Testimony before the Senate Finance Committee
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Good afternoon Chairman Oelslager, Vice Chairman Coley, Ranking Member Skindell, and Members of the Committee. My name is Amy Bush Stevens and I am the Director of Prevention and Public Health Policy at the Health Policy Institute of Ohio (HPIO). The mission of HPIO is to provide the independent, unbiased and nonpartisan information needed to create sound health policy.

Last week, we released a policy brief called ***The state of tobacco use prevention and cessation in Ohio***. We have provided you with a copy of the executive summary and the full report, and I am here today to briefly describe the key findings and policy implications.

Smoking and secondhand smoke exposure are associated with many of Ohio's most pressing health policy challenges, including infant mortality, rising Medicaid costs and high rates of chronic diseases such as diabetes and cancer.

Tobacco use is particularly high among Medicaid enrollees and Ohioans with mental illness or other disabilities. Almost half of working-age Medicaid enrollees were current smokers in 2012.[1] Researchers estimate that 15% of U.S. Medicaid costs are attributable to cigarette smoking.[2]

When we released our ***Health Value Dashboard*** in December 2014, one of the most striking findings was that Ohio performed in the bottom quartile of states for:

- Adult cigarette smoking (Ohio ranks 44th),
- Secondhand smoke exposure for children (Ohio ranks 49th), and
- Tobacco prevention and control spending (Ohio ranks 46th).

This means that Ohio lags behind most other states on these key indicators of population health.[3]

Evidence-based strategies

There is a strong body of evidence on what works to reduce tobacco use. The U.S. Centers for Disease Control and Prevention (CDC) recommends strategies based upon rigorous reviews of large numbers of research studies.

Ohio is currently employing many of these strategies, which are listed in the executive summary, but the scope and intensity of these activities in recent years appears to be inadequate to produce the desired results.

Ohio's investment in tobacco prevention and control dropped from a high of $54.8 million in SFY 2005 to a low of $2.2 million in SFY 2011.[4] In SFY 2015, Ohio is spending 7.4% of the amount recommended by the CDC.[5] The number of Ohioans who are reached by the Quit Line, media campaigns, and prevention activities is therefore greatly diminished.

Policy implications

The policy brief provides a list of state-level policy options that research tells us are most likely to reduce tobacco use in Ohio:

- First, we identify policy options that send a strong message that tobacco use is harmful, including:
    - Increasing the scope and intensity of media campaigns; and,
    - Increasing the cigarette tax and taxes on other tobacco products. Research shows that the higher the tax increase, the greater the impact on tobacco use. This approach is particularly effective for preventing youth initiation and reducing tobacco use among people with low incomes.[6]
- Second, we identify policy options that scale up and enhance access to cessation services, including:
    - Increasing funding for cessation strategies and use of the Ohio Quit Line; and,
    - Monitoring compliance of private health insurance plans with cessation coverage requirements.
- Third, we identify policy options that integrate tobacco cessation into Medicaid modernization and behavioral health system redesign.
- Finally, we identify policy options that would strengthen Ohio's tobacco prevention and control infrastructure.

Taken together, these policy options emphasize the importance of:

- Pairing policies that encourage smokers to quit, such as an increase in the cigarette tax, with the availability of cessation services for those who are ready to quit; and
- Increasing the intensity of our focus on helping today's smokers quit, while also preventing young people from ever starting to use tobacco in the first place.

Thank you to Chairman Oelslager for the opportunity to share this policy brief with the committee.

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[1] Current smokers (every/some days) among non-senior adults (ages 19-64). Data from the 2012 Ohio Medicaid Assessment Survey (OMAS). "2012 OMAS Public Data and Tables." OMAS. Accessed April 10, 2015. http://grc.osu.edu/omas/datadownloads/2012omaspublicdata/index.cfm

[2] Xu, X., et al. "Annual Healthcare Spending Attributable to Cigarette Smoking: An Update." American Journal of Preventive Medicine 48, no.3 (2015): 326- 333.

[3] HPIO Health Value Dashboard, 2014.

[4] Data provided by the American Lung Association (ALA). FY2003-FY2015 Tobacco Prevention and Cessation Funding Overview spreadsheet. Provided May 21, 2015.

[5] American Lung Association. *State of Tobacco Control 2015.*

[6] The Guide to Community Preventive Services. http://www.thecommunityguide.org

hpio health policy institute of ohio Health Policy Brief

Executive summary

The state of tobacco use prevention and cessation in Ohio

Environmental scan and policy implications

Policy landscape and tobacco use prevalence

Smoking and secondhand smoke exposure are associated with many of Ohio's most pressing health policy challenges, including infant mortality, rising Medicaid costs and high rates of chronic diseases such as diabetes and cancer.

Ohio now lags behind most other states, ranking 44th for adult smoking.[1]

A decade ago Ohio was making significant progress in reducing smoking rates. Funded by the Master Settlement Agreement (MSA) with major tobacco companies, the Ohio Tobacco Use Prevention and Control Foundation helped 38,000 Ohioans quit smoking.[2] In 2006, Ohio passed the comprehensive Smoke-Free Workplace Act. From 2002 to 2008, Ohio's adult smoking rate declined 24.4%, placing Ohio in the top quartile of states with the steepest declines during that time period.[3]

When the MSA was securitized and the Foundation was abolished in 2008, Ohio's investment in tobacco prevention and control dropped from a high of $54.8 million in SFY 2005 to a low of $2.2 million in SFY 2011 (see trend graph on next page). As a result, the scope and intensity of prevention and cessation activities in Ohio was greatly diminished.

Key facts

- Ohio ranks 44th for adult cigarette smoking and 49th for secondhand smoke exposure for children, indicating that Ohio has higher tobacco use rates than most other states.[4]
- Ohio's youth tobacco use rate (21.7%) is slightly below the national rate (22.4%).[5] Youth are much more likely than adults to use tobacco products other than cigarettes, such as smokeless tobacco. E-cigarette and hookah use among young people is quickly rising.[6]
- Tobacco use is particularly high among Medicaid enrollees and Ohioans with mental illness or other disabilities. Almost half of working-age Medicaid enrollees were current smokers in 2012.[7]
- Researchers estimate that 15% of Medicaid costs are attributable to cigarette smoking.[8]

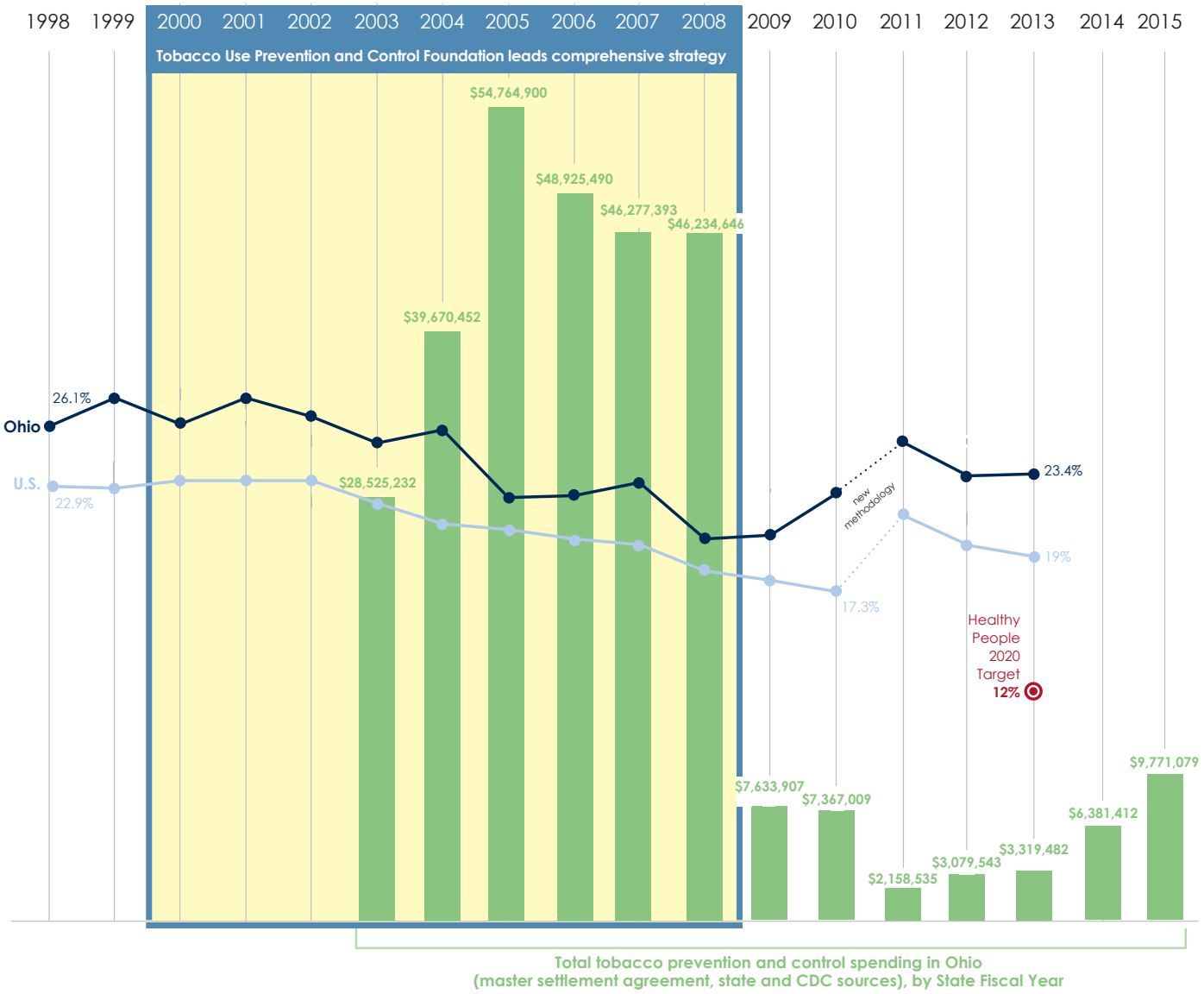
Ohio's implementation of evidence-based strategies

There is a strong body of evidence on what works to prevent tobacco use, help smokers quit, and reduce exposure to secondhand smoke (see box on next page). Ohio is currently employing many of these strategies, but the scope and intensity of these activities in recent years appears to be inadequate to produce the desired results. Ohio's Quit Line, for example, achieves excellent quit rates, although Quit Line utilization is much lower than in most other states and eligibility is limited. As a result, only a small number of Ohioans are able to take advantage of this effective service.

Ohio's strengths in implementing evidence-based strategies include:

- **Highly comprehensive Smoke-Free Workplace law** that includes restaurants, bars and casinos.
- **Medicaid cessation benefits** that align well with evidence-based recommendations for cessation counseling and medications.

Adult cigarette smoking prevalence and tobacco prevention and control funding in Ohio, 1998-2015



Source for smoking prevalence: Behavioral Risk Factor Surveillance Survey (BRFSS)
Source for spending amounts: American Lung Association

Ohio's challenges in implementing evidence-based strategies include:

- **Stagnant cigarette tax rate.** Ohio has not raised its cigarette tax since 2005 and other tobacco products are taxed at a lower rate than cigarettes.
- **Barriers to cessation support.** Some Ohioans with private health insurance coverage face barriers to getting help to quit, such as co-pays, prior authorization requirements and annual limits.
- **Weak investment in comprehensive tobacco prevention and control infrastructure.** Ohio ranks 46th in tobacco prevention and control spending, meaning that most other states invest more.[9] In SFY 2015, Ohio spent 7.4% of the amount the CDC recommends to support a comprehensive program.[10]

Evidence-based strategies

The U.S. Centers for Disease Control and Prevention recommends the following strategies based upon rigorous reviews of large numbers of research studies:[11]

- **Comprehensive tobacco control programs.** Coordinated multi-component strategy with administrative support, surveillance and evaluation.
- **Increased unit price for tobacco products**, such as increasing cigarette taxes and taxes on other tobacco products.
- **Smoke-free policies** that prohibit smoking within indoor spaces and designated public areas.
- **Mass reach health communication interventions.** Media campaigns designed to motivate tobacco users to quit or to prevent youth from ever starting.
- **Community mobilization with additional interventions.** Campaigns to reduce youth access to tobacco through education and active enforcement of regulations pertaining to tobacco retailers.
- **Reduced out-of-pocket costs for cessation.** Policies and programs that make recommended medications and counseling more accessible.
- **Quitline interventions.** Widely accessible counseling by phone.
- **Incentives and competitions to increase smoking cessation among workers.** Rewards combined with activities such as cessation services, smoke-free policies and social support networks.

Policy implications

Strategically focusing on several of the following state-level policy options would likely have significant impact on improving health outcomes and controlling healthcare costs in Ohio.

Policy options that send a strong message that tobacco use is harmful

- **Increase the cigarette tax and taxes on other tobacco products.** Effects are proportional to the size of the price increase, so the higher the tax increase, the greater the impact on tobacco use. This approach is particularly effective for preventing youth initiation and reducing tobacco use among people with low incomes.
- **Increase scope and intensity of media campaigns,** including campaigns that motivate tobacco users to quit and seek cessation support, as well as youth counter-marketing activities that prevent teens from starting in the first place. Design messages to reach specific populations, such as pregnant women, Appalachian counties, people with disabilities, low-income Ohioans, Hispanic youth, LGBT community, etc.
- **Raise the legal age to purchase tobacco to 21.** Emerging evidence suggests that this approach would likely delay initiation of tobacco use among adolescents and young adults and eventually reduce the overall prevalence of tobacco use. Because this policy affects young adults, it is an important tool for reducing maternal tobacco exposure and improving birth outcomes.

Policy options that scale up and enhance access to cessation services

- **Increase funding for cessation strategies**. For example:
  - Increase awareness and use of cessation coverage among healthcare providers, Medicaid enrollees, state employees, and Ohioans with private health insurance coverage.
  - Expand Quit Line eligibility and capacity (see below).
  - Train and support additional Tobacco Treatment Specialists to provide cessation services in a variety of clinical and community settings.
  - Implement culturally competent programs designed to reach communities with higher rates of tobacco use and secondhand smoke exposure, and poor birth outcomes.
- **Increase use of the Ohio Quit Line.** For example:
  - Recruit new members to the Ohio Tobacco Collaborative, a public-private partnership that provides commercial insurance carriers, employers, and third party administrators with access to the Ohio Tobacco Quit Line at reduced rates.
  - Change eligibility requirements to allow more Ohioans access to the Quit Line.
  - Increase marketing and targeted outreach to populations with high rates of tobacco use.
  - Integrate Quit Line referrals into Electronic Health Records.
- **Monitor compliance of private health insurance plans with cessation coverage requirements.** Ensure that Ohioans are able to make use of effective counseling services and medications that are required to be covered by health insurance.
- **Improve cessation benefits for state employees.** Reduce barriers, such as co-pays and annual limits on quit attempts.

Policy options that integrate tobacco cessation into healthcare system reform

Ohio policymakers are currently seeking ways to improve the Medicaid program and behavioral health system. Given the high rates of tobacco use among Medicaid enrollees, pregnant women and Ohioans with mental illness, strategic delivery of evidence-based tobacco services should be integrated into these efforts.

- **Incorporate tobacco cessation into Medicaid modernization.** For example:
  - Include reporting of performance on tobacco cessation metrics in managed care and provider contracts.

- Increase awareness and use of cessation coverage among providers and enrollees.
- Provide incentives for enrollees to quit.
- Remove all barriers to cessation (such as co-pays and prior authorizations).
- Focus efforts to reduce maternal and youth tobacco use in communities with poor birth outcomes.

- **Incorporate tobacco cessation into behavioral health system redesign.** For example:
  - Include tobacco cessation metrics in future outcome measurement or value-based purchasing systems.
  - Invest in research, evaluation and technical assistance on effective cessation strategies for people with mental illness and addiction.
- **Incorporate tobacco cessation into other payment and delivery design efforts, such as Patient Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs).** For example:
  - Include tobacco cessation performance metrics in contracts
  - Institutionalize cessation interventions as a routine part of primary care
  - Increase use of reminder systems that prompt providers to deliver or refer to cessation services

Policy options that strengthen Ohio's tobacco prevention and control infrastructure

- **Invest in staffing for the Tobacco Free Ohio Alliance.** Strengthen Ohio's "backbone" organization so that it can more effectively lead and coordinate state and local-level partners.
- **Release and promote a strategic plan** that provides a clear vision for how Ohio will implement a comprehensive tobacco prevention and control program based on CDC recommendations.
- **Fund research and evaluation** on cessation for specific populations, tobacco 21, e-cigarettes and other emerging issues.

Download the full publication, "The state of tobacco use prevention and cessation in Ohio: Environmental scan, accountability map and policy implications," at

www.hpio.net/category/publications/

Notes

1. *HPIO Health Value Dashboard*, 2014.
2. Office of the Auditor of State. "Ohio Tobacco Use Prevention and Control Foundation Regular Audit for the Period ended May 6, 2008." February 24, 2009.
3. The percent of adults in Ohio who smoked dropped from 26.6% in 2002 to 20.1% in 2008. Ohio ranked 13th among all states and DC for the size of this decline during this time period. Data from the BRFSS. "Prevalence and Trends Data: Ohio 2013, Tobacco Use." CDC Office of Surveillance, Epidemiology, and Laboratory Services. Accessed April 3, 2015. http://apps.nccd.cdc.gov/brfss
4. *HPIO Health Value Dashboard*, 2014.
5. Students (grades 9 through 12) reporting use of tobacco products in the past 30 days (cigarettes, cigars, and/or smokeless tobacco). Data from the 2013 Youth Risk Behavior Surveillance survey (YRBS). Accessed through CDC Youth Online: High School YRBS. Accessed April 15, 2015. http://nccd.cdc.gov/youthonline/App/Default.aspx
6. Data from the National Youth Tobacco Survey (NYTS). Arrazola, René A., et al. "Tobacco Use Among Middle and High School Students — United States, 2011–2014." Morbidity and Mortality Weekly Report 64, no. 14 (2015): 381-385. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6414a3.htm?s_cid=mm6414a3_w
7. Current smokers (every/some days) among non-senior adults (ages 19-64). Data from the 2012 Ohio Medicaid Assessment Survey (OMAS). "2012 OMAS Public Data and Tables." OMAS. Accessed April 10, 2015. http://grc.osu.edu/omas/datadownloads/2012omaspublicdata/index.cfm
8. Xu, X., et al. "Annual Healthcare Spending Attributable to Cigarette Smoking: An Update." American Journal of Preventive Medicine 48, no.3 (2015): 326-333. doi: 10.1016/j.amepre.2014.10.012
9. *HPIO Health Value Dashboard*, 2014.
10. American Lung Association. *State of Tobacco Control 2015*.
11. The Guide to Community Preventive Services. http://www.thecommunityguide.org