Proponent Testimony HB11
Ohio Senate Health, Human Services & Medicaid Committee
November 12, 2019

Chairman Burke, Ranking Member Antonio, and members of the Senate Health, Human Services and Medicaid Committee – I am Jeff Stephens with the American Cancer Society Cancer Action Network (ACS CAN), and I thank you for the opportunity to provide testimony on the smoking cessation provisions within HB11.

The American Cancer Society Cancer Action Network (ACS CAN) is the non-partisan, nonprofit advocacy affiliate of the American Cancer Society (ACS) dedicated to eliminating cancer as a major health problem. Tobacco use is the leading cause of preventable death in the U.S., with more than 480,000 deaths each year caused by cigarette smoking.[1,2] This includes 32% of all cancer deaths and 80% of lung cancer deaths.[3] Thus, ACS CAN supports policies to help people who use tobacco quit and prevent youth from ever starting.

ACS CAN appreciates Representatives' Manning and Howses' interest in ensuring that Medicaid enrollees receive comprehensive tobacco cessation treatment. It is of particular importance to ensure coverage for those on Medicaid because individuals who rely on Medicaid for their health care have a higher smoking rate (24.5%) than the overall adult population (14%) and more than double that of individuals with private insurance (10.5%).[4]

This results in smoking-related diseases costing Medicaid programs millions of dollars every year—an average of $833 million per state.[5] However, something can be done to help people who use tobacco quit and save states money. Tobacco use interventions are a gold standard in public health for cost-effectiveness. A 2010 study by the American Lung Association and Penn State University found a 26% return on investment for states investing in tobacco cessation treatment.[6] Yet, Medicaid spends less than 0.25% of the estimated cost of smoking related diseases on tobacco cessation efforts.[7,8,9] While 68% of people who smoke report that they want to quit, many of those on Medicaid are lower-income and unable to pay for this lifesaving treatment out-of-pocket.[10] Many Medicaid enrollees can successfully quit if they have access to a comprehensive tobacco cessation program with no cost-sharing.

As you know, federal law requires Medicaid expansion plans and marketplace plans (except those that are grandfathered) to cover all cessation treatment while traditional Medicaid programs must cover these services for pregnant women. We must go beyond this small population and cover all Medicaid enrollees, who are most in need of help, for all medications and counseling. Fortunately, federal law also incentivizes Medicaid to cover cessation treatment through a one percent increase in their federal dollar matching rate. A comprehensive Medicaid tobacco cessation benefit includes coverage for all three different types of counseling (individual, group, and phone-inclusive of the state's Quitline) and seven

FDA-approved pharmacological interventions (five nicotine replacement therapies and two additional prescription medications). People who use tobacco should be offered at least four counseling sessions and a 90-day supply of medication for each quit attempt and at least two quit attempts should be covered a year. People respond differently to different interventions; therefore, coverage for a range of counseling types and medications is essential. ACS CAN recommends this comprehensive coverage free of barriers.

There are six key barriers that prevent Medicaid recipients from utilizing comprehensive cessation programs: co-payments, prior authorization requirements, limits on treatment duration, yearly or lifetime dollar limits, step therapy, and required counseling for medications. Research shows that enrollees are more likely to quit successfully if their Medicaid coverage does not impose any of these barriers to care.[11]

In addition to barrier-free comprehensive cessation treatment, ACS CAN strongly recommends that Medicaid continue to reimburse the state Quitline for the services it provides to Medicaid enrollees as one option for telephone counseling. State quitlines are just as effective as individual or group counseling, and may be more convenient. Medicaid enrollees make up 39% of state quitlines users; therefore, it makes sense that Medicaid should provide reimbursement to the quitline for providing the service to enrollees.[14] Including state quitline coverage under Medicaid adds a layer of financial protection and provides more resources so that the quitline can expand to accommodate new users. This allows the state tobacco control dollars to provide free telephone counseling as a last resort for those are not covered by another source.

In summary, ACS CAN recommends that Medicaid cover a comprehensive tobacco cessation benefit that includes access to all three types of counseling and all FDA-approved medications, without enrollee cost-sharing or other barriers. While federal law has been effective in increasing coverage of tobacco cessation services for pregnant women enrolled in Medicaid as well as enrollees in most private insurances and Medicaid expansion plans, there are still gaps in coverage when it comes to enrollees in traditional Medicaid. Requiring traditional Medicaid plans to provide a comprehensive tobacco cessation benefit without barriers is key to helping people quit tobacco use. Ultimately this public health intervention will save money and lives.

Thank you for considering our recommendations. We look forward to providing further input as HB11 moves toward comprehensive tobacco cessation coverage for all Medicaid enrollees.

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