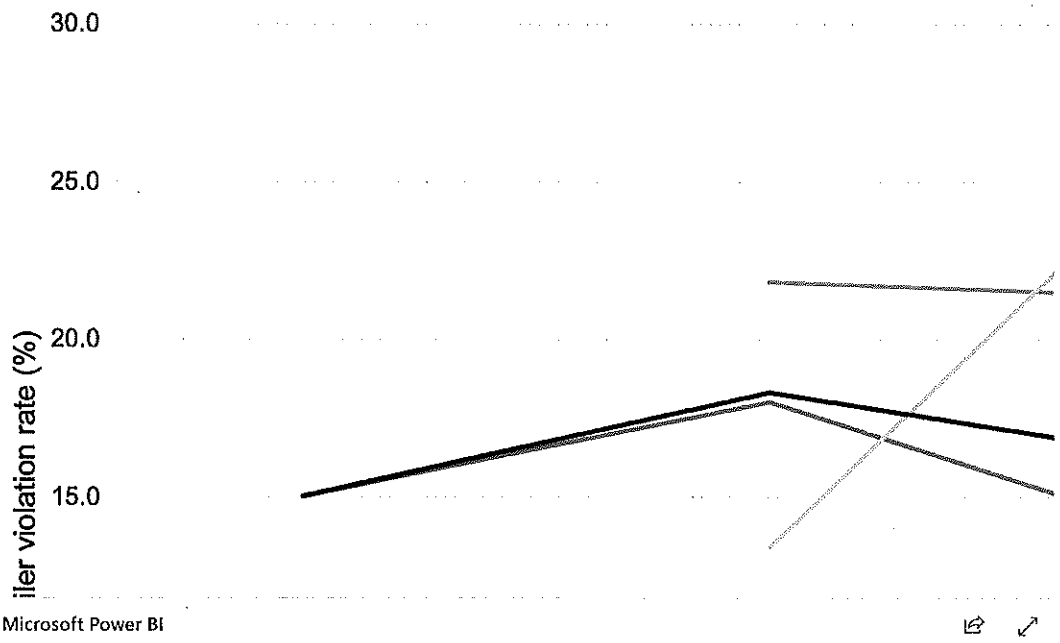
Table 7.6: Percentage of purchase locations for vaping products and cigarettes among adults, Oregon, 2021

Usual e-cigs and vaping products purchase source (among current e-cig users)	**(%)**
Store in Oregon	72.6
Store outside of Oregon	13.0
Internet	10.9
Other	3.4
Usual cigarettes purchase source (among current smokers)	**(%)**
Store in Oregon	90.4

Store outside of Oregon	6.4
Internet	2.0^
Other	1.1^
Usual store type for cigarettes purchase (among current smokers)	**(%)**
Convenience store or gas station	61.2
Tobacco shop	16.8
Grocery store or superstore	8.8
Liquor store	3.4
Other (discount, newspaper stand)	2.7
Drug store or pharmacy	7.2

^ Indicates the estimate may be statistically unreliable and should be interpreted with caution.
-- this number is suppressed because it is statistically unreliable.
Source: Oregon Health Matters Survey, 2021, Health Promotion and Chronic Disease Prevention section, Oregon Health Authority, Unpublished data.

Figure 7.3 Rate of tobacco sales to underage people by product type, Oregon, 2017-2020



* Inspections were stopped in March 2020 because of COVID-19. In addition, the peak of the outbreak of e-cigarette, or vaping, product use-associated lung injury (EVALI) occurred in September of 2019, which is included in the 2020 data collection period. Because of these issues, retail violation rates may not be representative of a normal year.
Source: Oregon Tobacco Retail Database, 2020. Unpublished data.
Note: Year follow the state fiscal year, with inspections generally starting in September of the prior year and continue through June of the published year.

Table 7.7 Rate of tobacco sales to underage people by Oregon county, 2017-2020(1)

	Retailer violation rate (RVR), Percent (%)			
	Overall RVR	Cigarettes	Cigarillos / Small cigars	E-cigarettes
Oregon	**16.2**	**15.5**	**17.7**	**19.2**
Baker	26.1	25.0	0.0	100.0
Benton	5.3	5.9	0.0	0.0
Clackamas	17.3	16.3	10.0	36.8
Clatsop	9.7	12.5	0.0	0.0
Columbia	16.3	15.9	0.0	100.0
Coos	13.8	11.6	0.0	37.5
Crook	11.8	11.5	0.0	14.3
Curry	25.0	24.0	100.0	0.0
Deschutes	8.1	7.0	15.4	6.7

Douglas	16.4	16.8	0.0	18.8
Gilliam	0.0	0.0	0.0	0.0
Grant	19.2	22.7	0.0	0.0
Harney	16.7	14.3	0.0	50.0
Hood River	6.5	7.1	0.0	0.0
Jackson	19.6	17.8	26.3	20.6
Jefferson	17.9	20.8	0.0	0.0
Josephine	24.3	26.8	22.2	16.7
Klamath	22.0	20.6	30.8	20.0
Lake	0.0	0.0	0.0	0.0
Lane	19.8	18.3	26.9	25.0
Lincoln	15.7	16.7	33.3	7.1
Linn	11.9	9.4	16.7	25.0
Malheur	2.8	0.0	0.0	9.1
Marion	16.4	18.2	6.9	12.0
Morrow	15.4	18.2	0.0	0.0
Multnomah	15.3	13.6	18.2	20.8
Polk	24.1	23.3	50.0	18.2
Sherman	18.2	20.0	0.0	0.0
Tillamook	12.2	9.7	25.0	16.7
Umatilla	15.9	16.1	20.0	10.0
Union	12.5	11.8	33.3	0.0
Wallowa	13.3	20.0	0.0	0.0
Wasco	6.1	4.0	16.7	0.0
Washington	16.2	16.7	16.7	13.3
Wheeler	25.0	25.0	0.0	0.0
Yamhill	17.8	14.9	0.0	31.8

(1) Inspections were stopped in March 2020 because of COVID-19. In addition, the peak of the outbreak of e-cigarette, or vaping, product use-associated lung injury (EVALI) occurred in September of 2019, which is included in the 2020 data collection period. Because of these issues, retail violation rates may not be representative of a normal year.

Source: Oregon Tobacco Retail Database, Combined years 2018-2020. Unpublished data.

Table 7.8 Rate and number of tobacco sales to underage people by store type, Oregon, 2017-2020(1)

	2017		2018		2019		2020	
Store type	Total Inspected	%	Total Inspected	%	Total Inspected	%	Total Inspected	%
Department store	75	8.0	50	6.0	67	9.0	50	10.0
Drug store	59	3.4	48	16.7	53	7.5	32	6.3
Grocery store	100	15.0	92	15.2	90	16.7	45	15.6
Market	98	15.3	83	27.7	92	20.7	79	15.2
Mini mart	446	14.6	381	16.3	407	15.2	250	12.8
Mini mart with gas	304	19.1	253	21.3	233	15.5	169	18.9
Tobacco shop	10	30.0	14	28.6	13	23.1	11	36.4
Vape shop	0	0.0	11	18.2	13	23.1	13	7.7
Other	42	14.3	41	22.0	41	31.7	38	13.2

(1) Inspections were stopped in March 2020 because of COVID-19. In addition, the peak of the outbreak of e-cigarette, or vaping, product use-associated lung injury (EVALI) occurred in September of 2019, which is included in the 2020 data collection period. Because of these issues, retail violation rates may not be representative of a normal year.

Source: Oregon Tobacco Retail Database, 2020. Unpublished data.

Note: Year follow the state fiscal year, with inspections generally starting in September of the prior year and continue through June of the published year.

Back to Table of Contents

Citations

1. Federal Trade Commission. Federal Trade Commission cigarette report for 2020. Issued 2021. Available at https://www.ftc.gov/system/files/documents/reports/federal-trade-commission-cigarette-report-2020-smokeless-tobacco-report-2020/p114508fy20cigarettereport.pdf. Accessed 2022 August 12.
2. Federal Trade Commission. Federal Trade Commission smokeless tobacco report for 2020. Issued 2021. Available at https://www.ftc.gov/system/files/documents/reports/federal-trade-commission-cigarette-report-

Available at https://www.ftc.gov/system/files/documents/reports/federal-trade-commission-cigarette-report-2020-smokeless-tobacco-report-2020/p114508fy20smokelesstobacco.pdf (https://www.ftc.gov/system/files/documents/reports/federal-trade-commission-cigarette-report-2020-smokeless-tobacco-report-2020/p114508fy20smokelesstobacco.pdf). Accessed 2021 August 12.

3. CounterTobacco.org. Spending at the point of sale: Federal Trade Commission Reports. Available at: https://countertobacco.org/the-war-in-the-store/#ftcreports (https://countertobacco.org/the-war-in-the-store/#ftcreports). Accessed 2022 July 10.
4. Federal Trade Commission. Federal Trade Commision E-Cigarette Report for 2015-2018. Issued 2022. Available at https://www.ftc.gov/system/files/ftc_gov/pdf/E-Cigarette-Report-2015-2018.pdf (https://www.ftc.gov/system/files/ftc_gov/pdf/E-Cigarette-Report-2015-2018.pdf). Accessed 2022 March 30.
5. U.S. Department of Health and Human Service Public Health Service Office of the Surgeon General. The health consequences of smoking—50 years of progress: A report of the surgeon general, 2014. Available at https://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf (https://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf). Accessed 2016 Oct 21.
6. Oregon Health Authority. Public Health Division. Oregon Health Promotion and Chronic Disease Prevention section. Oregon Behavioral Risk Factor Surveillance System. Unpublished data.
7. U.S. Department of Health and Human Services. Preventing tobacco use among youth and young adults: A report of the Surgeon General, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2012.
8. Health and Human Services (HHS). Preventing tobacco use among youth and young adults: A report of the surgeon general, 2012. Available at http://www.surgeongeneral.gov/library/ reports/preventing-youth-tobacco-use/full-report.pdf (http://www.surgeongeneral.gov/library/%20reports/preventing-youth-tobacco-use/full-report.pdf). Accessed 2016 Oct 21. See also, Hegmann KT, et al. The effect of age at smoking initiation on lung cancer risk. Epidemiology 4(5):444-48, September 1993; Lando HA, et al. Age of initiation, smoking patterns, and risk in a population of working adults. Preventive Medicine 29(6 Pt 1):590–98, December 1999.
9. U.S. Department of Health and Human Services, Preventing tobacco use among young people: A report of the surgeon general, 1994.
10. Centers for Disease Control and Prevention. (2012). Preventing tobacco use among youth and adults: a report of the surgeon general. Page 2. Available at: http://www.cdc.gov/tobacco/data_statistics/sgr/2012/consumer_booklet/pdfs/consumer.pdf (http://www.cdc.gov/tobacco/data_statistics/sgr/2012/consumer_booklet/pdfs/consumer.pdf).
11. Burrows, D. (1984). Strategic research report: Young adult smokers-startegies and opportunities. Legacy Tobacco Docuemnts Library. RJ Reynods. Bates No: 508783540. Available at: http://legacy.library.ucsf.edu/tid/swx83d00/pdf.
12. Myers ML. New study finds over 40 percent of youth smokers use flavored little cigars or cigarettes, shows need for FDA to regulate all tobacco products. Campaign for Tobacco-Free Kids. Oct. 22, 2013.
13. Achieving Health Equity in Tobacco Control. December 2015. Available at: https://truthinitiative.org/sites/default/files/media/files/2019/03/Achieving%20Health%20Equity%20in%20Tabacco%20Co%20Version%201.pdf (https://truthinitiative.org/sites/default/files/media/files/2019/03/Achieving%20Health%20Equity%20in%20Tabacco%20Cc%20Version%201.pdf).
14. Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion. https://www.cdc.gov/tobacco/basic_information/tobacco_industry/menthol-cigarettes/index.html (https://www.cdc.gov/tobacco/basic_information/tobacco_industry/menthol-cigarettes/index.html).
15. Discrimination in America: Summary Report. (2018) National Public Radio, the Robert Wood Johnson Foundation, and Harvard T.H. Chan School of Public Health. Available at https://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2018/rwjf443620 (https://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2018/rwjf443620).
16. Tan, A., Young-Wolff, K. C., Carter-Harris, L., Salloum, R. G., & Banerjee, S. C. (2018). Disparities in the Receipt of Tobacco Treatment Counseling within the US Context of the Affordable Care Act and Meaningful Use Implementation. Nicotine & tobacco research: official journal of the Society for Research on Nicotine and Tobacco, 20(12), 1474–1480. https://doi.org/10.1093/ntr/ntx233 (https://doi.org/10.1093/ntr/ntx233).
17. Centers for Disease Control and Prevention (CDC). American Indians/Alaska Natives and Tobacco Use. Available at https://www.cdc.gov/tobacco/disparities/american-indians/index.htm (https://www.cdc.gov/tobacco/disparities/american-indians/index.htm). Accessed 2020 July 10.
18. American Cancer Society, Cancer Action Network. (n.d.) Manipulating a sacred tradition: an investigation of commercial tobacco marketing & sales strategies on the Navajo nation and other native tribes. Available at: http://action.fightcancer.org/site/DocServer/Industry_Influence-_Indi- an_Lands-_Indian_Gaming.pdf ?docID=8902 (https://secure.fightcancer.org/site/DocServer/Industry_Influence-_Indian_Lands-_Indian_Gaming.pdf?docID=8902).
19. Tobacco Free Kids. Broken promises to our children, a state-by-state look at the 1998 state tobacco settlement 16 years later. December 2014. Available at: http://www.tobaccofreekids.org/content/what_we_do/state_local_issues/settlement/FY2015/2014_12_11_brokenpromises (https://www.tobaccofreekids.org/assets/content/what_we_do/state_local_issues/settlement/FY2015/2014_12_11_brokenp

Accessed 2016 Oct 21.
20. CounterTobacco.org. Spending at the point of sale: Federal Trade Commission Reports. Available at: https://countertobacco.org/the-war-in-the-store/#ftcreports (https://countertobacco.org/the-war-in-the-store/#ftcreports). Accessed 2020 July 10.
21. Feighery EC, Ribisl KM, Clark PI, Haladjian HH. How tobacco companies ensure prime placement of their advertising and products in stores: interviews with retailers about tobacco company incentive programmes. Tobacco Control 2003; 12:184–188.
22. Kostygina G, Glantz SA, Ling PM. Tobacco industry use of flavours to recruit new users of little cigars and cigarillos. Tob Control. 2016;25(1):66–74.

Back to Table of Contents

Help us improve! Was this page helpful?

Yes | No

Oregon Health Authority

Find us on Facebook (https://www.facebook.com/OregonHealthAuthority)
Follow us on Twitter (https://twitter.com/OHAOregon)
Website Feedback (/oha/Pages/WebsiteFeedback.aspx)

Contact Us (/oha/Pages/Contact-Us.aspx)

Media (/oha/ERD/Pages/Contacts.aspx)

Request Public Records (/oha/ERD/Pages/Records.aspx)

Director's Office (mailto:OHA.DirectorsOffice@dhsoha.state.or.us)

Questions about the Oregon Health Plan?

To learn more about your new health plan, welcome packet, and what to do if you have an urgent health care issue please visit the New to Oregon Health Plan (/oha/HSD/OHP/Pages/New-OHP.aspx) web page.

Access

Language Access (/oha/Documents/OHA-Language-Access-Policy.pdf)

OHA Nondiscrimination Policy (https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/de2690.pdf)

OHA ADA Policy and Request for Modification (/oha/Pages/ADA-Notice.aspx)

OHA Notice of Privacy Practices (/oha/Pages/Notice-of-Privacy-Practices.aspx)

About Oregon

(https://www.oregon.gov)

State Employee Search (https://www.oregon.gov)

Agencies A to Z (https://www.oregon.gov/pages/a_to_z_listing.aspx)

Accessibility (https://www.oregon.gov/pages/accessibility.aspx)

Privacy Policy (https://www.oregon.gov/pages/terms-and-conditions.aspx)

Supported Browsers (https://www.oregon.gov/pages/supported-browsers.aspx)

↑ Back to Top

Select Language
Powered by Google Translate (https://translate.google.com