

**Finance, Revenue and Bonding Committee**  
**February 23, 2008**  
**Connecticut Cancer Partnership Testimony**

**SB 930 –An Act Concerning the Cigarette Tax, The Tobacco Products Tax and the Alcoholic Beverages Tax**

Senator Daily, Representative Staples, distinguished members of the committee, good afternoon. My name is Dr. Andrew Salner. I am the Director of the Helen and Harry Gray Cancer Center at Hartford Hospital. I am the Past-Chair, American Cancer Society New England Division. I am also Chair of the Connecticut Cancer Partnership, a public and private coalition of over 300 cancer experts and health care organizations funded by a grant from the CDC to create and implement a Comprehensive Cancer Control Plan here in Connecticut. The Connecticut Cancer Partnership is in strong support of the health benefits derived from **SB 930 –An Act Concerning the Cigarette Tax, The Tobacco Products Tax and the Alcoholic Beverages Tax**

We respectfully ask the committee to support an increase to the cigarette tax by \$1.00 with a dedication of a portion of that revenue towards funding Medicaid coverage of smoking cessation services.

Our current \$2.00 cigarette tax ties for 6<sup>th</sup> place on the list of state excise tax rates. All three of our neighboring states—New York at \$2.75, Massachusetts at \$2.51 and Rhode Island at \$2.46 have significantly higher cigarette taxes with Massachusetts dedicating funds from their recently enacted \$1.00 increase towards health care costs and Rhode Island poised to raise their cigarette tax to almost \$3.50. Currently, 22 other states are looking at cigarette tax increases as a means of bringing in much needed revenue and addressing tobacco related health care issues.

Each year in America, tobacco use causes more than 440,000 deaths among smokers and contributes to disability, pain and lost productivity for many others. Tobacco use costs the U.S. economy over \$194 billion each year in direct health care costs and lost productivity. Men who smoke have \$15,800 more in medical expenses over their lifetime than non-smokers and women who smoke have \$17,500 greater lifetime expenses. Each year, a smoking employee costs employers \$1,850 in additional direct medical expenses and \$1,897 in reduced productivity. Secondhand smoke causes between 35,000 and 40,000 deaths from heart disease every year and the total annual costs of exposure to secondhand smoke are estimated to be at least \$5 billion in direct medical costs and at least \$5 billion in indirect costs.

Currently, 455,850 (17%) adults in Connecticut smoke, spending on average \$1825 per year on the habit and costing the state \$1.63 billion in related healthcare costs as well as in excess of \$1 billion in smoking related loss of productivity. Connecticut annually receives in excess of \$420 million in MSA and Tobacco tax revenue while spending barely over 1% of that revenue on tobacco prevention and cessation programs

Research indicates that one of the most effective and sweeping methods of significantly reducing smoking among adults and youth is through increasing cigarette taxes. Increases in the cigarette tax also result in substantial revenue for states all while reducing smoking rates and reducing smoking-caused health care costs. The other most successful method of reducing smoking rates is through providing cessation services. 70% on Connecticut's smokers indicate they want to quit while 40% attempt to quit each year. While the percentage of successful quits is encouraging, many fail because, in part, of a lack of access to successful cessation programs.

Smokers and other tobacco users need access to a range of treatments and combinations to find the most effective cessation tools that work for them. Not all tobacco users are the same; they vary in what products they use, how much, how often, and individual medical conditions. Nicotine addiction is classified as, and should be treated as, a chronic disease. Tobacco users often need several attempts over a period of years to quit successfully. Including cessation treatments increases quit rates by 30%.

Evidence on cessation counseling shows that person-to person counseling over at least 4 sessions is especially effective at increasing quit rates, including group and individual therapy and telephone quitlines. Longer and more frequent counseling sessions are more effective than more limited sessions in getting people to quit. A comprehensive cessation counseling program or benefit should allow for multiple in-person sessions with a trained health professional.

Quitlines reduce smoking prevalence by providing referrals, counseling, materials, and free or discounted medications while offering an effective alternative to in-person counseling services. This evidence based effective tool can increase quit success more than 50% compared to using no cessation intervention by providing easy access to cessation services to a larger population of smokers at little or no cost to the smoker. In 2007, upon expanding Connecticut quitline services through the addition of Nicotine Replacement Therapy, the volume of callers increased by 750% in the first month of availability.

Medicaid recipients are less likely to be able to take advantage of private smoking cessation services and tend to rely on the state Quitline in greater numbers than the population as a whole. Dedicating tobacco tax revenue to funding Medicaid coverage of cessation services allows for the state to take advantage of federal matching funds, reach a higher concentration of lower income smokers and ease the impact tobacco related illnesses have on the cost of the program.

This increase in the state cigarette tax as well as the increase in the taxes on other tobacco products will result in increased revenue to Connecticut, reduced tobacco related health care costs and lives saved. The Connecticut Cancer partnership asks for your support.

Thank you.

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