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The Honorable Kathleen Sebelius
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 120F
Washington, DC 20201

Dear Secretary Sebelius:

I write today as your agency is in the process of writing regulations implementing Sec. 2001 of the Affordable Care Act regarding the Medicaid expansion population. The American Lung Association strongly urges you to help the millions of addicted smokers in this country have the best opportunity to quit by including a comprehensive tobacco cessation benefit as part of the minimum standard requirement for the Essential Health Benefit in Medicaid benchmark and benchmark equivalent coverage.

As you well know, tobacco use is the leading cause of preventable death in this country, responsible for more than 400,000 deaths each year. Tobacco use results in $96 billion annually in healthcare expenditures and an additional $97 billion each year in lost productivity. Over 70 percent of smokers want to quit – but most smokers require multiple attempts before they are successful because the addiction to tobacco is incredibly powerful.

Currently, people on Medicaid and the uninsured smoke at rates significantly higher than the general population (36.5 percent, 33.2 percent vs. 22.7 percent, respectively).[i] Smokers on Medicaid cost the federal and state governments hundreds of millions of dollars every year – an average of $607 million per state per year.[ii] Most Medicaid programs are currently not providing smokers enough help to quit. Only six states provide a comprehensive tobacco cessation benefit to all Medicaid enrollees.[iii]

For all these reasons, it is vital that the Medicaid expansion population be ensured access to tobacco cessation treatment. The Department of Health and Human Services (HHS) has an important opportunity to alleviate costs and improve health by requiring coverage for such treatments in the Essential Health Benefit required for benchmark and benchmark equivalent Medicaid enrollees.

Tobacco Cessation Treatment
A comprehensive tobacco cessation benefit is one that includes all treatments recommended in the most recent U.S. Public Health Service guideline, *Treating Tobacco Use and Dependence.*[iv] There is a model for defining and implementing such a benefit. In 2011, the U.S. Office of Personnel Management began requiring insurance plans that participate in the Federal Employees Health Benefits Program to cover:

- Four tobacco cessation counseling sessions of at least 30 minutes for at least two quit attempts per year. This includes proactive telephone counseling, group counseling and individual counseling.
- All 7 Food and Drug Administration-approved tobacco cessation medications with a doctor's prescription.[v]
- Coverage provided for two quit attempts per year.
- These benefits must be provided with no copayments or coinsurance and not subject to deductibles, annual or life time dollar limits.

The American Lung Association strongly recommends HHS require a similar benefit for the Medicaid expansion population through the Essential Health Benefit.

Preventive Services
As you know, Section 2713 of the Affordable Care Act requires all non-grandfathered private health insurance plans to cover all preventive services rated an 'A' or 'B' by the U.S. Preventive Services Task Force. Tobacco cessation treatment is an 'A' rated preventive service. While this requirement does not guarantee a comprehensive benefit in all private plans, it does guarantee some level of coverage for smokers who need help to quit. There are also many other preventive services that the American Lung Association cares about included in this requirement.

As you also know, HHS has indicated in its "Frequently Asked Questions on Essential Health Benefits Bulletin" that these same preventive services will be required to be included in health plans in state exchanges through the Essential Health Benefit. The American Lung Association supports this action. It is consistent with other parts of the Affordable Care Act, and ensures that the requirement for non-grandfathered private plans is not undermined.

Following in this same vein, ***the American Lung Association urges HHS to include preventive services given an 'A' or 'B' rating by the U.S. Preventive Services Task Force in the Essential Health Benefit requirement for Medicaid benchmark and benchmark equivalent plans.*** Requiring these services for the Medicaid expansion population will save lives and money. Low income Medicaid enrollees should have the same preventive services available to them as patients in the exchanges. Additionally, taxpayers will benefit from cost savings associated with a focus on prevention. It will also move the country towards a national standard in preventive services coverage, and will ensure that the Essential Health Benefit includes benefits in a "typical employer plan," as the ACA requires.

Secretary Approval of Benchmark Plans
The concept of benchmark plans in Medicaid was first introduced as part of the Deficit Reduction Act of 2005 (enacted as §1937 of the Social Security Act). Relatively few states have taken advantage of these provisions, and most of the states that have used benchmark Medicaid plans have done so in a very targeted and limited way. Of the small number of these states, most have used the "Secretary-

approved" option, which allows the state to use a plan that the Secretary of HHS approves as the benchmark.[vi]

If this trend continues and many state Medicaid programs opt for the "Secretary-approved" option in picking Medicaid benchmarks, HHS will have to establish a standard for approving these plans. ***The American Lung Association urges HHS to make public health and prevention a major consideration when making approval decisions regarding "Secretary-approved" benchmark plans. Specifically, we encourage you to only approve plans that provide a comprehensive tobacco cessation benefit to all enrollees***.

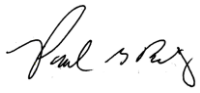
Prescription Drug Coverage

In its December 2011 Bulletin on Essential Health Benefits in state exchanges, HHS indicated that only one drug per class from the benchmark plan's formulary would be required for all other plans in the exchange. This requirement is weaker than the Medicare Part D standard (at least two drugs per category), and could seriously limit patients' access to necessary, life-saving quit-smoking medications. Furthermore, this standard does not reflect the coverage in a typical employer plan – most plans have many more than one drug per category on their formularies.

Low-income Medicaid enrollees are particularly unable to pay for medications not on their plan's formulary, so it is especially important that all Medicaid plans have robust formularies**. *The American Lung Association encourages HHS to require at least two drugs per category on Medicaid benchmark and benchmark-equivalent plans' formularies.***

The American Lung Association appreciates the commitment HHS has shown to reducing tobacco use and preventing tobacco-caused diseases, and hopes to see this commitment continued by the adoption of these recommendations.

Sincerely,



Paul G. Billings,
Vice President of National Policy and Advocacy

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[i] Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey, provisional data. 2009.

[ii] Centers for Disease Control and Prevention. Sustaining State Programs for Tobacco Control: Data Highlights 2006. Available at: www.cdc.gov/tobacco/data_statistics/state_data/data_highlights/2006/00_pdfs/DataHighlights06rev.pdf

[iii] American Lung Association. Helping Smokers Quit: Tobacco Cessation Coverage. December 2011. Available at: www.lung.org/helpingsmokersquit

[iv] Available at: http://www.ncbi.nlm.nih.gov/books/NBK63952/

[v] The American Lung Association recommends that the benefit refer to "all FDA-approved medications" and not specify a number in order to provide maximum flexibility.

[vi] Department of Health and Human Services, Benchmark and Benchmark Equivalent State Plans Approved by the Secretary since Passage of the Deficit Reduction Act of 2005, http://www.cms.hhs.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/070607benchmarkssection1937.pdf; Health Management Associates, Key Medicaid Reform Elements in States Adopting DRA State Plan Amendments: Idaho, Kansas, Kentucky, and West Virginia (June 2007).