

Statement of
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In relation to New York State 2026 Joint Legislative Budget Hearing
regarding proposed nicotine pouch taxation

To the Honorable Members of the New York State Legislature,

I submit this testimony in response to Governor Kathy Hochul’s FY2026 budget proposal to increase the wholesale tax on nicotine pouch products by 75%, a policy that would raise the retail price of a single tin from approximately \$5 to nearly \$20. As a military veteran, Georgetown University doctoral candidate, and published researcher focused on public health and disease prevention, I am deeply concerned that this proposal reflects a ***fundamental misunderstanding*** of nicotine pouches and their role in tobacco harm reduction.

Nicotine pouches are frequently conflated with traditional tobacco products, yet they are chemically and functionally distinct. These products are tobacco-free and **non-combustible**. They do not contain tobacco leaf, and they eliminate exposure to the combustion byproducts that are the primary drivers of smoking-related cancers and cardiopulmonary disease. The overwhelming burden of tobacco-attributable mortality is linked to inhalation of tar, carbon monoxide, oxidant gases, thousands of toxic particulates, and more than 70 known carcinogenic compounds generated during burning to include (*but not limited to*), acetaldehyde, N-Nitrosamines, benzene, 1,3-Butadiene, and acrolein¹². Nicotine itself, while addictive, is not the principal carcinogenic agent. Treating nicotine pouches as equivalent to cigarettes in tax policy ignores a well-established continuum of risk across nicotine delivery systems.

From a public health perspective, aggressive taxation of reduced-risk alternatives risks undermining harm-reduction strategies that are increasingly recognized in modern tobacco control. Many adults who use nicotine pouches are current or former smokers seeking a less harmful substitute. When the price differential between combustible cigarettes and safer alternatives is compressed, the incentive to transition away from smoking is weakened. In economic terms, nicotine demand among dependent users is relatively price inelastic (as evidenced by attached data summarizations). Large tax increases often do not eliminate use; instead, they encourage substitutions toward cheaper or illicit products, cross-border purchasing, or a return to more hazardous combustible options.

There is also an equity dimension to consider. Excise taxes on nicotine products are inherently regressive and disproportionately affect lower-income populations, who already bear a higher burden of tobacco-related disease. For individuals using nicotine pouches as a bridge away from smoking, a dramatic price increase may not produce cessation. Instead, it may impose financial strain or push users back toward more dangerous products. Policies that unintentionally widen health disparities run counter to the goals of public health.

Equally concerning is the degree to which policy discussions have blurred the distinction between tobacco and tobacco-free nicotine. Public messaging that treats all nicotine products as equally dangerous risks discouraging smokers from switching to demonstrably lower-risk alternatives. Effective tobacco control requires accurate risk

¹ Food and Drug Administration (FDA). Harmful and potentially harmful constituents in tobacco products and tobacco smoke: established list. Federal Register. 2012; 77(64): 20034-20037.

² International Agency for Research on Cancer (IARC). Smokeless Tobacco and Some Tobacco-Specific N-Nitrosamines. Lyon, France: World Health Organization, International Agency for Research on Cancer; 2007.

communication. Legislators and executive leadership have a responsibility to base fiscal and regulatory decisions on rigorous, peer-reviewed evidence and a clear understanding of toxicological differences among products.

If the objective is to reduce smoking-related morbidity and mortality, taxation should be aligned with relative risk. A coherent strategy would preserve affordability of reduced-harm alternatives for adult smokers, pair fiscal policy with robust cessation support, and invest in education that accurately differentiates between combustible tobacco and non-combustible nicotine products. A blunt tax instrument that fails to recognize these distinctions may generate revenue, but it is unlikely to deliver proportional public health gains.

I respectfully urge the Legislature to re-examine the proposed tax increase considering current scientific evidence and harm-reduction principles. Policies that conflate nicotine with tobacco and safer alternatives with cigarettes risk slowing progress against the very diseases we are trying to prevent. Thoughtful, evidence-based regulation can protect youth, support adult smokers seeking safer options, and advance the shared goal of reducing tobacco-related cancer and chronic disease in New York.

In the following appendices, my intent is to explain as simple to understand as possible the concern at hand.

Thank you for your consideration.

A handwritten signature in black ink, appearing to be 'CS', with a long horizontal line extending to the right.

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Tobacco vs. Nicotine

Route of Exposure: Inhalation vs. Absorption

Since the beginning of the 20th century, global tobacco consumption has increased steadily, culminating in approximately 1.1 billion current smokers worldwide. Smoking remains the leading cause of preventable premature death, responsible for millions of deaths annually, with lung cancer representing one of its most devastating consequences. The central mechanism driving tobacco-related harm is not simply the presence of nicotine, but the route of toxicant delivery, specifically, the inhalation of combustion-derived particulate matter and gases deep into the pulmonary system.

This distinction is critical when comparing combustible tobacco products (cigarettes), vaporized tobacco systems (e-cigarettes/vaping), oral smokeless tobacco, and nicotine pouches. Cigarette smoke is a complex aerosol containing ultrafine particulate matter (PM_{2.5} and smaller), volatile organic compounds, aldehydes, and carcinogenic combustion byproducts. These particles are engineered by combustion to remain suspended in air and to penetrate deeply into the alveoli, where gas exchange occurs. Once deposited, ultrafine particles can cross the alveolar–capillary membrane, enter systemic circulation, trigger oxidative stress, and initiate inflammatory cascades directly in lung tissue. The size of these particles is inversely related to their biological hazard: the smaller the particle, the deeper the penetration and the greater the toxic potential. Combustible cigarettes generate extremely high indoor concentrations of fine particulate matter, often exceeding 1,000 µg/m³ in experimental settings, levels strongly associated with cardiovascular and respiratory morbidity³.

Inhalation is uniquely dangerous because the lungs provide an enormous absorptive surface area (~70 m²) with a thin epithelial barrier optimized for rapid gas exchange. This anatomy allows inhaled toxicants to bypass first-pass hepatic metabolism and enter the bloodstream almost immediately. In contrast, **oral or buccal absorption** occurs with nicotine pouches or chewing tobacco, occurs across thicker mucosal tissues with slower diffusion kinetics and partial metabolic buffering. While oral chewing tobacco carries its own risks, particularly local carcinogenesis (oropharynx, esophageal) it does not deliver the same burden of combustion-generated ultrafine particulates to the pulmonary system. The absence of combustion eliminates the primary source of tar, carbon monoxide, and many polycyclic aromatic hydrocarbons responsible for lung cancer pathogenesis.

Electronic cigarettes occupy an intermediate position. Although they eliminate combustion, they still generate fine and ultrafine aerosol particles composed primarily of propylene glycol, vegetable glycerin, nicotine, and trace toxicants. Indoor studies demonstrate that e-cigarette use can substantially elevate PM_{2.5} concentrations, sometimes approaching levels observed with combustible tobacco under heavy use conditions. These aerosols may still reach the alveoli and exert biological effects, including airway irritation and oxidative stress, though generally at lower toxicant concentrations than cigarette smoke⁴.

The fundamental toxicological principle is that inhalation delivers substances directly to the most vulnerable interface between the environment and the bloodstream. Combustion-driven tobacco products maximize this exposure pathway by producing respirable particles specifically suited for deep lung deposition. Non-combustible nicotine delivery systems that rely on oral absorption avoid this primary pulmonary exposure route. Therefore, when evaluating relative risk profiles among nicotine products, the presence or absence of inhaled combustion-derived particulate matter becomes a defining determinant of long-term pulmonary harm.

³ Braun, M., Koger, F., Klingelhofer, D., Muller, R. & Groneberg, D. (2019). Particulate Matter Emissions of Four Different Cigarette Types of One Popular Brand: Influence of Tobacco Strength and Additives. *International Journal of Public Health and Environmental Research*. Vol. 16(263). <https://doi.org/10.3390/ijerph16020263>

⁴ Li, L., Lin, Y., Xia, T. & Zhu, Y. (2020). Effects of Electronic Cigarettes on Indoor Air Quality and Health. *Annual Review of Public Health*. Vol. 2(41): 363-380. <https://doi.org/10.1146/annurev-publhealth-040119-094043>

Oral (Absorption) Products: Nicotine Pouches vs. Smokeless Tobacco

Nicotine pouches and traditional smokeless tobacco products are often grouped together, but from a cancer-risk perspective they are **fundamentally different**. Smokeless tobacco products like moist snuff or chewing tobacco contain tobacco leaf, which naturally carries tobacco-specific nitrosamines (TSNAs) including compounds such as NNN (N'-nitrosornicotine) and NNK (4-(methylnitrosamino)-1-(3-pyridyl)-1-butanone). These chemicals are among the most potent carcinogens in tobacco and are strongly linked to cancers of the oral cavity, esophagus, and pancreas⁵. Chronic exposure occurs because the product sits in direct contact with oral tissues for extended periods, allowing carcinogens to be absorbed locally and systemically.

Nicotine pouches (such as Zyn), by contrast, are **tobacco-free**. They deliver pharmaceutical-grade nicotine without using tobacco leaf, which means they avoid the primary source of TSNAs found in traditional dip or chew. While trace contaminants can exist in any manufactured product, well-regulated nicotine pouches typically contain orders of magnitude lower levels of carcinogenic nitrosamines than smokeless tobacco. **Nicotine itself is addictive and has cardiovascular effects, but it is not the principal carcinogenic driver in tobacco products.** From a harm-reduction standpoint, removing tobacco leaf substantially reduces exposure to the chemicals most responsible for tobacco-related cancers and have shown in various studies that there is evidence to support nicotine pouches show lower toxicity in vitro toxicology and human pharmacokinetics data, supporting reduced cytotoxicity, mutagenicity, and abuse potentials compared to cigarettes, e-cigarettes (“vape”) and moist snuff/chewing tobacco⁶.

This difference in chemical exposure translates into an important public health concept: **relative risk reduction**. For individuals who already use smokeless tobacco and are unable or unwilling to quit nicotine entirely, switching to a tobacco-free nicotine pouch is expected to **lower their long-term cancer risk** by reducing TSNA exposure. The safest option remains complete cessation of all nicotine products, but when comparing alternatives, products that eliminate combustion and tobacco leaf generally represent a **meaningful step down in carcinogenic burden**⁷. Education around these distinctions is important so lawmakers can make informed decisions based on chemistry and risk, rather than assuming all oral nicotine products carry the same cancer profile.

⁵ [National Academies, Public Health Consequences of E-Cigarettes, Chapter 18: Harm Reduction](#)

⁶ Back, S., Masser, A., Rutqvist, L. & Lindholm, J. (2023). Harmful and potentially harmful constituents (HPHCs) in two novel nicotine pouch products in comparison with regular smokeless tobacco products and pharmaceutical nicotine replacement therapy products (NRTs). *BMC Chemistry*, Vol 17(9). <https://doi.org/10.1186/s13065-023-00918-1>

⁷ Shi, R., Feldman, R., Liu, J. & Clark, P. (2020). The dilemma of correcting Nicotine misperceptions: Nicotine replacement therapy versus electronic cigarettes. *Health Communication*, Vol. 36(14): 1856-1866. <https://doi.org/10.1080/10410236.2020.1800288>

Taxation ≠ Harm Reduction

Behavioral Deterrence Theory does not clearly apply

There are two competing economic and behavioral schools of thought when governments attempt to generate tax revenue from addictive products. The **first** assumes that large price shocks will reduce consumption by exploiting price elasticity and behavioral deterrence: make the product expensive enough and people will quit. The **second**, grounded in addiction economics and harm-reduction research, recognizes that demand for addictive substances is relatively inelastic. When faced with steep tax increases, many users do not stop; instead, they substitute toward cheaper or higher-efficiency delivery systems that maximize pharmacologic effect per dollar.

A 75% tax increase (as the one proposed by Gov. Kathy Hochul) **risks accelerating this substitution effect by incentivizing consumers to seek more concentrated, unregulated, or black-market alternatives that deliver nicotine more cost-effectively, potentially with greater toxic exposure.** If the policy objective is deterrence, this dynamic can backfire. Behavioral deterrence theory assumes rational disengagement from the product, but addiction alters decision-making by prioritizing immediate neurochemical reward over long-term cost.

As a result, aggressive taxation may disproportionately burden dependent users while shifting them toward riskier consumption patterns⁸, undermining public health goals and producing unintended harm rather than meaningful reductions in utilization. There's evidence that higher cigarette taxes have reduced cigarette use long term, but also may have increased e-cigarette use in both New York state adults (42.6% decrease in cigarette usage and 7% increase [percentage-point absolute increase] in e-cigarette usage) and in New York state high school aged teens (67.1% decrease in cigarette usage and 24.8% increase [percentage-point absolute increase] in e-cigarette usage⁹ over an ten-year period (2014-2024) as noted in the chart below¹⁰, which displays data from 2000-2024 obtained from the New York Health Department¹¹.

Year	Cigarette users (adults)	Avg. Cigarettes per day	State Tobacco Tax	E-Cigarette users (adults)	Cigarette users (High School)	E-Cigarette users (High School)
2000	23.2%	19.2	\$1.11	-	28.9%	-
2002	21.5%	17.6	\$1.50	-	23.5%	-
2004	19.9%	15.2	-	-	19.1%	-
2006	18.2%	13.6	-	-	17.6%	-
2008	16.8%	11.0	\$2.75	-	13.8%	-
2010	18.9%	10.5	\$4.35	-	12.6%	-
2012	16.2%	10.4	-	3.1%	11.9%	-
2014	14.8%	10.8	-	5.7%	7.3%	10.5%
2016	14.5%	9.9	-	4.1%	4.3%	20.2%
2018	13.4%	8.5	-	5.4%	4.8%	27.4%
2020	12.8%	7.9	-	4.1%	2.4%	22.5%
2022	11.3%	7.6	-	7.2%	2.1%	18.7%
2024	9.3%	7.1	\$5.35	6.1%	2.4%	13.1%

⁸ Cho, A., Li, C., Sun, T., Chan, G. & Gartner, C. (2024). The effect of tobacco tax increase on price-minimizing tobacco purchasing behaviors: A systematic review and meta-analysis. *Addiction*. Vol. 119(11): 1857-2040. <https://doi.org/10.1111/add.16618>

⁹ Pesko, M., Courtemanche, C. & Maclean, J. (2020). The effects of traditional cigarette and e-cigarette tax rates on adult tobacco product use. *Journal of Risk Uncertainty*. Vol. 60(3):229-258. <https://doi.org/10.1007/s11166-020-09330-9>

¹⁰ Independent Evaluation Report Highlights, New York Tobacco Control Program (2010-2022). https://www.health.ny.gov/prevention/tobacco_control/reports.htm

¹¹ Behavioral Risk Factor Surveillance System (BRFSS) Report(s), 2005-2025. https://www.health.ny.gov/prevention/tobacco_control/reports.htm

Taxing Nicotine Products

Taxing Nicotine Pouches: Category Inconsistency

To reiterate that nicotine pouches (i.e., Zyn) and tobacco products, combustible (i.e., cigarettes, e-cigarettes, vaporizers) and smokeless (i.e., Snus, Copenhagen, Grizzly, etc.) do NOT provide the same risk(s) and should not be considered as such.

A price shock aimed at one category does not occur in isolation; it reshapes the entire market. While vaping itself remains a legitimate and unresolved public-health concern, taxing lower-risk alternatives such as Zyn, with no known or confirmed risk associated with cancer, to near price parity with cigarettes risks compressing the harm-reduction gradient that public health strategies depend on. Approximately half of all smokers nationwide make a serious attempt to quit each year, however, less than 8% are successful¹². As evidenced in the chart above, addiction will prevail most of the time.

The proposed 75% tax increase on Zyn and other nicotine pouches would not meaningfully alleviate the financial burden on consumers struggling with dependence, nor is it likely to generate stable long-term revenue for New York if substitution, cross-border purchasing, or illicit markets expand. Most importantly, it does little to advance sustained reductions in nicotine-related harm. Effective policy must distinguish between deterrence and displacement: raising taxes alone cannot guarantee healthier behavior, and without parallel investments in cessation support, education, and risk-stratified regulation, such a tax increase is unlikely to benefit the consumer, the state's fiscal position, or the long-term health trajectory of people addicted to nicotine and tobacco.

“Vape juice” for an e-cigarette (on average) costs \$16.00 per 3oz. bottle + 20% NYS Tax = \$19.20.

- Average 3oz. bottle lasts the average user ~ 3 weeks (21 days).
- Average e-cigarette user takes approximately 50 “hits” per day.
- The average 3oz. bottle = 1,000 “hits”
- The average user will buy approximately 17-20 bottles annually.
- The average user will spend \$384 annually on liquid tobacco, the State of New York will receive \$64 in tax revenue in total.

The most important factor is that over a three-week period, an individual's lungs will be exposed more than 1,000 times to known carcinogens (formaldehyde, acrolein, lead, cadmium), propylene glycol/glycerin, tobacco-specific nitrosamines (TSNAs), and measurements of small micron particulates (PM2.5 and smaller) that enter deep into lung tissue, alveoli and trigger oxidative stress and immune activation, leading to long term damage. Given the significance in utilization amongst middle and high school students, focusing on this type of tobacco exposure is more clinically relevant and sound than nicotine pouches.

Contrarily, the average nicotine tin holds (15) nicotine pouches, ranging from 3-6mg each. The average person uses 4-8 pouches per day, approximately 2-4 tins per week. The average tin of nicotine pouches costs \$6.00, so the average person will spend approximately \$1,200 annually on nicotine pouches (~208 tins). However, this user would NOT be exposed to the same combustible carcinogens as the tobacco user (e-cigarettes, cigarettes), **and their risk of exposure and smoking-related cancer is reduced by ~90-95% and preventing secondary smoke/inhalation exposures greatly.**

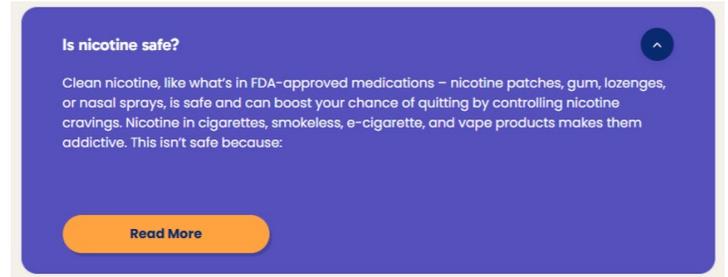
If the State of New York added a 75% tax to all nicotine pouches, in addition to the state sales tax (8%), the total price of one tin would be approximately \$11.34 each. Annually, that would increase the cost from \$1,200 to

¹² Centers for Disease Control, Smoking and Tobacco Use: Smoking Cessation Facts. <https://www.cdc.gov/tobacco/php/data-statistics/smoking-cessation/index.html>

\$2,200, nearly doubling costs with half going to state taxes. It would be more financially acceptable and feasible for the user to switch from nicotine pouches to tobacco e-cigarettes and vaping as they would save 82.6% (\$1,816) annually in costs. However, their long-term risk for cancer is doubled and increases their long-term risk for lung cancer by 15-30-fold.

This financial burden would negatively impact those who are most vulnerable and allow for increased ease of access in young adults and teens.

New York gives out qualified New York residents with nicotine patches, gum, and lozenges for free through NYS Quitline for four weeks per year. The website also states that clean nicotine is safe, like what is FDA-approved medications¹³... The FDA authorized the marketing of certain nicotine pouch products, making them the only nicotine pouch products that may be lawfully sold in the United States, 20 of the 26 items approved are from the brand, Zyn. Furthermore, a study published in BMC Chemistry (Back et al., 2023) screened (43) compounds potentially present in tobacco products in seven oral nicotine-delivery pouches (Zyn, Snus, moist snuff) and two pharmaceutical, nicotine replacement therapy products (NRT) (Nicorette gum and lozenge)¹⁴.



Per the study: “The tested products contained nicotine at varying levels. The two ZYN products contained no nitrosamines or polycyclic aromatic hydrocarbons (PAHs) but low levels of ammonia, chromium, formaldehyde, and nickel. In the NRT products we quantified low levels of acetaldehyde, ammonia, cadmium, chromium, lead, nickel, uranium-235, and uranium-238... No nitrosamines or PAHs were quantified in the ZYN and NRT products. Overall, the number of quantified HPHCs were similar between ZYN and NRT products and found at low levels.” (see measurements below).

Analyte	Units	Limit of quantification	ZYN (dry)	ZYN (moist)	NRT (lozenge)	NRT (gum)	Snus (pouch)	Moist snuff (loose)	Moist snuff (pouch)
Arsenic	µg/g	0.050	*	*	*	*	0.062 ± 0.002	0.077 ± 0.004	0.083 ± 0.012
Beryllium	µg/g	0.050	*	*	*	*	*	*	*
Cadmium	µg/g	0.010	*	*	*	0.043 ± 0.002	0.270 ± 0	0.730 ± 0.010	0.670 ± 0.017
Chromium	µg/g	0.050	0.160 ± 0.036	0.099 ± 0.053	*	0.850 ± 0.030	0.523 ± 0.032	0.490 ± 0.060	0.463 ± 0.045
Lead	µg/g	0.020	*	*	*	0.067 ± 0.003	0.177 ± 0.006	0.203 ± 0.012	0.157 ± 0.012
Mercury	µg/g	0.020	*	*	*	*	*	*	*
Nickel	µg/g	0.050	0.067 ± 0.006	*	0.086 ± 0.030	0.243 ± 0.015	0.817 ± 0.046	0.707 ± 0.042	0.800 ± 0.017
Polonium-210	Bq/kg	5.0	*	*	*	*	5.4 ^a	9.0 ^a	8.1 ^a
Selenium	µg/g	0.050	*	*	*	*	0.088 ± 0.006	0.113 ± 0.006	0.067 ± 0.001
Uranium-235	Bq/kg	0.02	*	*	*	0.14 ± 0.04	*	*	*
Uranium-238	Bq/kg	0.25	*	*	*	2.76 ± 0.66	*	*	*

^a Based on a single measurement

* The measured analyte was below the quantification limit

¹³ NYS Quitline, retrieved from: <https://www.nysmokefree.com/services/>

¹⁴ *Ibid.*

Excessive taxation of nicotine pouches is difficult to justify when viewed through a modern public-health lens grounded in harm reduction. Combustible tobacco remains the leading preventable cause of cancer and cardiopulmonary disease because combustion generates thousands of toxic compounds, including carcinogenic polycyclic aromatic hydrocarbons and tobacco-specific nitrosamines. Nicotine pouches deliver nicotine without combustion and without tobacco leaf, resulting in dramatically lower toxicant exposure compared with cigarettes and other smokeless tobacco products. The FDA’s authorization for marketing products such as Zyn¹⁵ reflects an evaluation that their availability may be appropriate for the protection of public health when adult smokers switch completely. Tax policy that treats these reduced-risk products as equivalent to cigarettes ignores the fundamental risk gradient that underpins contemporary tobacco control strategy.

There is also a policy inconsistency in heavily taxing nicotine pouches while states subsidize nicotine replacement therapies (NRT) such as gum, patches, and lozenges through NYS Quitline programs. Both NRT and nicotine pouches provide nicotine without combustion and with minimal carcinogenic exposure. Yet NYS Quitline programs distribute NRT at no cost to promote smoking cessation, while proposed excise taxes would make nicotine pouches financially inaccessible to many users. This asymmetry is counterintuitive: if the public health objective is to reduce smoking-related disease, policies should encourage transitions to any substantially lower-risk alternative that improves adherence and substitution success in real-world settings.

Equity considerations further argue against excessive taxation. Tobacco use remains disproportionately concentrated among lower-income populations, veterans, and blue-collar workers. Price barriers to reduced-risk alternatives may lock vulnerable groups into continued cigarette use, perpetuating disparities in cancer, cardiovascular disease, and respiratory illness. A risk-proportionate tax structure, where the highest taxes target the most harmful products better aligns fiscal policy with disease prevention and health equity goals.

Finally, public health taxation is most defensible when applied to products that impose substantial societal costs through disease burden and secondhand exposure. Combustible tobacco meets this threshold; nicotine pouches do not to a comparable degree. Over-taxing reduced-risk nicotine products risks reinforcing the very harms tobacco control policies seek to reduce. A more coherent approach is to align taxation with relative risk, support cessation efforts, and maintain access to lower-harm alternatives that facilitate a complete transition away from smoking.

¹⁵ FDA Authorizes Marketing of 20 Zyn Nicotine Pouch Products after Extensive Scientific Review. U.S. Food and Drug Administration. January 16, 2025. Retrieved from: <https://www.fda.gov/news-events/press-announcements/fda-authorizes-marketing-20-zyn-nicotine-pouch-products-after-extensive-scientific-review>

What is the Real Objective of this proposal?

If harm reduction and health equity were the central drivers of public health taxation policy, alcohol would warrant far greater scrutiny than reduced-risk nicotine alternatives. Alcohol use is causally linked to more than 200 disease and injury conditions and is a known carcinogen associated with cancers of the breast, liver, esophagus, colorectum, and head and neck. It contributes to liver cirrhosis, cardiovascular disease, pancreatitis, impaired judgment leading to motor vehicle fatalities, interpersonal violence, and significant mental health burden. Unlike nicotine pouches, alcohol has no harm-reduction analogue that eliminates toxic exposure while maintaining use; risk is dose-dependent and cumulative. Nationally, excessive alcohol use is associated with over 140,000 deaths annually and billions in healthcare and societal costs. These harms disproportionately affect lower-income communities and communities of color, reinforcing health inequities—precisely the public health equity frameworks aim to protect.

Despite this burden, alcohol remains deeply integrated into New York’s economic infrastructure. Hospitality, nightlife, tourism, professional sports venues, and large cultural events rely heavily on alcohol sales for revenue generation. New York City’s tourism and entertainment sectors produce billions in economic activity and tax receipts annually, with alcohol sales representing a substantial component of restaurants, bar, and event profitability. Increasing alcohol taxes or restricting availability risks economic ripple effects across employment, small business sustainability, and tourism competitiveness. Additionally, the beverage and hospitality sectors maintain significant lobbying presence and political influence at the state level, shaping regulatory priorities and fiscal policy debates.

These economic and political realities create structural disincentives for aggressive alcohol taxation, even when the public health burden is clear. Consequently, policymakers may target products with less economic entanglement and lower political resistance. In contrast to alcohol, nicotine pouches exist outside the hospitality economy and do not drive tourism revenue, nightlife activity, or large event sponsorship ecosystems. This asymmetry raises an important policy question: if the stated goals are harm reduction and health equity, why focus punitive taxation on lower-risk nicotine products while leaving a far greater contributor to disease burden comparatively untouched?

This dynamic suggests that fiscal dependence, economic incentives, and stakeholder influence can shape regulatory priorities as much as public health evidence. A harm-reduction-oriented framework would align taxation with relative risk and population health burden, rather than disproportionately targeting lower-risk products that may facilitate transition away from far more dangerous behaviors.

If the proposed tax increase on nicotine pouches is intended to secure a stable revenue stream, policymakers should state that objective transparently.

Framing a substantial excise increase as a health and safety intervention is difficult to reconcile with the broader risk landscape and existing regulatory priorities. New York maintains comparatively moderate alcohol taxation and broad retail availability despite alcohol’s well-documented contribution to cancer, liver disease, injury, and community harm. By contrast, nicotine pouches deliver nicotine without combustion and with markedly lower toxicant exposure than cigarettes. When lower-risk products are singled out for punitive taxation while higher-burden contributors to disease remain comparatively insulated, the policy rationale appears fiscal rather than health-driven. Public trust is strengthened when governments align stated goals with evidence and policy consistency; if revenue stabilization is the primary aim, acknowledging that reality is more credible than invoking harm reduction while targeting products that sit lower on the risk continuum.