UP IN SMOKE:

NEW JERSEY REAPS BILLIONS IN REVENUE FROM TOBACCO WHILE SHORT CHANGING ANTI-SMOKING PROGRAMS

ENDORSED BY:

- AMERICAN CANCER SOCIETY
- AMERICAN HEART ASSOCIATION
- AMERICAN LUNG ASSOCIATION OF THE MID-ATLANTIC
- CAMPAIGN FOR TOBACCO-FREE KIDS

September 2011

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Written by Russ Sciandra, Blair Horner and Jennifer Sullivan of the American Cancer Society, Eastern Division.

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You can download the report, by going to the American Cancer Society website at:
www.cancer.org/nynj

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WRITTEN BY:
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UP IN SMOKE:
EXECUTIVE SUMMARY

New Jersey has raised billions of dollars in tobacco revenues, largely resulting from several significant increases in its excise tax on tobacco products. These hikes in taxes act as an important deterrent to smoking among adults and children. However, those benefits are severely undercut because the state uses almost no tobacco tax revenue to fund smoking cessation and anti-tobacco public education programs.

This report examines the inadequacy of New Jersey's anti-smoking efforts in light of the significant resources available. We find that only a tiny fraction of revenue the state derives from tobacco use is being used for tobacco control efforts, and that the state is spending far less than recommended by the federal government. As a result, the potential public health benefits and savings that would be realized through robust funding of tobacco control programs are going "Up In Smoke."

FINDINGS:

- New Jersey has raised $5 billion in tobacco revenues over the past five years, yet only 0.08 percent been spent on tobacco control programs. To be clear, not even a full penny of every dollar raised by tobacco taxes goes to help people quit smoking. This inadequate spending stands in stark contrast to previous promises made by public officials to invest these state dollars in tobacco control.
- In the current fiscal year, New Jersey will spend almost nothing on tobacco control, providing only one percent of the amount recommended by the Centers for Disease Control and Prevention, most of that is paid for through federal grants. In fact, this year the state of New Jersey actually turned away people wanting help to quit smoking because of a lack of funding.
- Tobacco use takes a terrible toll on New Jersey. In 2009, 11,200 lives are prematurely lost due to tobacco use. In addition, tobacco use costs the state an estimated $3.17 billion in health care bills annually, including $967 million in Medicaid payments alone.
- Tobacco control programs have been proven to reduce youth smoking and help current smokers to quit. When more adequately funded, the New Jersey tobacco control programs achieved successes in the effort to curb tobacco use.
- Raising tobacco taxes helps curb tobacco use, especially among children. For every 10 percent increase in price, there is a 4 percent decrease in overall consumption.

RECOMMENDATIONS:

- New Jersey should spend about a dime of every dollar of revenue from tobacco sales on tobacco control. New Jersey must fulfill its promises to use tobacco revenues for programs to help smokers to quit and to keep children from smoking. We recommend that New Jersey's tobacco control be **incrementally increased to the CDC-recommended level of $119.8 million per year**. The program's annual budget should be increased to $30 million in 2012-13 and then, as its capacity grows, increased by $30 million every year until it reaches the target appropriation.
- **Target more resources to adult cessation.** Achieving near-term reductions in tobacco use rates, and the incidence of tobacco-caused disease, will best be accomplished by encouraging adult smokers to quit and providing resources to help them succeed. Only by motivating smokers to attempt to quit smoking and providing the pressure, resources, and support to make those attempts successful will near-term smoking rates decline, disease rates decline, premature deaths decline, and economic savings accrue. Most smokers want to quit, and encouraging and assisting adult cessation is a cost-effective tobacco control strategy.
- **Increase community level interventions, especially in disadvantaged urban neighborhoods and rural areas.** To change social norms a program must be well integrated into a community. Program personnel must understand and, preferably, live in, the communities they work in. At least one-third of any budget increase should be directed to increasing the level of community activity.
- **Increase funding for anti-smoking media messages.** As quickly as possible, the New Jersey tobacco control program should increase its media budget and target messages to those, such as the poor and non-English speakers, that the program has not been reaching.
- **Develop and implement strategies for reaching those with mental illness or addictive disorders.** People with mental illness smoke at a rate almost twice that of the general public. Increasingly, tobacco use is concentrated in this population, and if the problem is not addressed now, the burden of tobacco use will increasingly fall on those least able to absorb it.
- **Increase the cigarette tax by $1 to $3.70 per pack and raise the tax on other tobacco products to an equivalent level.** New Jersey has the sixth highest cigarette tax rate in the nation ($2.70 per pack). However, if policy makers cannot bring themselves to divert a small fraction of the money that the state *already* collects in tobacco revenues, then a tax hike may be needed. Not only would such an increase boost revenues for the state as well as the tobacco control program, it would also help save lives and reduce health care costs.

UP IN SMOKE:
IN FIVE YEARS, TOBACCO HAS GENERATED FIVE BILLION DOLLARS IN TOBACCO REVENUES FOR NEW JERSEY

New Jersey generates a staggering amount of revenue from tobacco each year. These tobacco revenues come from two main sources: (1) the state's tobacco taxes; and (2) monies that result from litigation commenced by New Jersey against tobacco product manufacturers.

TOBACCO TAXES

New Jersey's cigarette excise tax is $2.70 per pack. Other tobacco products, such as cigars, "little cigars," and snuff are proportionately taxed at significantly lower rates. In the past fiscal year, New Jersey collected **$750 million** in taxes on cigarettes and other tobacco products.[1]

THE MASTER SETTLEMENT AGREEMENT

In the same fiscal year, New Jersey received $239.9 million in Master Settlement Agreement (MSA) payments from tobacco manufacturer, bringing total annual revenue from tobacco to nearly **$1 billion**. It is important to note that most, if not all, of this cost is borne by the consumers of tobacco products in the form of higher retail prices.

The revenue generated from New Jersey's litigation arises from the "Master Settlement Agreement" (MSA), an agreement between the nation's largest cigarette companies and 46 states. The MSA requires those cigarette companies to, among other things, annually pay billions of dollars to the states as compensation for the health costs to their Medicaid programs resulting from tobacco use.

After the MSA was signed in November 1998, many governors, state attorneys general, and other high-ranking state officials expressed strong support for investing substantial portions of the tobacco settlement payments in new efforts to prevent and reduce tobacco use in their states.

For example, Governor Thomas Carper, Chairman of the National Governors Association and Utah Governor Michael Leavitt, Vice Chair, wrote in letter to U.S. Senate Minority Leader Daschle, March 5, 1998:

> "The nation's Governors are committed to spending a significant portion of the tobacco settlement funds on smoking cessation programs, health care, education, and programs benefiting children."

Then-New Jersey Governor Christie Whitman released a statement on November 16, 1998 which stated:

> "Every penny of these funds should be used for health purposes including prevention programs and counter advertising to protect kids, cessation programs and community partnerships to serve those who have already put their health at risk by smoking, in addition to existing important health programs such as charity care and KidCare."

However, it was not just promises made by high-ranking public officials in press releases. The pledge to use the MSA revenues to curb tobacco use is found in the agreement itself. Most notably, the MSA begins with a series of "Whereas" clauses, including the following:

- **WHEREAS**, the Settling States that have commenced litigation have sought to obtain equitable relief and damages under state laws, including consumer protection and/or antitrust laws, in order to further the Settling States' policies regarding public health, including policies adopted to achieve a significant reduction in smoking by Youth …
- **WHEREAS**, the Settling States and the Participating Manufacturers are committed to reducing underage tobacco use by discouraging such use and by preventing Youth access to Tobacco Products;

[1] Orzechowski & Walker, *The Tax Burden on Tobacco, 2010*.

- **WHEREAS**, the undersigned Settling State officials believe that entry into this Agreement and uniform consent decrees with the tobacco industry is necessary in order to further the Settling States' policies designed to reduce Youth smoking, to promote the public health and to secure monetary payments to the Settling States; and
- **WHEREAS**, the Settling States and the Participating Manufacturers … have agreed to settle their respective lawsuits and potential claims pursuant to terms which will achieve for the Settling States and their citizens significant funding for the advancement of public health, the implementation of important tobacco-related public health measures, including the enforcement of the mandates and restrictions related to such measures, as well as funding for a national foundation dedicated to significantly reducing the use of Tobacco Products by Youth.[2]

These excerpts clearly indicate that the states are supposed to use their MSA payments to advance public health and support tobacco-prevention efforts. Indeed, the last clause explicitly says just that, and also very clearly declares that the states are expected to use their MSA funding for tobacco-prevention and other public health efforts.

However, more than 12 years later, the promises to use the settlement monies for tobacco prevention has eroded – or been ignored.

As seen in the chart below, New Jersey has raised over $5 billion in tobacco revenues over the past five years. Yet during that time, spending to prevent kids from smoking and to help smokers quit has plummeted.

The money is amply available; it is the commitment that is missing.

New Jersey Has Raised Billions From Tobacco and Spent Little On Tobacco Control

FISCAL YEAR	AMOUNT SPENT ON TOBACCO CONTROL (Millions)	TOTAL REVENUE FROM TOBACCO (Billions)	REVENUE FROM TOBACCO TAXES (Millions)	REVENUE FROM TOBACCO SETTLEMENT (Millions)
FY 2007	$11.0	$1.01 b	$776.4	$234.7
FY 2008	$11.0	$1.04 b	$778.2	$262.2
FY 2009	$9.1	$1.03 b	$742.3	$287.4
FY 2010	$7.6	$0.99 b	$747.5	$240.0
FY 2011	$1.5	$0.99 b	$750.0	$239.9
TOTAL	$40.2	$5.09 b	$3.79 b	$1.26 b

The MSA also had an effect on the *price* of cigarettes. Reports at that time cited statements by the largest cigarette companies that they estimated per pack price increases of 45 cents – the largest price increase up to that date.[3] Coupled with soon-to-be enacted tobacco tax hikes, the cost of smoking was about to go up.

These price increases have impacted tobacco consumption. A recent paper[4], examined 523 published estimates of cigarette price elasticity from the academic literature. It found a median adult short-run price elasticity of 0.40 (long-run elasticity was 0.44). This means that for every 10 percent increase in price, there is a 4 percent decrease in consumption. About half of this decreased consumption is due to adult smokers quitting, and half due to smokers who continue smoking at a reduced rate. In the years since the MSA-caused price increase took effect (and most states raised their cigarette excise tax, many more than once), tobacco consumption throughout the U.S. has declined.

[2] *Master Settlement Agreement*, November 23, 1998, See: http://www.naag.org/backpages/naag/tobacco/msa.

[3] Meier, B. "Cigarette Maker Raises Price 45 Cents A Pack", *The New York Times*, October 24, 1998, p. A 20.

[4] Gallet, C.A., List, J. A., "Cigarette Demand: A Meta-Analysis of Elasticities", *Journal of Health Economics*, V. 12, p.821-835

UP IN SMOKE:
THE BURDEN OF TOBACCO EXPOSURE IN NEW JERSEY

Tobacco kills more than 11,000 New Jersey residents every year, more than any other cause.[5] Unless current trends are changed, 168,000 children under 18 and now living in New Jersey will eventually die prematurely from diseases caused by tobacco – diseases that can be avoided. [6]

Tobacco is a source of considerable revenue to New Jersey government. Unfortunately, it is a source of even greater costs.

The Centers for Disease Control & Prevention (CDC) estimates New Jersey residents spend **$3.17 billion** annually (FY 2009) on direct medical care to treat smoking caused illness. These costs are concentrated at the two ends of the life span: nursing home expenses incurred by patients with tobacco-caused lung and cardiovascular diseases, and low birth weight babies born to mothers who smoke during pregnancy, and include $967 million spent on tobacco-caused Medicaid costs in New Jersey.[7] The state and federal governments each pay half of Medicaid costs.

In that year, state government revenue from tobacco taxes and the MSA totaled $1 billion. Thus, there was a gap of more than $2 billion, or $679 per household, between tobacco-caused health care expenditures and tobacco-generated state revenues.

Tobacco imposes additional costs of more than $2.60 billion in lost productivity due to acute and chronic illness, with the consequent reduced economic activity leading to lost tax revenue.

The Toll of Tobacco Use in New Jersey, 2009 [8]

High school students who smoke	17% (78,800)
Male high school students who use smokeless or spit tobacco	9.0% (females use much lower)
Kids (under 18) who become new daily smokers each year	10,400
Kids exposed to secondhand smoke at home	398,000
Packs of cigarettes bought or smoked by kids each year	18.5 million
Adults in New Jersey who smoke	15.8% (1,052,500)
Adults who die each year from their own smoking	11,200
Kids now under 18 and alive in New Jersey who will ultimately die prematurely from smoking	168,000
Adult nonsmokers who die each year from exposure to secondhand smoke	1,070
Annual health care costs in New Jersey directly caused by smoking	$3.17 billion
Portion covered by the state Medicaid program	$967 million
Residents' state & federal tax burden from smoking-caused government expenditures	$658 per household
Smoking-caused productivity losses in New Jersey	$2.60 billion

[5] Centers for Disease Control and Prevention, "Best Practices for Comprehensive Tobacco Control Programs – 2007, October 2007, p. 90 (NY), p. 88 (NJ). See: http://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2007/BestPractices_Complete.pdf.

[6] Centers for Disease Control and Prevention, State Data Highlights Report, 2006. http://www.cdc.gov/tobacco/data_statistics/state_data/data_highlights/2006/pdfs/dataHighlights06rev.pdf

[7] Ibid.

[8] Campaign for Tobacco Free Kids, See: http://www.tobaccofreekids.org/facts_issues/toll_us/new_jersey

UP IN SMOKE:
EXPERT RECOMMENDATIONS FOR TOBACCO CONTROL SPENDING IN NEW JERSEY

In the past three decades, a substantial body of scientific evidence has been developed about how to best reduce tobacco use in the population. Indeed, more is understood about how to change human tobacco use behavior than is known about impacting most behavior-based health problems.

TOBACCO CONTROL WORKS

Since 1990, several states, including New Jersey, have for at least a period of time funded comprehensive programs that implement this body of knowledge in a coordinated way. In a 2007 publication, Ending the Tobacco Problem: A Blueprint for the Nation, the prestigious Institute of Medicine of the National Academy of Science concluded, "The evidence … shows that comprehensive state programs have achieved substantial reductions in the rates of tobacco use … this is particularly true … when states aggressively funded and implemented their tobacco control programs."[9]

Tobacco use still afflicts more than one million New Jersey residents, and interventions must reach large numbers of people to have a significant public health impact. Where a public health benefit has been realized, it has been due to the synergistic impact of multiple, well-funded interventions and public policies, applied over a period of several years. Experts have stressed the importance of a comprehensive and balanced intervention that adequately addresses all the vital elements of a tobacco control program.

The best way for a state to substantially reduce tobacco use and its attendant harms and costs is to establish an adequately funded comprehensive tobacco prevention program employing a variety of effective approaches, including smoke-free laws and periodic tobacco tax increases. Nothing else will compete as successfully against the addictive power of nicotine and the tobacco industry's aggressive marketing tactics.

A 2006 study published in the *American Journal of Health Promotion* provides evidence of the effectiveness of comprehensive tobacco control programs and tobacco control policies. The study's findings suggest that well-funded tobacco control programs combined with strong tobacco control policies increase cessation rates. Quit rates in communities that experienced both policy and programmatic interventions were higher than quit rates in communities that had only experienced policy interventions (excise tax increases or secondhand smoke regulations). This finding supports the claim that state-based tobacco control programs can accelerate adult cessation rates in the population and have an effect beyond that predicted by tobacco-control policies alone.[10]

By itself, a significant increase to a state's excise tax on cigarettes will directly reduce smoking, especially among youth. But combining tobacco tax increases with a comprehensive statewide tobacco prevention campaign will accelerate, expand, and sustain the tobacco use declines in the state, thereby saving more lives and saving more money, and saving both sooner.

The rise in smokers' calls to Quitlines following state cigarette tax increases shows how important it is to have cessation resources available to smokers who wish to quit in response to cigarette tax increases. For example, after the most recent cigarette tax increases in Michigan (from $1.25 to $2.00 per pack) and Montana ($0.70 to $1.70), smoker calls to the state smoking Quitlines skyrocketed. In the six months after the tax increase, the Michigan Quitline received 3,100 calls, compared to only 550 in the previous six months; and in Montana more than 2,000 people called in the first 20 days after the tax increase, compared to only 380 calls per month previously.[11] Likewise, in Texas and Iowa, the numbers of calls to their state Quitlines were much higher after each increased their cigarette taxes by $1.00 in 2007, compared to the previous year.[12] Probably the most dramatic example is from Wisconsin, which received a record-breaking 20,000 calls to its state Quitline in the first two months after its $1.00 cigarette tax increase went into effect on January 1, 2008 – compared to typically 9,000 calls per year prior to the tax increase.[13]

[9] Institute of Medicine of the National Academies, Ending the Tobacco Problem: A Blueprint for the Nation. Washington, D.C., The National Academies Press, p. 171.

[10] Hyland, A, et al., "State and Community Tobacco-Control Programs and Smoking - Cessation Rates Among Adult Smokers: What Can We Learn From the COMMIT Intervention Cohort?" *American Journal of Health Promotion* 20(4):272, April/March 2006.

[11] "Tobacco Tax Pushing Smokers to Quit, State Says," *WMMT* News, January 26, 2005; Ecke, R, "Phone Lines Smokin' With Quit Line Calls," *Great Falls Tribune*, January 26, 2005.

[12] Souza, M, "Thank you for Smoking," *Longview-News Journal*, April 22, 2007; "Calls to Quitline Iowa double after cigarette tax raised," AP, March 22, 2007.

[13] Wisconsin Tobacco Quitline, "Calls to Wisconsin Tobacco Quit Line Break All Records," Press Release, February 28, 2008.

Experts regard the volume of Quitline calls as only one indicator of cessation activity in the population at large. For every would-be quitter that calls the Quitline, there are several that make an attempt without the Quitline's assistance, and an increase in the number of Quitline calls should be interpreted as a much larger increase in the total number of smokers attempting to quit.

The evidence is clear – when states increase their tobacco tax, quit attempts and the demand for assistance in quitting increase, and in many cases, increase dramatically.

But there is also evidence that, independent of policy changes such as higher tobacco taxes, comprehensive programs are effective in reducing smoking rates.

▸ **CALIFORNIA.** A study in the *American Journal of Public Health* found that both the 25-cent cigarette tax increase and the state's anti-smoking media campaign were statistically significant in reducing cigarette sales in California from 1990 to 1992. Results show that the tax increase contributed to an 819 million pack decline in cigarette sales, and the anti-smoking media campaign reduced cigarette sales by 232 million packs.[14]

▸ **MASSACHUSETTS.** A study of smoking declines in Massachusetts found that more than 55% of the declines in state cigarette sales from 1992 and 1998 were due to the efforts of the Massachusetts Tobacco Control Program. The study noted that, while other factors, such as rising cigarette prices, contributed to the declines in smoking, "the single most important factor appears to be the Tobacco Control Program." [15]

▸ **OREGON** increased its state cigarette tax by 30 cents per pack in 1997 to establish the state's new Tobacco Prevention and Education Program. Between 1996 and 1998, per capita cigarette consumption declined by 11.3 percent. Discounting other factors, the CDC estimated that slightly more than half of the decrease was prompted by the tax increase, with most of the remainder likely caused by the state's comprehensive prevention program.[16]

▸ INCREASED FUNDING EQUALS DECREASED TOBACCO USE

A recent study published in the American Journal of Public Health examined state tobacco prevention and cessation funding levels from 1995 to 2003 and found that the more states spent on these programs, the larger the declines they achieved in adult smoking, even when controlling for other factors such as increased tobacco prices. The researchers also calculated that if every state had funded their programs at the levels recommended by the CDC during that period, there would have been between 2.2 million and 7.1 million fewer smokers in the United States by 2003.[17] The Campaign for Tobacco-Free Kids estimates that such smoking declines would have saved between 700,000 and 2.2 million lives as well as between $20 billion and $67 billion in health care costs.

The study described above adds to earlier research, using similar methods, which demonstrated the same type of relationship between program spending and youth smoking declines. A 2005 study concluded that if every state had spent the minimum amount recommended by the CDC for tobacco prevention, youth smoking rates nationally would have been between three and 14 percent lower during the study period, from 1991 to 2000. Further, if every state funded tobacco prevention at CDC minimum levels, states would prevent nearly two million kids alive today from becoming smokers, save more than 600,000 of them from premature, smoking-caused deaths, and save $23.4 billion in long-term, smoking-related health care costs.[18]

A study published in the *Journal of Health Economics* found that states with the best funded and most sustained tobacco prevention programs during the 1990s – Arizona, California, Massachusetts and Oregon – reduced cigarette sales more than twice as much as the country as a whole (43% compared to 20%). This new study, the first to compare cigarette sales data from all the states and to isolate the impact of tobacco control program expenditures from other factors that affect cigarette sales, demonstrates a dose-response relationship between spending on tobacco prevention and declines in smoking. In essence, the more states spend on tobacco prevention, the greater the reductions in smoking, and the longer states invest in such programs, the larger the impact. The study concludes that cigarette sales would have declined by 18% instead of nine percent between 1994 and 2000 had all states fully funded tobacco prevention programs.[19]

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[14] Hu, T-W, et al., "Reducing Cigarette Consumption in California: Tobacco Taxes vs. an Anti-Smoking Media Campaign," *American Journal of Public Health*, 85:1218-1222, 1995.

[15] Farrelly, M, letter to the editor, *Boston Globe*, December 9, 2002 [Farrelly is a tobacco researcher at the Research Triangle Institute in Research Triangle Park, North Carolina].

[16] Centers for Disease Control and Prevention, "Decline in cigarette consumption following implementation of a comprehensive tobacco prevention and education program - Oregon 1996 -1998," *MMWR* 48(07):140-03, February 26, 1999, http://www.cdc.gov/mmwr/preview/mmwrhtml/00056574.htm.

[17] Farrelly, MC, et al., "The Impact of Tobacco Control Programs on Adult Smoking," *American Journal of Public Health* 98:304-309, February 2008.

[18] Tauras, JA, et al., "State Tobacco Control Spending and Youth Smoking," *American Journal of Public Health* 95:338-344, February 2005.

[19] Farrelly, MC, et al., "The impact of tobacco control program expenditures on aggregate cigarette sales: 1981-2000," *Journal of Health Economics* 22:843-859, 2003.

PROGRESS STALLS WHEN FUNDING IS REDUCED

A 1998 study in the *Journal of the American Medical Society* found that California's progress in reducing adult and youth smoking stalled when the state cut its tobacco prevention funding in the mid 1990s. Similarly, the impressive initial declines in youth smoking after Florida began its own state tobacco control program completely stopped among some age groups and even reversed among others after subsequent funding cuts.[20]

TOBACCO CONTROL IS A GOOD INVESTMENT

Given the effectiveness of tobacco control programs, it is not surprising that other studies have found that, when adequately funded, the Massachusetts tobacco prevention program was reducing smoking-caused healthcare costs in the state by two dollars for every single dollar spent on the program, and that the longer-running California program was saving more than $3.50 for every dollar the state spent on the program.[21]

A more recent study of California's tobacco prevention program found that for every dollar the state spent on its tobacco control program from 1989 to 2004, the state received tens of dollars in savings in the form of sharp reductions to total healthcare costs in the state.[22] This study confirms that the cost-saving benefits from sustained state investments in effective tobacco control programs quickly grow over time to dwarf the state expenditures; producing massive gains for the state not only in terms of both improved public health and increased worker productivity but in reduced government, business, and household costs.

COMPONENTS OF A MODEL TOBACCO CONTROL PROGRAM

Programs that successfully encourage smokers to quit can produce a more immediate and probably larger short-term public health benefit than any other component of a comprehensive tobacco control program. Recommendations that define a comprehensive statewide tobacco control program are provided in the CDC's *Best Practices for Comprehensive Tobacco Control Programs*. [23]

A comprehensive tobacco control program has three main components: (1) mobilizing communities to change social norms and public policies so that they discourage tobacco use by adults and children, including promoting smoking restrictions to protect nonsmokers from exposure to second hand smoke; (2) using media and counter-marketing to educate both adults and children about tobacco issues, expose tobacco industry propaganda, and deglamorize tobacco use; and (3) treating adult smokers' nicotine addiction. These components are supported and strengthened by surveillance and evaluation activities and by training and program administrative support.

In a comprehensive program, these individual program elements (and additional effective interventions which may be identified) work together to prevent and reduce tobacco use. Reducing the broad social acceptability of tobacco use necessitates changing many facets of the social environment in which tobacco products are used and marketed. This scale of societal change is a complex process that must be addressed by multiple program elements working together.

Inadequately supported interventions have been shown to have little or no effect. Tobacco control is analogous to treating an infection: sufficient dose of the right medicine must be applied for a sufficient duration of time in order to eradicate the condition.

[20] Pierce, JP, et al., "Has the California Tobacco Control Program Reduced Smoking?," *Journal of the American Medical Association* (JAMA) 280(10):893-899, September 9, 1998; Florida Department of Health, *2001 Florida Youth Tobacco Survey*, Volume 4, Report 1; October 22, 2001, www.doh.state.fl.us/disease_ctrl/epi/FYTS.

[21] Harris, J, "Status Report on the Massachusetts Tobacco Control Campaign, with a Preliminary Calculation of the Impact of the Campaign on Total Health Care Spending in Massachusetts," 2000; Tobacco Control Section, California Department of Health Services, *California Tobacco Control Update*, April 2000, www.dhs.ca.gov/tobacco.

[22] Lightwood, JM et al., "Effect of the California Tobacco Control Program on Personal Health Care Expenditures," PLOS Medicine 5(8): 1214-22, August 2008, http://medicine.plosjournals.org/perlserv/?request=getdocument&doi=10.1371%2Fjournal.pmed.0050178.

CDC's *Best Practices* lays out how a comprehensive tobacco control program can be operationalized as a state program. Using evidence-based analysis of existing comprehensive state tobacco control programs and published evidence-based practices, the CDC provides guidance on the scale of funding necessary to support an effective tobacco control program, and presents state-specific funding ranges and programmatic recommendations. **It estimates that New Jersey should spend between $72.1 million and $154.3 million every year on its comprehensive tobacco control program, with a median recommendation of $119.8 million.**[24] Approximately a dime of every dollar of the annual revenue generated by tobacco would fund New Jersey's tobacco control program at the CDC-recommended level.

CDC's *Best Practices* includes a detailed breakdown of programmatic spending within a tobacco control program. The following chart presents CDC's recommended funding level for each program element versus the reality of the most recent state budget.[25]

INTERVENTION	CDC RECOMMENDATION (Millions)	REALITY: NJ FY 2011-12 (Millions)
TOTAL	**$119.8**	**$4.54**
STATE AND COMMUNITY	$41.5	$2.27
HEALTH COMMUNICATION	$34.0	$0.59
CESSATION	$28.7	$0.68
SURVEILLANCE AND EVALUATION	$10.4	$0.05
ADMINISTRATION AND MANAGEMENT	$5.2	$0.95

New Jersey spends a total of $4,541,800 or 3.8 percent of the CDC-recommended level, on tobacco control activities. Of this total, $1.3 million (29%) is spent on enforcement of tobacco age of sale laws. Sixty-eight percent of the allocation is derived from various forms of federal aid. Nearly $900,000 of the federal contribution is in the form of stimulus program grants that will not be renewed. The state appropriation is less than $1.5 million.

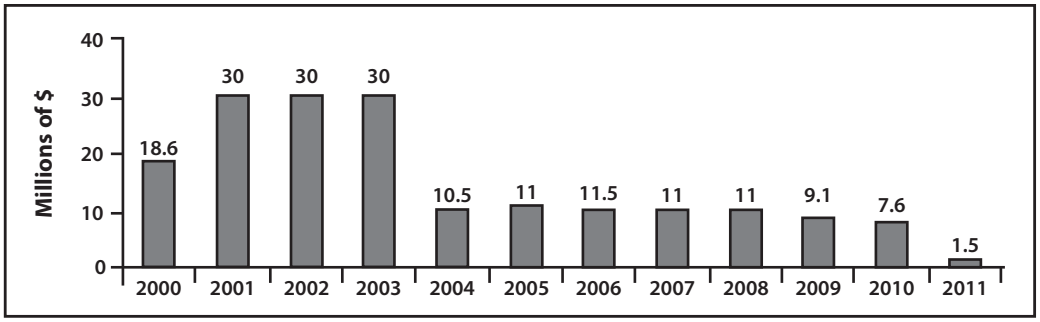
[24] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs - 2007.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; October 2007, p. 54. See: http://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2007/BestPractices_Complete.pdf

[25] Ibid. p. 54, 55.

UP IN SMOKE:
NEW JERSEY'S FAILURE TO MEET THE NEEDS OF THOSE WISHING TO QUIT SMOKING

New Jersey's Tobacco Use Prevention and Control Program (NJ CTP) is supported through annual state budget appropriations. The program was first implemented in 2000 with $18.6 million in funding. Funding for the program peaked in years 2001-04 at $30 million and has since precipitously declined to roughly $1.5 million in state funds for the most recent fiscal year.[26]

Annual Tobacco Program Funding



When the NJ CTP was funded at higher levels, it supported a media campaign, community-based coalitions educating the public about tobacco, and a network of youth-centered groups called REBEL, as well as comprehensive smoking cessation services readily available to all state residents. These included a telephone based Quitline, web-based quit service, and hospital based Quit Centers, where people could receive individual or group counseling to quit. Over 100,000 individuals throughout New Jersey utilized these vast quit services from 2000-07.

Now, only the Quitline remains, and with minimal funding and little advertising, reaches only a fraction of smokers who want to quit. Research shows that utilization of services like the Quitline is based on an ongoing mass media advertising campaign that reaches smokers at the critical moment when they are contemplating cessation. Lacking such advertising, the Quitline has recorded a low volume of calls.

With a one-time stimulus funding grant earlier in 2011, the NJ CTP completed a FREE Nicotine Replacement Therapy Campaign for a limited time through the NJ Quitline. The results speak for themselves, with over 2,400 New Jersey residents receiving counseling during the campaign (5-6 times the rate that would normally occur on a weekly basis), and 1,890 New Jersey residents receiving free NRT during the campaign. Clearly, if cessation services are made available, New Jersey residents will seek assistance with quitting.

Yet, the inadequate funding of the NJ TCP means that critical needs are unmet. For example, this past June the Quitline had to suspend its services when it ran out of money. Below is an outline of what occurred:[27]

- **June 10, 2011:** NJ Quitline concluded a very successful free NRT campaign on Friday, June 10th which not only depleted the entire free NRT budget, but due to an overwhelming response by NJ residents interested in quitting smoking, also completely depleted the NJ Quitline Counseling Budget with Alere Well Being (formerly Free & Clear), the contractor providing the service to New Jersey residents.
- **June 11-13:** Alere Well Being collected names and phone numbers of callers while the NJ TCP negotiated continuation of NJ Quitline.
- **June 14-16:** Negotiations continued between Alere Well Being and NJ TCP – agreement was signed after NJ TCP found funds within the NJ DOH that were supposed to last until the end of the NJ Fiscal Year, 6/30.
- **June 17 - 3:00 AM:** NJ Quitline resumed - all NJ residents that left contact information during negotiations were contacted ASAP.
- **June 21:** Funds for NJ Quitline Restoration were once again depleted - Alere Well Being did not collect names and a voicemail message told callers that NJ Quitline will not be accepting new clients until July 1st.

Despite the fact that the state of New Jersey collected hundreds of millions of dollars in revenues from a cigarette excise tax and settlement payments, it does not adequately fund a Quitline that would help smokers to quit – a way for them to not only improve their health, but to also reduce their households' costs.

[26] New Jersey Department of Health and Senior Services.

[27] Conversation between Alere Well Being, NJ Quitline Contractor with American Cancer Society, Eastern Division.

While it is clear that the state of New Jersey *currently* collects overwhelming revenues that could be earmarked for tobacco control efforts, it may require an increase in tobacco taxes to provide new monies to fund the program.

Significant tobacco tax increases – particularly for cigarettes – are the fastest way to sharply reduce tobacco use and, more importantly, smoking-caused disease, death, and costs. Recent reports by the National Academy of Sciences' Institute of Medicine and the President's Cancer Panel have strongly recommended that states raise their tobacco tax rates to effectively reduce the toll that tobacco use takes on the states.[28]

Even the cigarette companies have repeatedly acknowledged, both publicly and in internal company documents disclosed in tobacco lawsuits, that raising cigarette prices through state tobacco tax increases significantly reduces smoking, especially among kids. For instance, in 1994, Ellen Merlo, Senior Vice President of Corporate Affairs for Philip Morris, stated, "When the tax goes up, industry loses volume and profits as many smokers cut back."[29]

EXPERT CONCLUSIONS ON CIGARETTE PRICES AND SMOKING LEVELS

- In its 2007 report, *Ending the Tobacco Problem: A Blueprint for the Nation*, the National Academy of Sciences' Institute of Medicine recommended raising cigarette taxes in states with low rates and indexing them to inflation, to reduce cigarette consumption and to provide money for tobacco control. The report stated, "Tobacco excise tax revenues pose a potential funding stream for state tobacco control programs. Setting aside about one-third of the per-capita proceeds from tobacco excise taxes would help states fund programs at the level suggested by CDC."[30]
- The President's Cancer Panel's 2007 report, *Promoting Healthy Lifestyles*, advised increasing state tobacco taxes and stated, "Increases in tobacco excise taxes, which are passed along to consumers in the form of higher tobacco product prices, have proven highly effective in reducing tobacco use by promoting cessation among current users, discouraging relapse among former users, preventing initiation among potential users, and reducing consumption among those who continue to use tobacco. These revenues also provide crucial dollars needed to fund anti-tobacco efforts."[31]
- The 2000 U.S. Surgeon General's Report, *Reducing Tobacco Use*, found that raising tobacco-product prices decreases the prevalence of tobacco use, particularly among kids and young adults, and that tobacco tax increases produce "substantial long-term improvements in health." From its review of existing research, it concluded that raising tobacco taxes is one of the most effective tobacco prevention and control strategies.[32]
- In its 1998 report, *Taking Action to Reduce Tobacco Use*, the National Academy of Sciences' Institute of Medicine concluded that "the single most direct and reliable method for reducing consumption is to increase the price of tobacco products, thus encouraging the cessation and reducing the level of initiation of tobacco use."[33]

CIGARETTE TAX INCREASES REDUCE SMOKING

Numerous economic studies in peer-reviewed journals have documented that cigarette tax or price increases reduce both adult and underage smoking. The general consensus is that every 10 percent increase in the real price of cigarettes reduces overall cigarette consumption by approximately three to five percent, reduces the number of young-adult smokers by 3.5 percent, and reduces the number of kids who smoke by six or seven percent.[34]

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[28] Institute of Medicine (IOM), *Ending the Tobacco Problem: A Blueprint for the Nation*, Washington, DC: National Academies Press, May 2007, http://www.nap.edu/catalog.php?record_id=11795#toc; President's Cancer Panel, *Promoting Healthy Lifestyles: Policy, Program, and Personal Recommendations for Reducing Cancer Risk*, August 2007, http://deainfo.nci.nih.gov/advisory/pcp/pcp07rpt/pcp07rpt.pdf

[29] Ellen Merlo, Senior Vice President of Corporate Affairs, Philip Morris, 1994 draft speech to the Philip Morris USA Trade Council, Bates No. 2022811708-1755, http://legacy.library.ucsf.edu/tid/oyf35e00.

[30] Institute of Medicine (IOM), Ending the Tobacco Problem: A Blueprint for the Nation, Washington, DC: The National Academies Press, 2007, http://www.iom.edu/CMS/3793/20076/43179.aspx

[31] President's Cancer Panel, *Promoting Healthy Lifestyles*, 2006-2007 Annual Report, August 2007, http://deainfo.nci.nih.gov/advisory/pcp/pcp07rpt/pcp07rpt.pdf.

[32] HHS, Reducing Tobacco Use: A Report of the Surgeon General, 2000, http://profiles.nlm.nih.gov/NN/B/B/L/Q/_/nnbblq.pdf.

[33] IOM, *Taking Action to Reduce Tobacco Use*, Washington, DC: National Academy Press, 1998, http://www.nap.edu/catalog.php?record_id=6060.

[34] See, e.g., Chaloupka, F, "Macro-Social Influences: The Effects of Prices and Tobacco Control Policies on the Demand for Tobacco Products," *Nicotine and Tobacco Research*, 1999; other studies at http://tigger.uic.edu/~fjc/; Tauras, J, "Public Policy and Smoking Cessation Among Young adults in the United States," *Health Policy* 6*:321-32, 2004; Tauras, J, et al., "Effects of Price and Access Laws on Teenage Smoking Initiation: A National Longitudinal Analysis," Bridging the Gap Research, ImpacTeen, April 24, 2001, and others at http://www.impacteen.org/researchproducts.htm. Chaloupka, F & Pacula, R, *An Examination of Gender and Race Differences in Youth Smoking Responsiveness to Price and Tobacco Control Policies*, National Bureau of Economic Research, Working Paper 6541, April 1998, http://tigger.uic.edu/~fjc; Emery, S, et al., "Does Cigarette Price Influence Adolescent Experimentation?," *Journal of Health Economics* 20:261-270, 2001; Evans, W & Huang, L, *Cigarette Taxes and Teen Smoking: New Evidence from Panels of Repeated Cross-Sections*, working paper, April 15, 1998, www.bsos.umd.edu/econ/evans/wrkpap.htm; Harris, J & Chan, S, "The Continuum-of-Addiction: Cigarette Smoking in Relation to Price Among Americans Aged 15-29," *Health Economics Letters* 2(2):3-12, February 1998, www.mit.edu/people/jeffrey. 9 U.S. Department of Health and Human Services (HHS), *Reducing Tobacco Use: A Report of the Surgeon General*, Atlanta, Georgia: HHS, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000, http://profiles.nlm.nih.gov/NN/B/B/L/Q/_/nnbblq.pdf.

Research studies have also found that:

- Cigarette price and tax increases work even more effectively to reduce smoking among males, Blacks, Hispanics, and lower-income smokers.[35]
- A cigarette tax increase that raises prices by ten percent will reduce smoking among pregnant women by seven percent, preventing thousands of spontaneous abortions and still-born births, and saving tens of thousands of newborns from suffering from smoking-affected births and related health consequences.[36]

TAX IMPACT ESPECIALLY STRONG AMONG KIDS

- Higher taxes on smokeless tobacco reduce its use, particularly among young males; and increasing cigar prices through tax increases reduce adult and youth cigar smoking.[37]
- Cigarette price increases not only reduce youth smoking but also reduce both the number of kids who smoke marijuana and the amount of marijuana consumed by continuing users.[38]
- By reducing smoking levels, cigarette tax increases reduce secondhand smoke exposure among nonsmokers, especially children and pregnant women.

RECENT STATE EXPERIENCES

In every single state that has significantly raised its cigarette tax rate, pack sales have gone down sharply.[39] While some of the decline in pack sales comes from interstate smuggling and from smokers going to other lower-tax states to buy cigarettes, reduced consumption from smokers quitting and cutting back plays a more powerful role. Nationwide data – which counts both legal in-state purchases and the vast majority of packs purchased through cross-border, Internet, or smuggled sales – shows that overall packs sales go down as state cigarette tax increases push up the average national price. In-state evidence shows that state cigarette tax increases are prompting many smokers to quit or cutback.

For example, as noted previously, state Quitlines in Wisconsin, Texas, Iowa, and others received surges in calls immediately after significant tax increases.[40] And when the federal tobacco tax rates increased in April 2009, the national Quitline, 1-800-QUIT-NOW also experienced immediate increases in calls for assistance. It is clear that these efforts to quit by smokers after tax increases translate directly into lower future smoking rates. In Washington State, for example, adult smoking from the year before its 60-cent cigarette tax increase in 2002 to the year afterwards declined from 22.6 to 19.7 percent, reducing the number of adult smokers in the state by more than 100,000, despite overall population increases.[41]

While U.S. cigarette prices are largely controlled by the cigarette companies' price-setting decisions, from 1970 to 2010, the federal tax on cigarettes also increased from eight cents to $1.01 per pack and the average state cigarette tax increased from 10 cents to $1.45 per pack. Without these federal and state tax increases, U.S. cigarette prices would be much lower and U.S. smoking levels would be much higher.

[35] See, e.g., Centers for Disease Control and Prevention, "Responses to Cigarette Prices By Race/Ethnicity, Income, and Age Groups – United States 1976-1993," *Morbidity and Mortality Weekly Report* 47(29):605-609, July 31, 1998, http://www.cdc.gov/mmwr/preview/mmwrhtml/00054047.htm; Chaloupka, F & Pacula, R, *An Examination of Gender and Race Differences in Youth Smoking Responsiveness to Price and Tobacco Control Policies*, National Bureau of Economic Research, Working Paper 6541, April 1998.

[36] Ringel, J & Evans, W, "Cigarette Taxes and Smoking During Pregnancy," *American Journal of Public Health*, 2001, See also, TFK Factsheet, *Harm Caused by Pregnant Women Smoking or Being Exposed to Secondhand Smoke*, http://www.tobaccofreekids.org/research/factsheets/pdf/0007.pdf.

[37] Ringel, JS, Wasserman, J, & Andreyeva, T, "Effects of Public Policy on Adolescents' Cigar Use: Evidence From the National Youth Tobacco Survey," *American Journal of Public Health* 95:995-998, 2005.

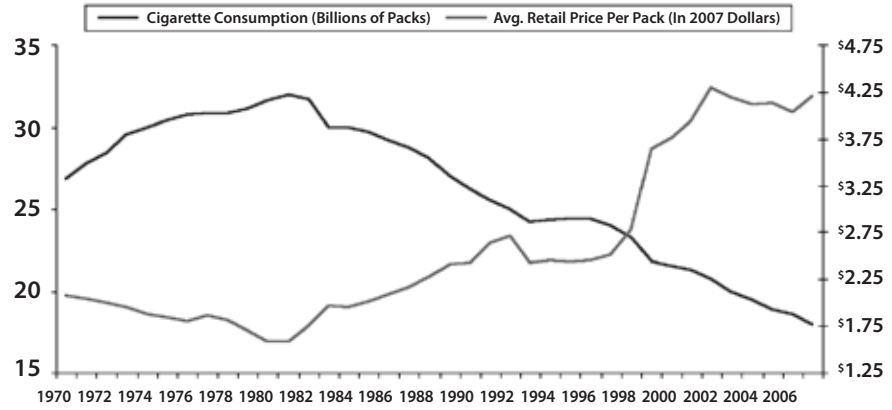
[38] Chaloupka, F, et al., *Do Higher Cigarette Prices Encourage Youth to Use Marijuana?*, National Bureau of Economic Research, Working Paper No. 6939, February 1999.

[39] Campaign for Tobacco Free Kids, Factsheet, *Raising State Cigarette Taxes Always Increases State Revenues (and Always Reduces Smoking)*, http://tobaccofreekids.org/research/factsheets/pdf/0098.pdf.

[40] "Calls to Wisconsin Tobacco Quit Line breaks all records," The Dunn County News, March 12, 2008. Souza, M, "Thank you for Smoking," *Longview-News Journal*, April 22, 2007; "Calls to Quitline Iowa double after cigarette tax raised," AP, March 22, 2007. See also, TFK Factsheet, *Quitlines Provide Essential and Effective Treatment Services*, http://www.tobaccofreekids.org/research/factsheets/pdf/0326.pdf.

[41] Centers for Disease Control and Prevention, Current Adult Smokers, Behavioral Risk Factor Surveillance System (BRFSS).

U.S. Cigarette Prices vs. Consumption 1970-2007

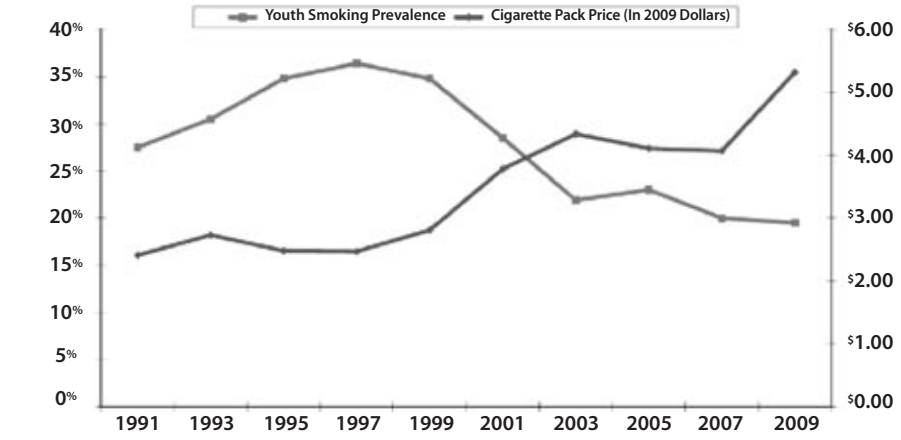


Sources: *The Tax Burden on Tobacco*, 2007; USDA Economic Research Service; US Bureau of Labor

PRICE AND YOUTH SMOKING RATES

In addition, a prices climbed in the late 1990s and early 2000s, youth smoking rates declined, but as the price decreased between 2003 and 2005 (along with funding for tobacco prevention programs in many states), youth rates increased. Even the slight increase in price between 2005 and 2007 corresponds with a decline in youth smoking rates.

U.S. Youth Smoking Prevalence vs. Cigarette Pack Price, 1991-2009



2009 Youth prevalence does not reflect the impact of the Federal cigarette tax increase effective April 1, 2009 and the March 2009 tobacco industry price increases because the survey was conducted in early 2009.

Sources: *The Tax Burden on Tobacco*, 2009; CDC, Youth Behavioral Risk Surveillance System; U.S. Bureau of Labor Statistics

A recent report examined the huge public health benefit to raising New Jersey's cigarette tax rates by $1 per pack. Using Fiscal Year 2011 data, the report estimated that a $1.00 increase in New Jersey's cigarette tax would prevent approximately 30,700 youth from smoking and, over five years, save an estimated $13.13 million in lung cancer, heart attack, and stroke costs.[42]

Estimated Impact of a $1 Cigarette Tax Increase in New Jersey	
Number of adults who would quit smoking	27,000
Number of youth who would not begin smoking	30,700
The reduction in smoking-related deaths	24,600
Savings from avoided lung cancer treatments	$3.9 million annually
Savings from reduced heart attacks and strokes	$9.23 million annually
Savings to the state's Medicaid program	$2.38 million annually
Savings related to reductions in the number of smokers who are pregnant	$6.22 million annually

Studies have offered a range of estimates as to how much revenue a $1 per pack hike would generate. The most conservative number has estimated that such an increase could generate $80 million in additional revenue; others have estimated that the amount could be as high as $130 million.[43] No matter what the estimate, one thing is clear: the hike would provide more than enough resources for an adequately funded tobacco control program.

Raising the excise tax on cigarettes is one of the most effective ways to reduce smoking, save lives, and raise government revenue – even in tough economic times. Excise taxes decrease the number of youth who start smoking, increase the number of smokers who quit, cut health care costs, and reduce deaths from lung and other cancers, heart attacks, strokes, and other preventable diseases. The health benefits of cigarette taxes are even greater when the revenue raised is earmarked for tobacco control or public health programs.

Moreover, New Jersey's taxes on tobacco products are inequitably low relative to cigarettes, making it easier for people to switch to and kids to access the less-expensive options. Meanwhile, the state loses revenue whenever people switch to the lower-taxed products. For instance, cigars are taxed at 30 percent of wholesale price. To make the tax comparable to that currently assessed on cigarettes, the cigar tax should be at least 90 percent of wholesale price. This tax inequity has made cigars relatively cheap. Manufacturers of "little cigars," which are really cigarettes wrapped in a paper partially made from tobacco leaf, have used this legal loophole to market their products at prices well below those for cigarettes. Not surprisingly, almost as many high school students report using cigars as cigarettes.[44] Smokeless tobacco is similarly under taxed.

[42] American Cancer Society Cancer Action Network, "Saving Lives, Saving Money: A state-by-state report on the health and economic impact of tobacco taxes, 2011". See: http://www.acscan.org/pdf/tobacco/reports/acscan-tobacco-taxes-report.pdf, p. 39.

[43] Estimates by the Campaign for Tobacco-Free Kids and the American Cancer Society Cancer Action Network.

[44] New Jersey Department of Health and Senior Services, *2008 New Jersey Youth Tobacco Survey*, p. 6.

RECOMMENDATIONS: FUND AND IMPROVE NEW JERSEY'S PROGRAM

1. **Incrementally Increase Spending on the State's Tobacco Control Program to the CDC-Recommended Level of $119 Million per Year.** Obviously, the state's tobacco control program needs more money. The experts at the CDC recommend it and it is quite clear that money is available. What is lacking is the will to invest in a program that can prevent tobacco-caused death and disease, significantly reduce health care costs and enhance the productivity of the state's workforce. The lack of resources allocated to on the Tobacco Control Program by repeated budget cuts prevents it from implementing the type and intensity of interventions that would make it genuinely comprehensive in scope and impact. Therefore we recommend: The program's annual budget should be increased to $30 million in 2012 – 13 and then, as its capacity grows, increased by $30 million every year until it reaches the CDC target appropriation.

2. **Base New Jersey's Revitalized Tobacco Control Program on the Evidence-Based Model Developed by the CDC.** Evidence-based, statewide tobacco control programs that are comprehensive, sustained, and accountable have been shown to reduce smoking rates, tobacco-related deaths, and diseases caused by smoking. A comprehensive statewide tobacco control program is a coordinated effort to establish smoke-free policies and social norms, to promote and assist tobacco users to quit, and to prevent initiation of tobacco use. This comprehensive approach combines educational, clinical, regulatory, economic, and social strategies. Research has shown greater effectiveness with multi-component intervention efforts that integrate the implementation of programmatic and policy interventions to influence social norms, systems, and networks. In addition to being woefully underfunded, New Jersey's program has been uncoordinated and scattershot. The new program should be restructured and managed following the guidance presented in Best Practices for Comprehensive Tobacco Control Programs, published by the CDC.

3. **Target Resources to Adult Cessation.** It is clear that achieving near-term reductions in tobacco use rates, and the incidence of tobacco-caused disease, will best be accomplished by encouraging adult smokers to quit. Treating tobacco dependence in adults is one of 20 priority areas targeted in a recent report from the National Academy of Sciences identifying ways to transform the healthcare system and translate knowledge into lifesaving clinical practice.[45] The National Task Force on Clinical Preventive Services ranks tobacco cessation second only to childhood immunizations in its list of priority preventive services.[46] Only by motivating smokers to attempt to quit smoking and providing the pressure, resources, and support to make those attempts successful will smoking rates decline, disease rates decline, premature deaths decline, and economic savings accrue. Most smokers want to quit, and encouraging and assisting adult cessation is a cost-effective tobacco control strategy. The main purpose of reducing tobacco use among teens is to reduce tobacco use among adults in the future, when most tobacco-caused disease occurs. The public health benefits of preventing teen tobacco use accrue only many years later. A recent study predicted that even if youth tobacco policies eliminated initiation of smoking by those under age 18 and none of those persons prevented from smoking began to smoke after age 18, there would be only modest reductions in the number of smokers over the next 10 years. It would take about 35 years before the number of smokers was halved. With a 50 percent reduction in youth initiation, it has been estimated that the number of smokers would be reduced by only about 30 percent, even after 50 years.[47] While it is recognized that the majority of adult smokers initiated tobacco use before age 18, all adult tobacco use cannot be prevented by youth-focused interventions; historically, 25% of smokers begin after age 18.[48] Moreover, increased tobacco industry marketing targeting the 18-25 year old age group threatens to undermine efforts preventing uptake before age 18. Finally, it should be noted that teens grow up in an environment created and controlled by adults. Reducing the prevalence of adult smoking can only positively affect the incidence of adolescent initiation.[49]

[45] Institute of Medicine, Board on Health Care Services, Priority Areas for National Action: Transforming Health Care Quality, 2002.

[46] Ashley B. Coffield, Michael V. Maciosek, J. Michael McGinnis, Jeffrey R. Harris, M. Blake Caldwell, Steven M. Teutsch, David Atkins, Jordan H. Richland, Anne Haddix, "Priorities among recommended clinical preventive services", *American Journal of Preventive Medicine* 21 (1) (2001) pp. 1-9.

[47] Levy, D.T., et. al., "Simulation of the Effects of Youth Initiation Policies on Overall Cigarette Use", *American Journal of Public Health*, August, 2000, 90, no. 8, 1311-1314.

[48] Glied, S., "Is Smoking Delayed Smoking Averted?", *American Journal of Public Health*, March, 2003, 93, no. 3, 412 – 416.

[49] Farkas AJ, Distefan JM, Choi WS, Gilpin EA, Pierce JP. "Does parental smoking cessation discourage adolescent smoking?", *Preventive Medicine* 28:213-218, 1999.

4. **Increase Community Level Interventions, Especially in Disadvantaged Neighborhoods and Rural Areas.** To change social norms a program must be well integrated into a community. Program personnel must understand and, preferably, live in, the communities they work in. CDC recommends that about 35% of program funding be devoted to community activities. At least one-third of any budget increase should be directed to increasing the level of community activity.

5. **Conduct a Well-Funded, Aggressive Health Communications Campaign.** CDC recommends that 25% of the program budget be dedicated to media interventions, but the state tobacco control program currently spends less than one percent of its budget on anti-tobacco advertising. This is simply not enough to effectively reach the general public, let alone develop and implement communication strategies to reach racial and ethnic minorities, non-English speakers and other hard to reach audiences. As quickly as possible, the tobacco control program should increase its media budget to $34 million a year and target messages to those the program has not been reaching.

6. **Develop and Implement Strategies for Reaching Those With Mental Illness or Addictive Disorders** People with mental illness smoke at a rate almost twice that of the general public. Nearly half the cigarettes smoked in the United States are consumed by people with co-occurring psychiatric or addictive disorders.[50] The implications of these differences are staggering. There is a 25 year mortality gap between people with behavioral health conditions and the general public.[51] More alcoholics die of tobacco-caused disease than alcohol-related problems.[52] Many mental health clients are poor, and cigarettes consume a large proportion of their discretionary spending. Smokers with behavioral health problems respond to the same smoking cessation treatments as the general population and, like the general population, most want to quit.[53] Clearly, this is an important initiative that must be enhanced if we are to eliminate the scourge of tobacco-caused disease, including providing enhanced Medicaid coverage for smoking cessation services in New Jersey.

7. **Increase New Jersey's Cigarette Excise Tax by One Dollar to $3.70 a Pack, and Raise the Tax on Other Tobacco Products to an Equal Level.** New Jersey has the sixth highest cigarette tax rate in the nation ($2.70 per pack). However, if policymakers cannot bring themselves to divert a small fraction of the money that the state *already* collects in tobacco revenues, then a tax hike may be needed. Not only would such an increase boost revenues for the state as well as the tobacco control program, it would also help save lives and reduce health care costs.

[50] A Hidden Epidemic: Tobacco Use and Mental Illness. The Legacy Foundation, June 2011, p 4.

[51] Colton, C., Mandersheid, R. "Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states." *Preventing Chronic Disease: Public Health Research, Practice and Policy*, 3. 2006.

[52] Hurt, R.D., et. al. "Mortality following inpatient addictions treatment." *Journal of the American Medical Association*, 274(14), 1097 -1103.

[53] Schroeder, S. A., Morris, C. D. "Confronting a neglected epidemic: Tobacco cessation for persons with mental illness and substance abuse problems." *Annual Review of Public Health*, 31: 16.1 – 16.18. 2008.