American Lung Association.

June 23, 2021

The Honorable Anna Eshoo
Chairwoman
Energy and Commerce, Health Subcommittee
United States House of Representatives
Washington, DC, 20515

The Honorable Brett Guthrie
Ranking Member
Energy and Commerce, Health Subcommittee
United States House of Representatives
Washington, DC, 20515

Re: Hearing on "Empowered by Data: Legislation to Advance Health Equity and Public Health"

Dear Chairwoman Eshoo and Ranking Member Guthrie:

Tobacco use is the leading cause of death and disease in the United States.[1] Nearly half a million people die from a tobacco-related illness annually and another 16 million Americans live with a tobacco related disease. The burden of tobacco use disproportionally falls on people of lower socio-economic status, who are more likely to be covered by Medicaid.[2]

During the COVID-19 pandemic, the need to address health equity became more apparent. The Centers for Disease Control and Prevention (CDC) identified smoking as a high-risk comorbidity relative to COVID-19; smokers (including those who used to smoke) have a much higher risk of developing serious complications due to COVID-19.[3] While the pandemic highlighted one way that smoking can exacerbate health issues, COVID-19 is not the only risk smokers face.

The American Lung Association applauds the Subcommittee's decision to include H.R. 2125, the Quit Because of COVID-19 Act, in Thursday's hearing, "Empowered by Data: Legislation to Advance Health Equity and Public Health," as this bill will help reduce health disparities. According to CDC, substantial disparities exist in smoking rates, specifically among Native Americans, lesbian, gay, and bisexual (LGB) individuals, low-income individuals, and the behavioral health population.[4] Partially due to these disparities, the Medicaid population, in particular, smokes at high rates, more than double their counterparts in private insurance (24.9% vs. 10.7%).[5] Members of groups that smoke at higher rates are at greater risk of cancer, cardiovascular disease and premature death. Additionally, due to the higher smoking rates, member of these communities and their loved ones are also exposed to secondhand smoke at greater rates. Secondhand smoke causes another 41,000 deaths each year.

Data show that across demographics, including age, insurance status and education level, most smokers want to quit.[6] However, data also show that not all Medicaid enrollees have access to a comprehensive tobacco cessation benefit.[7] Currently, 13 states (CA, CO, CT, KS, KY, MA, MN, MO, ME, OH, OR, RI, and SC) provide a comprehensive cessation benefit to all their Medicaid enrollees. The remaining 37 states and DC can improve their coverage.

In January 2020, Surgeon General Jerome Adams released *Smoking Cessation: A Report of the Surgeon General.*[8] One of the major conclusions of this report was that "insurance coverage for smoking cessation treatment that is comprehensive, barrier-free, and widely promoted increases the use of these treatment services, leads to higher rates of successful quitting, and is cost-effective." H.R. 2125 would provide this coverage for the millions of individuals enrolled in Medicaid programs across the country.

In 2020, the U.S. Surgeon General found that quitting smoking has many health benefits.[9] This includes reducing the risk of 13 different types of cancer, including lung cancer, pancreatic cancer and colorectal cancer; reducing the risk of morbidity and mortality from cardiovascular disease; and more.[10] Quitting smoking can also generate significant cost-savings, specifically in terms of healthcare spending. A recent analysis found that 11.7% of healthcare costs ($225 billion) in the United States are attributable to smoking, with Medicare and Medicaid responsible for more than half of that amount.[11] There is a cost to taxpayers of not helping smokers quit. And that cost is growing – Medicaid's share of those costs is growing: from 2010 to 2014 Medicaid's share of the smoking attributable healthcare costs grew by 30%.[12]

Helping people quit smoking can reduce the prevalence of smoking-caused disease, save lives and save money. One study estimated that a 1% absolute decrease in states' smoking rates would result in $2.5 billion in healthcare savings the following year, with the median state saving $26 million.[13] H.R. 2125 targets a population that smokes at a high rate, which would help achieve these outcomes.

Medicaid enrollees who smoke want to quit at the same rates as their counterparts on private insurance (69.2% vs. 69%), however they quit at lower rates (5.9% vs. 9.4%).[14] H.R. 2125 would provide states with funding to promote the comprehensive cessation benefit created by the bill. This promotion coupled with the expanded benefit would encourage Medicaid enrollees who smoke to make a quit attempt and quit for good.

The American Lung Association is the official source of the Medicaid cessation coverage data for the Centers for Disease Control and Prevention (CDC) and the data source for the Healthy People 2030 metric related to Medicaid's coverage of tobacco cessation treatment in state Medicaid programs. Based on our experiences collecting these data, we believe this bill is an important step toward helping smokers in the Medicaid program quit. The current patchwork of coverage is not sufficiently conducive to giving all Medicaid beneficiaries across the nation who smoke a real chance to quit.

- First, many states administer their Medicaid programs with managed care organizations (MCOs). The MCOs can change from year to year. Absent state requirements, their coverage of these treatments can vary, resulting in frequent changes in coverage.
- Secondly, a comprehensive tobacco cessation benefit consists of seven medications and three forms of counseling. Three of the seven medications are over-the-counter (OTC) medications. Historically, OTC medications have been excluded from coverage.
- Thirdly, it takes typical smokers between eight and eleven tries to quit successfully. Many state Medicaid programs limit the number of times a person can try to make a quit attempt, and a couple of states limit the total number of tries per lifetime.

The Quit Because of COVID-19 Act can help reduce disparities in tobacco use and tobacco-related disease and death. This bill will save money and save lives. The American Lung Association fully supports its swift passage.

Sincerely,

Harold P. Wimmer
President and CEO

Cc: The Honorable Frank Pallone, Chairman, Committee on Energy and Commerce Committee
The Honorable Catherine McMorris Rodgers, Ranking Member, Committee on Energy and Commerce Committee

[1] U.S. Department of Health and Human Services. Smoking Cessation. A Report of the Surgeon General. Atlanta, GA: 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, 2020.
[2] Cornelius ME, Wang TW, Jamal A, Loretan CG, Neff LJ. Tobacco Product Use Among Adults — United States, 2019. MMWR Morb Mortal Wkly Rep 2020;69:1736–1742. DOI: http://dx.doi.org/10.15585/mmwr.mm6946a4
[3] Centers for Disease Control and Prevention. COVID-19: People with Certain Health Conditions. May 13, 2021. Accessed at: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html
[4] Cornelius ME, Wang TW, Jamal A, Loretan CG, Neff LJ. Tobacco Product Use Among Adults — United States, 2019. MMWR Morb Mortal Wkly Rep 2020;69:1736–1742. DOI: http://dx.doi.org/10.15585/mmwr.mm6946a4
[5] Cornelius ME, Wang TW, Jamal A, Loretan CG, Neff LJ. Tobacco Product Use Among Adults — United States, 2019. MMWR Morb Mortal Wkly Rep 2020;69:1736–1742. DOI: http://dx.doi.org/10.15585/mmwr.mm6946a4
[6] Babb S, Malarcher A, Schauer G, Asman K, Jamal A. Quitting Smoking Among Adults — United States, 2000–2015. MMWR Morb Mortal Wkly Rep 2017;65:1457–1464. DOI: http://dx.doi.org/10.15585/mmwr.mm6552a1
[7] DiGiulio A, Jump Z, Babb S, et al. State Medicaid Coverage for Tobacco Cessation Treatments and Barriers to Accessing Treatments — United States, 2008–2018. MMWR Morb Mortal Wkly Rep 2020;69:155–160. DOI: http://dx.doi.org/10.15585/mmwr.mm6906a2

[8] U.S. Department of Health and Human Services. Smoking Cessation. A Report of the Surgeon General. Atlanta, GA: 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, 2020.
[9] U.S. Department of Health and Human Services. Smoking Cessation. A Report of the Surgeon General. Atlanta, GA: 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, 2020.
[10] Ibid.
[11] Xin Xu, Sundar S. Shrestha, Katrina F. Trivers, Linda Neff, Brian S. Armour, Brian A. King, U.S. healthcare spending attributable to cigarette smoking in 2014, Preventive Medicine, 2021, 106529, ISSN 0091-7435, https://doi.org/10.1016/j.ypmed.2021.106529.
[12] Ibid.
[13] Glantz SA. Estimation of 1-Year Changes in Medicaid Expenditures Associated With Reducing Cigarette Smoking Prevalence by 1%. JAMA Netw Open. 2019;2(4):e192307. doi:10.1001/jamanetworkopen.2019.2307
[14] Babb S, Malarcher A, Schauer G, Asman K, Jamal A. Quitting Smoking Among Adults — United States, 2000–2015. MMWR Morb Mortal Wkly Rep 2017;65:1457–1464. DOI: http://dx.doi.org/10.15585/mmwr.mm6552a1