HB 209

<TARGET><BILL>HB 209</BILL><SUBJECT>HB 209</SUBJECT><COMM>HHSS27</COMM></TARGET>

ALASKA STATE LEGISLATURE

Representative Bob Herron

State Capitol
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House District 38
Kuskokwim and Johnson Rivers
Kuskokwim Bay, Nelson Island

MEMORANDUM

DATE: 31 January 2012

TO: Representative Wes Keller
Chair, House Health and Social Services Committee

CC: Janet Ogan
Committee Aide, House Health and Social Services Committee

FROM: Representative Bob Herron

RE: House Bill 209

Please accept this request for a second hearing of HB 209, "an Act requiring a health care insurer to provide coverage for tobacco cessation treatment" in the House Health and Social Services Committee.

House Bill 209 requires that insurance companies provide tobacco cessation treatment to addicts seeking help in ending addiction. This bill gives Alaskans the resources and support they need to end tobacco addiction by requiring insurance companies to provide smoking cessation programs and treatment. With the implementation of House Bill 209, insurance companies would provide coverage for a minimum of two courses of treatment during each year as well as over the counter or prescription medications approved by the U.S.F.D.A. Two courses of treatment allow for multiple attempts for those smokers who continue to work towards ending addiction. Coverage provides for not less than four counseling sessions in each course of treatment as well as over the counter or prescribed medication.

Counseling is not a precondition for receiving medication; patients may tailor treatment plans and methods for individual needs. Also, coverage for treatment may not require preauthorization or require a referral.

HB 209 does not force lifestyle choices on anyone, but will provide the assistance many Alaskans need to end tobacco addiction and live healthy, long, productive lives. Long-term effects include cost savings in medical expenditures, increased workplace productivity, lower long-term insurance costs for insurance providers, and healthier, happier Alaskans.

Feel free to contact myself or aide Liz Clement (465-6576) with any further questions.

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

February 13, 2012

Jack C. McRae
Senior Vice President

Representative Wes Keller
State Capitol Room 432
Juneau, Alaska 99801

Re: HB 209, Tobacco Cessation

Dear Representative Keller,

I am writing with respect to House Bill 209, *An Act requiring a health care insurer to provide coverage for tobacco cessation treatment*. We wanted to share some concerns with the current version of the bill.

Premera Blue Cross Blue Shield of Alaska covers over 70,000 members and provides comprehensive coverage to our members, including innovative programs focused on wellness and prevention. Accordingly, our plans cover tobacco cessation counseling and treatment programs to help our members achieve the goal of smoking cessation. If the plan covers a prescription drug plan, certain prescription drugs are covered without cost sharing. Some plans also cover over-the-counter medications.

The Affordable Care Act requires non-grandfathered health plans, including insured and self-funded plans, to cover preventive services without cost sharing. Tobacco cessation counseling and interventions are included in this benefit.

We are concerned that HB 209 includes a provision that removes a critical cost-control tool for health insurers. Insurers utilize medical management tools, such as prior authorization, to control costs and ensure members receive appropriate care. 45 C.F.R Subtitle A related to coverage of preventive services under the Patient Protection and Affordable Care Act, § 147.130(4) states that "nothing prevents a plan from or issuer from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or services described..." The language of HB 209 is ineffectual in its attempt to support financially sound health plans focused on wellness for Alaskans.

Instead, we recommend these amendments to the bill:

- In Section 1(b)(2), **removing** "over-the-counter medication or" and **adding** "if the insurance plan covers prescription medication and is available in the plan's formulary or preferred drug list" following "prescribed medication approved by the United States Food and Drug Administration for tobacco cessation treatment" This change will preserve coverage for prescription drugs if the plan covers prescription benefits.

- **Removing** Section 1(c)(1) altogether, again to preserve prior authorization of prescription drug tobacco cessation treatment.

- **Changing** Section 1(c)(2) by replacing "treatment" with "counseling."

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- **Removing** Section 1(c)(4) altogether.

- **Adding** a new (d) to Section 1 that reads, "The coverage required by this section is subject to the standard policy provisions applicable to other benefits, including deductible, coinsurance, or copayment provisions."

We appreciate your consideration of this input with respect to House Bill 209. Please feel free to give me a call if you have any questions pertaining to this letter.

Sincerely,

Jack C. McRae
Senior Vice President

RESEARCH ARTICLE

The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts

Patrick Richard[1¤], Kristina West[1], Leighton Ku[2*]

1 Department of Health Policy, School of Public Health and Health Services, The George Washington University, Washington, District of Columbia, United States of America, **2** Center for Health Policy Research, School of Public Health and Health Services, The George Washington University, Washington, District of Columbia, United States of America

Abstract

Background and Objective

A high proportion of low-income people insured by the Medicaid program smoke. Earlier research concerning a comprehensive tobacco cessation program implemented by the state of Massachusetts indicated that it was successful in reducing smoking prevalence and those who received tobacco cessation benefits had lower rates of in-patient admissions for cardiovascular conditions, including acute myocardial infarction, coronary atherosclerosis and non-specific chest pain. This study estimates the costs of the tobacco cessation benefit and the short-term Medicaid savings attributable to the aversion of inpatient hospitalization for cardiovascular conditions.

Methods

A cost-benefit analysis approach was used to estimate the program's return on investment. Administrative data were used to compute annual cost per participant. Data from the 2002–2008 Medical Expenditure Panel Survey and from the Behavioral Risk Factor Surveillance Surveys were used to estimate the costs of hospital inpatient admissions by Medicaid smokers. These were combined with earlier estimates of the rate of reduction in cardiovascular hospital admissions attributable to the tobacco cessation program to calculate the return on investment.

Findings

Administrative data indicated that program costs including pharmacotherapy, counseling and outreach costs about $183 per program participant (2010 $). We estimated inpatient savings per participant of $571 (range $549 to $583). Every $1 in program costs was associated with $3.12 (range $3.00 to $3.25) in medical savings, for a $2.12 (range $2.00 to $2.25) return on investment to the Medicaid program for every dollar spent.

Conclusions

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PLoS one

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Methods: A cost-benefit analysis approach was used to estimate the program's return on investment. Administrative data were used to compute annual cost per participant. Data from the 2002–2008 Medical Expenditure Panel Survey and from the Behavioral Risk Factor Surveillance Surveys were used to estimate the costs of hospital inpatient admissions by Medicaid smokers. These were combined with earlier estimates of the rate of reduction in cardiovascular hospital admissions attributable to the tobacco cessation program to calculate the return on investment.

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Conclusions: These results suggest that an investment in comprehensive tobacco cessation services may result in substantial savings for Medicaid programs. Further federal and state policy actions to promote and cover comprehensive tobacco cessation services in Medicaid may be a cost-effective approach to improve health outcomes for low-income populations.

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Introduction

Smoking is a leading cause of preventable death in the United States, resulting in an estimated 450,000 annual premature deaths, or nearly one of every five deaths. It is responsible for roughly 30% of all cancer deaths, for nearly 80% of deaths from chronic obstructive pulmonary disease, and for early cardiovascular disease deaths [1–3]. More than one-third of the smoking-attributable years of potential life lost are related to cardiovascular disease [4]. The annual economic burden of smoking in the U.S. has been estimated at nearly $193 billion in direct medical costs and productivity losses [2]. While the life-time prevalence rate for adult smokers in the U.S. population is about 20% of this rate is about twice as high among adults insured by Medicaid [1–3]. Smoking-related medical costs are responsible for 11% of Medicaid expenditures, representing an estimated $22 billion in 2004 [5].

Federal policy has sought to reduce smoking by Medicaid beneficiaries as an important public health goal. For instance, one of the key objectives of Healthy People 2020 is to "increase comprehensive Medicaid insurance coverage of evidence-based treatment for nicotine dependency in States and the District of Columbia [6]." Considerable efforts have been made at the state level to reduce smoking. In 2009, Medicaid programs in 47 states and the District of Columbia offered at least some form of coverage for tobacco-dependence treatments, although most had a limited range of benefits [7]. The Patient Protection and Affordable Care Act will increase this coverage; it requires all states to offer comprehensive tobacco cessation services for pregnant women as of 2010 (Section 4107 of the Act) and to

cover anti-smoking medications under Medicaid by 2014 (Section 2502).

The state of Massachusetts initiated early efforts to provide comprehensive tobacco cessation medications and services to low-income Medicaid enrollees under its Tobacco Cessation & Prevention Program, starting in 2006. Under the program, with a physician's prescription, Medicaid beneficiaries could obtain FDA-approved smoking cessation medications with a copayment ranging from $1 to $3 per month. No preauthorization was required for a nicotine patch, gum or lozenge, bupropion (e.g., Zyban) or varenicline (Chantix) [8]. Massachusetts also offered up to five sessions of free telephone counseling for the state's quit line (although this was not required to get medications).

Research by Thomas Land, et al. found that this program reached a substantial share of smokers in Medicaid, achieving about a 37% use rate, and was successful in contributing to a 10% reduction in the rate of smoking by Medicaid beneficiaries [9]. Further analyses by Land, et al. examined the inpatient hospital utilization of Medicaid enrollees who used the smoking cessation benefit. The study used generalized estimating equations to examine changes in hospitalization trends among 21,656 Medicaid beneficiaries before and after the use of the tobacco cessation benefit, adjusting for demographics, comorbidities, seasonality, and other factors. On average, study participants were followed over four years, with 70 weeks in the post-benefit period. The study found that participation in the program was associated with statistically significant reductions of 46% in hospital inpatient admissions for acute myocardial infarction (AMI) ($p<.05$), 49% for coronary atherosclerosis and other heart disease ($p<.05$), and 32% for non-specific chest pain ($p<.1$), relative to the rate without the benefit [10]. There were no significant differences in hospitalizations for respiratory conditions or other seven other diagnostic groups evaluated.

In this study, we estimated the economic value of Massachusetts' tobacco cessation program's reduction on cardiovascular hospitalizations relative to program costs. We use the estimate of reductions in cardiovascular hospitalizations reported in Land's inpatient study [10]. Previous research has examined the efficacy of smoking cessation methods and found that pharmacotherapy can be a cost-effective treatment modality [11–18]. A recent study by Ladapo simulated the lifetime cost-effectiveness of a smoking counseling program for smokers hospitalized with AMI and concluded that counseling would reduce hospitalization costs but might increase lifetime healthcare costs by extending longevity [19]. In contrast, our study focuses on prevention of cardiovascular problems among smokers prior to hospitalization, primarily using pharmacotherapy, and focuses on short-term costs and savings, as opposed to lifetime cost-effectiveness. This study does not seek to measure all potential long-term savings due to the implementation of the tobacco cessation program, but represents a conservative estimate of short-term savings solely related to the avoidance of inpatient hospital admissions and treatment of cardiovascular diseases among Massachusetts Medicaid beneficiaries and smokers.

Methods

Objective

This study provides an independent estimate of cost savings and the return on investment (ROI) associated with reductions in inpatient hospital admissions for cardiovascular conditions by Medicaid beneficiaries participating in the Massachusetts Tobacco Cessation & Prevention Program from 2007 to 2009. It focuses on the costs and savings from the perspective of the Medicaid program.

Study Design and Analytical Framework

This study uses cost-benefit analysis to estimate short-term ROI of the Massachusetts tobacco cessation benefit, based on estimated program costs and savings attributable to reduced cardiovascular admissions among adult Medicaid enrollees. We used a blend of national and state data to estimate costs and savings, as described in the data section below. National data sources include the Medical Expenditure Panel Survey (MEPS), while state data include administrative program cost data, the Massachusetts Behavioral Risk Factor Surveillance System, and the Massachusetts hospital reduction estimates of Land, et al [10]. Figure 1 is a flowchart that summarizes the stages of this analysis and the data sources used at each stage.

Patient Population

The patient population is limited to Massachusetts Medicaid beneficiaries aged 18 to 64 years who are smokers. We excluded those enrolled in both Medicaid and Medicare (also known as "dual eligibles"), since most of their inpatient costs are paid by Medicare. The MEPS analytic sample included 805 Medicaid beneficiaries who are smokers. Smokers were defined as those who reported that they are current smokers as of the last year of participation in the survey.

Analytical Horizon, Perspective, and Setting of the Study

Land's study examined changes in hospital admissions in the period before and after use of tobacco cessation benefits; on average, patients were followed for 70 weeks after they began using tobacco cessation medications [10]. Thus, the time horizon of potential savings is about 1.3 years after the receipt of benefits. Our study does not seek to extrapolate longer term benefits associated with smoking reduction. Nor does it seek to extrapolate to benefits beyond reduced hospitalizations for cardiovascular conditions among Medicaid beneficiaries that smoke. Examples of benefits omitted from this analysis include benefits for other averted diseases, increases in worker productivity, and potential life years saved. It focuses on costs and savings incurred by the Medicaid program in Massachusetts.

Clinical Benefits and Economic Measures

Our primary clinical benefits are reduced admissions for certain cardiovascular diseases. Land, et al. grouped inpatient admissions into groups that had been defined by the Healthcare Utilization Project (HCUP) using clinical classification software (CCS) codes of 100 for acute myocardial infarction (AMI), 101 for coronary atherosclerosis and other heart disease, and 102 for non-specific chest pain. The same system is used in the MEPS data that we analyzed. These group codes are based on numerous specific CPT-9-CM procedure codes reported in hospital claims records and grouped by the CCS system [20]. It should be noted that non-specific chest pain may have multiple etiologies, which may include cardiovascular problems but might also include other problems, such as reflux disease or pleuritis. Following the CCS and Land, et al., we classified these as cardiovascular problems, but recognize that some could have other etiologies.

Our economic benefit data include costs to the Medicaid program for prescription drugs and counseling costs and savings due to averted inpatient admissions. All costs and savings were converted to 2010 dollars using medical price inflation data from the Bureau of Labor Statistics.

Data Sources

A variety of data sources were used. Administrative data on program costs were used to compute the annual average cost per

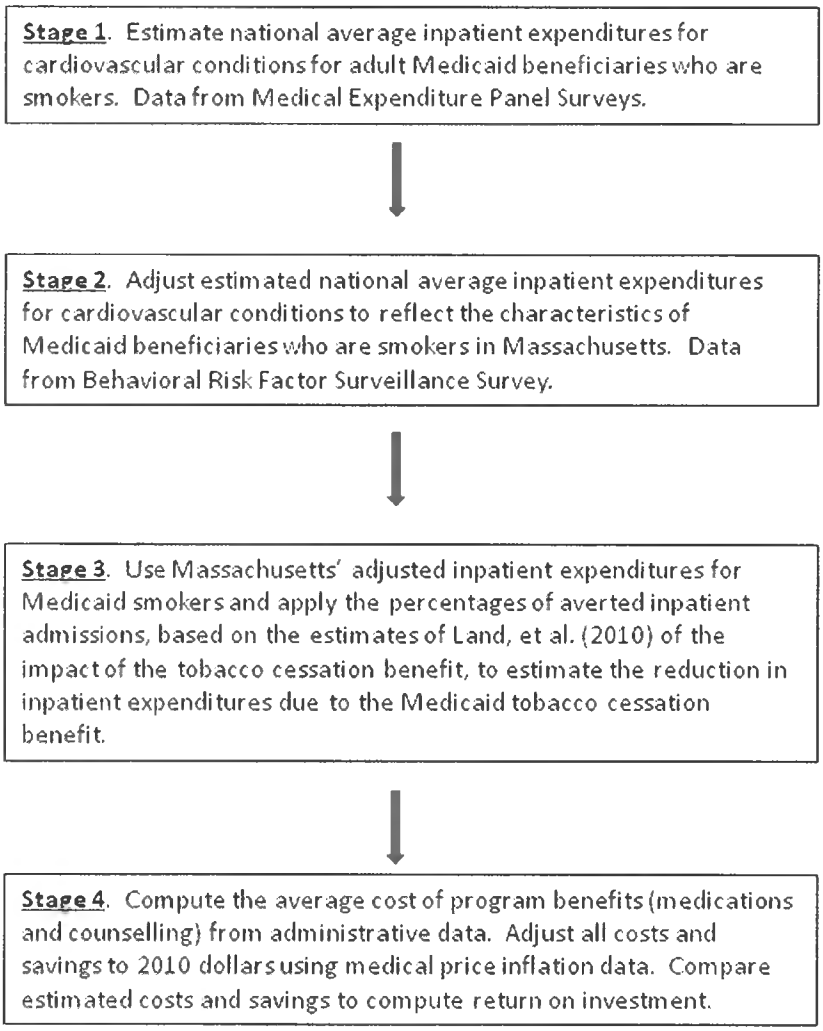

Figure 1. Flowchart summarizing the analyses.
doi:10.1371/journal.pone.0029665.g001

patient in implementing the program. Data on program costs for fiscal years 2007, 2008, and 2009 were provided by the Massachusetts Tobacco Cessation & Prevention Program, based on Medicaid (known as MassHealth in Massachusetts) administrative cost data. These included the cost of pharmacotherapy, counseling, and program outreach and promotion for fiscal years 2007, 2008, and 2009.

To compute the economic value of program benefits such as averted hospital inpatient admissions we used data from the *Medical Expenditure Panel Survey (MEPS). To increase the sample size of the study we pooled data from the 2002–8 MEPS. MEPS is a nationally representative survey of non-institutionalized individuals conducted by the Agency for Healthcare Research and Quality. It is a widely used survey* that collects information on socio-demographic characteristics, health services use, health conditions, access to care, health insurance coverage, medical expenditures, sources of payment, and income for each person surveyed, drawn both from surveys of individuals and health care providers. *We restricted* the analytic sample to unique individuals reported as 18 to 64 year old Medicaid beneficiaries who were current smokers. The MEPS longitudinal design allows repeated observations on the same individuals several times during the year. By restricting the sample to unique individuals we were able to compute robust *standard errors*. The MEPS data reflect a national sample of Medicaid smokers and is one of the few data sets that contain expenditures. (It is worth noting that we could not obtain hospital savings from administrative data; a substantial share of the hospital data from Massachusetts was from managed care systems and lacked cost or expenditure data.)

To adjust the results of the models to reflect the characteristics of adult Medicaid beneficiaries and smokers living in Massachusetts, we used data from the Massachusetts Department of Health's Behavioral Risk Factor Surveillance Survey (BRFSS) for 2007–9. The BRFSS does not contain data on medical expenditures. The state BRFSS survey includes some questions not included in other states' BRFSS data that permits identification of Medicaid smokers. We also used the Consumer Price Index for inpatient hospital data from the Bureau of Labor and Statistics (BLS) to inflate program costs and economic value of program benefits to 2010 dollars.

Analytical Approach and Models

Figure 1 summarizes the overall flow of analyses in this paper. For the first stage, *we estimated expenditure models for inpatient hospital expenditures for cardiovascular conditions for adult Medicaid beneficiaries who*

are smokers, using MEPS data. To specify the model, we used a modified version of Aday and Andersen's behavioral model of factors affecting health utilization [21]. This model hypothesizes that *utilization* depends on predisposing, enabling and health need factors. The predisposing factors included age, race/ethnicity, gender and marital status. The enabling factors included income as a percent of poverty, educational attainment and health insurance status. Health need factors included self-reported health status (fair or poor health), whether the respondent exercised and obesity status. We also included geographic factors that may affect use of care, including rural/urban status and Census region.

To test the robustness of the models, we tested different specifications. We estimated a version including having a diagnosis of diabetes as an additional health factor and a version with diabetes and hypertension. These variables were not significant in any of the models, so we reverted to our base models.

There are two well-recognized econometric problems in estimating medical expenditures. The first is that there are many zero observations leading to systematic differences in characteristics between patients with zero expenditure compared to those with positive expenditures. The second problem is that medical expenditures are highly skewed because a subset of patients with positive expenditures has very large expenditures [22–23]. Two-part models that take into consideration patients with zero expenditures and patient with positive expenditures are typically used to address the problem of many zero observations. However, in our case, we only look at those who have inpatient admissions and virtually all have non-zero expenditures. Hence, there is no need to use the first part of the two-part model, usually logistic or probit regressions, to account for the probability of using any medical care.

To address the skewness in expenditures, we used log-transformed generalized linear models (GLM) with log link and Gamma distribution to estimate direct hospital inpatient expenditures associated with cardiovascular services noted above by adult Medicaid beneficiaries who are also smokers. The log link was incorporated into the model specifically to address the skewness observed in the expenditures data. We developed several models to predict total healthcare expenditures and conducted sensitivity analyses for robustness. We used the diagnostic and specification tests recommended by Manning and Mullahy to select the final models [24]. Final models were adjusted for MEPS' complex survey design and weighting, using the survey design adjustment procedures in Stata 11.

The expenditure models using MEPS data reflect characteristics of Medicaid smokers nationwide. In order to calibrate our estimates to more closely correspond to Massachusetts residents, we then used data from the Massachusetts BRFSS to identify characteristics of adult Medicaid beneficiaries in Massachusetts. We then adjusted our expenditure estimates based on the demographic, socioeconomic, access, behavioral, health status and health condition variables of Massachusetts Medicaid smokers (see Table 1).

After that stage, we computed cost savings associated with inpatient expenditures related reductions in AMI, acute coronary heart disease, and non-specific chest pain among Medicaid smokers. Costs were based on administrative data provided by Massachusetts officials. All program costs and estimated savings were inflated to 2010 dollars using the Consumer Price Index for inpatient hospital costs from the Bureau of Labor Statistics.

We computed the return on investment (ROI) as:

$$ROI = \frac{Averted\ cost\ of\ hospitalization - Program\ cost}{Program\ cost}$$

That is, any ROI greater than zero means that more was saved (or gained) than was spent on the initiative.

To assess the uncertainty of the estimates, we computed different levels of ROI by using the 95% confidence intervals of the predicted expenditures for the noted cardiovascular conditions by adult Medicaid smokers into account. This enabled us to compute low, medium and high estimates of the potential savings due to reduced cardiovascular admissions.

Results

Descriptive Statistics

In our initial analyses of the 2002–8 MEPS data, 98% of adult Medicaid smokers 18 to 64 who had inpatient hospital admissions also had hospital expenditures reported. (We believe that the 2% without expenditures are due to the fact that MEPS does not report expenditures in cases where certain hospitals provide care without charge, on a "charity" basis.) The average expenditure for a Medicaid smoker's admission was $13,950. However, the average adult hospital in-patient in the U.S. spent about $28,691 with AMI diagnoses, $9,828 for coronary atherosclerosis and other heart disease, and $6,874 for non-specific chest pain.

Table 1 compares the characteristics of the overall sample of adult Medicaid beneficiaries who were smokers at the national level (based on MEPS data) and in Massachusetts (based on BRFSS data), regardless of whether they had an inpatient admission. A slightly higher proportion of Medicaid beneficiaries residing in Massachusetts were admitted for hospital inpatient services for AMI and coronary atherosclerosis and other heart disease, compared to the national average. But these differences were small and not significant. Other socio-demographic characteristics of Massachusetts Medicaid beneficiaries were similar to the national average, except that there were a higher proportion of males among Medicaid smokers compared to the national average. A higher proportion of Massachusetts residents had higher incomes or were college graduates, compared to adults at the national level, probably because Massachusetts has more generous Medicaid eligibility than most other states. In terms of behavioral factors, Massachusetts residents exercised more and reported a lower percentage of adults with obesity compared to the U.S. (though the lower percentage of adults with obesity was offset by higher rates over overweight). Similarly, those in the Massachusetts Medicaid program were more likely to report that they were in excellent, very or good health, and less likely to report diabetes and hypertension than those at the national level.

Program Costs

As indicated in Table 2, $20,178,210 was spent for medications or counseling under the state's Tobacco Cessation and Prevention Program from FY 2007 to 2009, representing an average of $6,726,070 per year. Additionally, $558,500 was spent on program's promotion and outreach during the three years, representing an average of $186,167 annually. A total of 550,067 individuals who were between 18 and 64 years old participated in the state's Medicaid program during fiscal years 2007–2009, of which 188,123 (34.2%) were identified as smokers. Over 75,000 unique Medicaid beneficiaries participated in the tobacco cessation program during the three-year period. During 2007–9, an annual average of 37,762 participants who were smokers used medications or counseling services. The annual average cost per user of medication and counseling services was $178; an additional $5 was spent on program outreach and promotion. In sum, a total of $183 was spent annually per user to implement the program from 2007–2009.

Table 1. Descriptive Characteristics of 18–64 Year Old Medicaid Beneficiaries Who are Current Smokers.

Variables	U.S. (from MEPS)	Massachusetts (from BRFSS)
Percent Admitted to Hospital by Diagnosis Group		
Acute myocardial infarction	1%	3%
Coronary atherosclerosis & other heart disease	1%	2%
Non-specific chest pain	3%	3%
Demographic Variables		
Mean Age	37.4 years	34.5 years
Gender		
Male	29%	42%
Female	71%	57%
Race/Ethnicity		
White	69%	66%
Hispanic	10%	17%
Black or African American	20%	9%
Asian	1%	1%
Marital status		
Married	27%	33%
Divorced	23%	15%
Widowed	3%	2%
Separated	6%	4%
Never married	47%	44%
Socioeconomic Status		
Income as % of Poverty		
0–100% of poverty	61%	63%
100–200% of poverty	23%	22%
200–400% of poverty	12%	9%
Over 400% of poverty	0.04	0.06
Education		
Less than high school degree	44%	24%
High school graduate	53%	66%
College graduate or more	03%	10%
Behavioral Variables		
No physical activity	59%	32%
Physical Activity	41%	68%
Normal weight	41%	39%
Overweight	24%	35%
Obese	35%	23%
Health Status		
Excellent/Very good/Good	54%	72%
Fair/Poor	46%	30%
Morbidity		
No diabetes	85%	94%
Diabetes	15%	6%
No Hypertension	69%	80%
Hypertension	31%	20%
Residence/Region		
Non-Metropolitan Statistical Area	22%	
Metropolitan Statistical Area	78%	

doi:10.1371/journal.pone.0029665.t001

Table 2. Program Costs for Adult Medicaid Smokers Who Participated in the Tobacco Cessation Program during Fiscal Years 2007–2009 (US $ 2010).

Category of Services	Total Program Costs	Annual Average Total Costs	Annual Average Number of Users	Annual Average Cost per User
Medications & counseling	$20,178,210	$6,726,070	37,762	$178
Program outreach and promotion	$558,500	$186,167	—	$5
Total	$20,736,710	$6,912,237	37,762	$183

Source: Based on authors' calculations using data from MassHealth, Office of Clinical Affairs.
doi:10.1371/journal.pone.0029665.t002

Economic Value of Hospital Inpatient Admissions for Cardiovascular Conditions

As shown in Table 3, results from expenditure models that were calibrated using characteristics of Medicaid smokers in Massachusetts showed adjusted inpatient expenditures of $26,044 for AMI (95% confidence interval from $25,026 to $27,060), of $12,760 for coronary atherosclerosis and other heart disease (95% confidence interval from $12,260 to $13,258) and $7,367 for non-specific chest pain (95% confidence interval from $7,086 to $7,647). The models were adjusted for socio-demographic, socio-economic, access, behavioral, health status and health condition variables of Massachusetts Medicaid smokers, as described in the methods section.

To compute the economic value of averted hospital inpatient admissions for cardiovascular conditions by adult Medicaid smokers in Massachusetts (or the benefits of the program), we multiplied the adjusted inpatient expenditures of the each of the conditions by their corresponding rate of reductions in hospital inpatient admissions estimated by Land et al [10]: AMI (46%), coronary atherosclerosis and other related conditions (49%) and non-specific chest pains (32%). Subsequently, we multiplied each of the respective results by the rate of hospital inpatient admissions among Medicaid smokers in Massachusetts, as reported in BRFSS (3% for AMI, 2% for coronary atherosclerosis, 3% for non-specific chest pain). As indicated in Table 4, we found that the economic value of averted hospital inpatient admissions for cardiovascular conditions per adult Medicaid smoker in Massachusetts ranged from $368 to $398 for AMI, from $113 to $117 for coronary atherosclerosis and other heart disease, and from $68 to $78 for non-specific chest pain. This resulted in total program benefits per adult Medicaid smokers in Massachusetts user of $571, ranging from $549 to $593.

Net Savings and Return on Investment

As reported in Table 5, we estimated net annual savings of $388 (ranging from $366 to $410) per user in Massachusetts, compared to program costs of $183 per user. This leads to an annual average ROI per adult Medicaid smoker in Massachusetts of $2.12, with a range from $2.00 to about $2.25. In other words, each $1 spent on medications and counseling, and promotion and outreach for Medicaid smokers was associated with a reduction of $3.12 (range $3.00 to $3.25) in Medicaid expenditures for cardiovascular hospital admissions, resulting in net savings between $2.00 and $2.25.

As noted earlier in this paper, it is possible that some of the admissions due to non-specific chest pain are not actually due to cardiovascular conditions, but disorders like reflux disease or pleuritis. Even if we net out these savings related to non-specific chest pain, the estimated ROI remains highly positive, ranging from $1.63 to $1.84.

Table 3. Estimated (Adjusted) Annual Average Expenditures Per Inpatient for Cardiovascular Conditions for Adult Medicaid Smokers in Massachusetts (US $ 2010).

Cardiovascular conditions	Low	Midpoint	High
Acute myocardial infarction	$25,026	$26,044	$27,060
Coronary atherosclerosis	$12,260	$12,760	$13,258
Non-specific chest pain	$7,086	$7,367	$7,647

doi:10.1371/journal.pone.0029665.t003

Discussion

The current study advances the literature on the economic evaluation of smoking cessation programs at the state level in the United States. Findings from this study indicate that a well-promoted program of comprehensive access to tobacco medications and counseling implemented in Massachusetts was cost beneficial. Over an average of 70 weeks after beginning to use smoking cessation medications, Medicaid beneficiaries experienced fewer hospital admissions due to cardiovascular conditions, leading to a net annual savings of $366 to $410 per Medicaid user or an ROI of $2.00 to $2.25 during the period of 2007–2009. These results were adjusted for an extensive set of control variables and the findings were robust to different model specifications.

This study has strengths and limitations. In terms of strengths, the study used detailed administrative data about program costs and relied on estimates of reductions in hospital admissions based on detailed hospital data analyzed by Land, et al [10]. Because we lacked actual administrative data on the costs of hospitalizations averted, we used a comprehensive national data set (MEPS) to estimate the costs of cardiovascular hospital admissions among adult Medicaid smokers. To control for

Table 4. Estimated Annual Value of Averted Hospital Inpatient Admissions for Cardiovascular Conditions Per User in Massachusetts (US $ 2010).

Cardiovascular Conditions	Low	Midpoint	High
Acute myocardial infarction	$368	$383	$398
Coronary atherosclerosis	$113	$117	$122
Non-specific chest pain	$68	$71	$68
Total	**$549**	**$571**	**$593**

doi:10.1371/journal.pone.0029665.t004

Table 5. Estimated Net Annual Savings Per User and Estimated Return on Investment Associated with Reduced Cardiovascular Admissions among Medicaid Smokers in Massachusetts (US $ 2010).

	Low	Midpoint	High
Net annual savings	$366	$388	$410
Return on investment	**$2.00**	**$2.12**	**$2.25**

doi:10.1371/journal.pone.0029665.t005

variations in the factors associated with expenditures, we controlled for an extensive set of demographic and health characteristics and then calibrated these to correspond the risk profile of Medicaid smokers in Massachusetts, using the BRFSS data. Our study is also limited by the limitations of Land's study [10] which generated estimates of reductions in hospitalization among Medicaid beneficiaries. That paper discussed its limitations, notably the use of claims data as a proxy for health events and of the receipt of the tobacco cessation benefit as a proxy for actual smoking cessation.

A key limitation of our analysis is that we assume that actual hospital savings are equivalent to the average costs per admission multiplied by the number of averted hospital admissions. This may introduce error in two ways. First, it is possible that averted admissions occur among either healthier or sicker patients who have lower (or higher) inpatient expenditures. If, for example, admissions were only averted among healthier patients, more expensive patients would still be admitted and our estimates would overstate cost savings. The second source of error is that in addition to reducing admissions, tobacco cessation programs may reduce the severity of problems among those admitted. In this case, there would be additional savings through the result of reduces expenditures even among those who were hospitalized, which our study has not captured. Our inclusion of a range of hospital expenditures, based on the confidence intervals incorporates some of the uncertainty about the actual savings and the heterogeneity of patient health.

Results from this study are consistent with previous research which has indicated the efficacy and cost-effectiveness of certain drug therapies in reducing smoking and the health benefits of smoking cessation. In particular, it has focused on reductions in medical expenditures related to hospitalizations for cardiovascular disease. It did not measure the long-term or lifetime impacts on medical expenditures. On the other hand, prior analyses have suggested that smoking cessation may be the most cost-beneficial long-term strategy for the reduction of the burden of cardiovascular disease in the United States [25].

Conclusions and Policy Recommendations

A disproportionate number of smokers in the United States are low-income and insured by Medicaid. Findings from Land, et al. [9–10] and from this study suggest that comprehensive tobacco cessation efforts can reduce the prevalence of smoking in a high risk population and reduce net costs for the Medicaid program. This analysis focused solely on medical care savings resulting from reduced cardiovascular admissions among program participants. For example, it did not estimate potential health improvements or savings that might be associated with reduced second hand smoke exposure for family members or intrauterine exposure from pregnant smokers. Nor did it consider other potential savings, such as the reduced burden to low-income families from the cost of purchasing cigarettes or the potential for improved productivity and confidence associated with quitting smoking.

It is well understood that it is difficult to stop smoking and that while many may successfully quit in the short- term, there is a substantial risk of recidivism. While we cannot be assured that Medicaid beneficiaries who quit smoking remain abstinent in the long run, there appear to be near-term reductions in smoking rates that lead to near-term Medicaid savings within the following year or so. These are conservative estimates given that we only measured short-term benefits associated with reductions in inpatient hospital admissions due to cardiovascular conditions. But program administrators are often most interested in near-term savings, since they do not know how long beneficiaries will remain covered by Medicaid and because fiscal concerns lead to pressure for near-term savings.

Both the federal and state governments share in the costs and savings related to stronger tobacco cessation efforts for Medicaid beneficiaries. Although both the federal and state governments are under substantial budgetary pressure, this research suggests that further investments in comprehensive tobacco cessation under Medicaid would be a sound investment that reduces medical expenditures relatively quickly. As noted earlier, the Patient Protection and Affordable Care Act already includes efforts to strengthen tobacco cessation services in Medicaid, including mandatory coverage of comprehensive services for pregnant women and enhanced coverage of pharmacotherapy for smoking cessation. Moreover, Medicaid coverage is scheduled to expand to serve millions of additional low-income non-elderly adults in 2014 [26]. Thus, tobacco cessation services in Medicaid could soon be offered to a much larger share of the low-income smoking population.

Despite the budgetary problems faced by Medicaid program administrators and state and federal officials, efforts to implement comprehensive tobacco cessation programs for Medicaid enrollees (not just those who are pregnant) may be an element of evidence-based policy to both improve public health and reduce health care expenditures. Because Medicaid provides health insurance coverage, including coverage for preventive services, for a very large share of a high-risk, low-income population, public health objectives include recommendations for comprehensive smoking cessation coverage under Medicaid [4]. Research concerning the efficacy and cost-effectiveness of these initiatives to encourage smoking cessation may provide valuable information to policymakers and researchers alike. Additionally, cost-effectiveness studies that account for heterogeneity in populations of smokers are needed to provide important information to policymakers and other key stakeholders.

Acknowledgments

We gratefully acknowledge the input and information shared by Thomas Land of the Office of Statistics and Evaluation, Bureau of Community Health and Prevention, Massachusetts Department of Health, and Mark Paskowsky and Lois Keithly of the Massachusetts Tobacco Cessation and Prevention Program, Massachusetts Department of Health. Without their groundbreaking efforts, this research could not have been done. We also acknowledge advice and encouragement from David Zauche of the Partnership for Prevention, and Diane Canova and Ripley Forbes (previously with the Partnership for Prevention) and Katie Horton of George Washington University.

Author Contributions

Analyzed the data: PR KW LK. Wrote the paper: PR LK.

References

1. Centers for Disease Control and Prevention (2010) Vital signs: Current cigarette smoking among adults aged ≥18 years—United States, 2009. MMWR 59(35): 1135–1140.
2. Centers for Disease Control and Prevention (2009) State-specific smoking-attributable mortality and years of potential life lost—United States, 2000–2004. MMWR 58(02): 29–33.
3. Centers for Disease Control and Prevention (2009) Adult cigarette smoking in the United States: current estimate. Available: http://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm. Accessed 2011 Aug 05.
4. Centers for Disease Control and Prevention (2008) Smoking-attributable mortality, years of potential life lost, and productivity losses – United States, 2000–2004. MMWR 57(45): 1226–28.
5. Armour BS, Finkelstein EA, Fiebelkorn IC (2009) State-level Medicaid expenditures attributable to smoking. Prev Chronic Dis 6(3): 1–10.
6. Office of the Surgeon General. Healthy People 2020: Summary of Objectives. Available: http://www.healthypeople.gov/2020/topicsobjectives2020/pdfs/TobaccoUse.pdf. Accessed 2011 Aug 09.
7. McMenamin SB, Halpin HA, Ingram M, Rosenthal A (2010) State Medicaid coverage for tobacco-dependence treatments — United States, 2009. MMWR 59(41): 1340–1343.
8. Massachusetts Tobacco Cessation Program. MassHealth Tobacco Cessation Program: Factsheet for Providers. No date. Available: http://quitworks.makesmokinghistory.org/uploads/section_quitworks/masshealth/ProviderFactSheet_ServiceRates.pdf. Accessed 2011 Nov 11.
9. Land T, Warner D, Paskowsky M, Cammaerts A, Wetherell L, et al. (2010) Medicaid coverage for tobacco dependence treatments in Massachusetts and associated decreases in smoking prevalence. PLoS ONE 5: e9770. doi:10.1371/journal.pone.0009770.
10. Land T, Rigotti N, Levy D, Paskowsky M, Warner D, et al. (2010) A longitudinal study of Medicaid coverage for tobacco dependence treatments in Massachusetts and associated decreases in hospitalizations for cardiovascular diseases. PLoS Med 7(12): e1000375. doi:10.1371/journal.pmed.1000375.
11. Fiore MC, Jaén CR, Baker TB, Bailey W, Benowitz N, et al. (2008) Treating tobacco use and dependence: quick reference guide for clinicians, 2008 update. US Department of Health and Human Services.
12. Hajek P, Stead LF, West R, Jarvis M, Lancaster T (2009) Relapse prevention interventions for smoking cessation. Cochrane Database System Rev (1): CD003999.
13. Nides M (2008) Update on pharmacologic options for smoking cessation treatment. Am J Med 121(4 Suppl 1): S20–31.
14. Stead LF, Perera R, Bullen C, Mant D, Lancaster T (2008) Nicotine replacement therapy for smoking cessation. Cochrane Database Syst Rev;1): CD000146.
15. Gonzales D, Rennard SI, Nides M, Oncken C, Azoulay S, et al. (2006) Varenicline, an a4b2 nicotinic acetylcholine receptor partial agonist, vs sustained release bupropion and placebo for smoking cessation: a randomized controlled trial. JAMA 296(1): 47–55.
16. Keating GM, Lyseng-Williamson KA (2010) Varenicline: a pharmacoeconomic review of its use as an aid to smoking cessation. Pharmacoeconomics 28(3): 231–54.
17. Jorenby DE, Leischow SJ, Nides MA, Rennard SI, Johnston JA, et al. (1999) A controlled trial of sustained-release bupropion, a nicotine patch, or both for smoking cessation. N Engl J Med 430(9): 685–91.
18. Zimovetz E, Wilson K, Samuel M, Beard S (2011) A review of cost-effectiveness of treatment for major smoking-related morbidities. J Eval Clin Pract 17(2): 288–97.
19. Ladapo J, Jaffer F, Weinstein M, Froelicher E (2011) Projected cost-effectiveness of smoking cessation interventions in patients hospitalized with myocardial infarction. Arch Intern Med 171(1): 39–45.
20. Agency for Healthcare Research and Quality (2011) HCUP Clinical Classification Software. Appendix A. Single Diagnosis Codes. Revised Oct. 28, 2011. Available: http://www.hcup-us.ahrq.gov/toolssoftware/ccs/AppendixASingleDX.txt. Accessed 2011 Nov 11.
21. Aday LA, Andersen R (1974) A framework for the study of access to medical care. Health Serv Res 9(3): 208–220.
22. Duan N, Manning W, Morris C, Newhouse J (1983) A comparison of alternative models for the demand for medical care. J Bus & Econ Stat 1(2): 115–26.
23. Buntin M, Zaslavsky A (2004) Too much ado about two-part models and transformation? Comparing methods of modeling Medicare expenditures. J Health Econ 23: 525–42.
24. Manning WG, Mullahy J (2001) Estimating log models: to transform or not to transform? J Health Econ 20(4): 461–494.
25. Kahn R, Robertson R, Smith R, Eddy D (2008) The impact of prevention on reducing the burden of cardiovascular disease. Circulation 118: 576–85.
26. Ku L (2010) Ready, set, plan, implement: Executing Medicaid's expansion. Health Aff (Millwood) 29(6): 1173–77.

ALASKA STATE LEGISLATURE

Representative Bob Herron

State Capitol
(907) 465-6576
Rep.Bob.Herron@legis.state.ak.us

House District 38
Kuskokwim and Johnson Rivers
Kuskokwim and Nelson Island

MEMORANDUM

DATE: 28 March 2011

TO: Representative Wes Keller, Chair of House Health and Social Services

CC: Janet Ogan, Committee Aide for House Health and Social Services

FROM: Representative Bob Herron

RE: House Bill 209

Please accept my request for a hearing on House Bill 209, "an Act requiring a health care insurer to provide coverage for tobacco cessation treatment" in House Health and Social Services.

House Bill 209 requires that insurance companies provide tobacco cessation treatment to addicts seeking help in ending addiction. This bill gives Alaskans the resources and support they need to end tobacco addiction by requiring insurance companies to provide smoking cessation programs and treatment. With the implementation of House Bill 209, insurance companies would provide coverage for a minimum of two courses of treatment during each year as well as over the counter or prescription medications approved by the U.S.F.D.A. Two courses of treatment allow for multiple attempts for those smokers who continue to work towards ending addiction. Coverage provides for not less than four counseling sessions in each course of treatment as well as over the counter or proscribed medication.

Counseling is not a precondition for receiving medication, therefore patients may tailor treatment plans and methods for individual needs. Also, coverage for treatment may not require preauthorization or require a referral.

This bill provides the assistance many Alaskans need to end tobacco addiction and live healthy, long, productive lives. The long term effects of House Bill 209 will be cost savings in medical expenditures, increased productivity in the work place, lower long-term insurance costs for insurance providers, and healthier, happier Alaskans.

Feel free to contact myself or Jane Boer (465-6576) with any further questions you may have and/or requests for additional information.

ALASKA STATE LEGISLATURE

Representative Bob Herron

State Capitol
(907) 465-6576
Rep.Bob.Herron@legis.state.ak.us

House District 38
Kuskokwim and Johnson Rivers
Kuskokwim and Nelson Island

SPONSOR STATEMENT

"An act requiring a health care insurer to provide coverage for tobacco cessation treatment."

Tobacco dependence is a chronic and lasting condition that negatively affects the health, productivity, and overall well being of Alaskans and their loved ones.

Statistics show that tobacco is a leading cause of death in Alaska. Tobacco addiction kills more Alaskans each year than suicide, motor vehicle crashes, chronic liver disease and cirrhosis, homicide, and HIV/AIDS combined. In 2007, tobacco use cost Alaskans $314 million in direct medical expenditures and an additional $177 million in lost productivity due to tobacco-related deaths.[1]

This bill gives Alaskans the resources and support they need to end tobacco addiction. It requires insurance companies to provide smoking cessation programs to aid those who wish to be free from tobacco addiction. With the implementation of House Bill 209, insurance companies would provide coverage for a minimum of two courses of treatment during each year. Two courses allow for multiple attempts for those smokers who continue to work towards ending addiction. Coverage provides for not less than four counseling sessions in each course as well as over the counter or proscribed medication approved by the USFDA.

While coverage includes both counseling and medication, counseling is not a precondition for medication so that treatment is flexible to personal preferences. Data show that programs where participants may tailor treatment to personal preferences and needs are the most effective.

This bill provides the assistance many Alaskans need to end tobacco addiction and live healthy, long, productive lives. The long term effects of House Bill 209 will be cost savings in medical expenditures, increased productivity in the work place, lower long-term insurance costs for insurance providers, and healthier, happier Alaskans.

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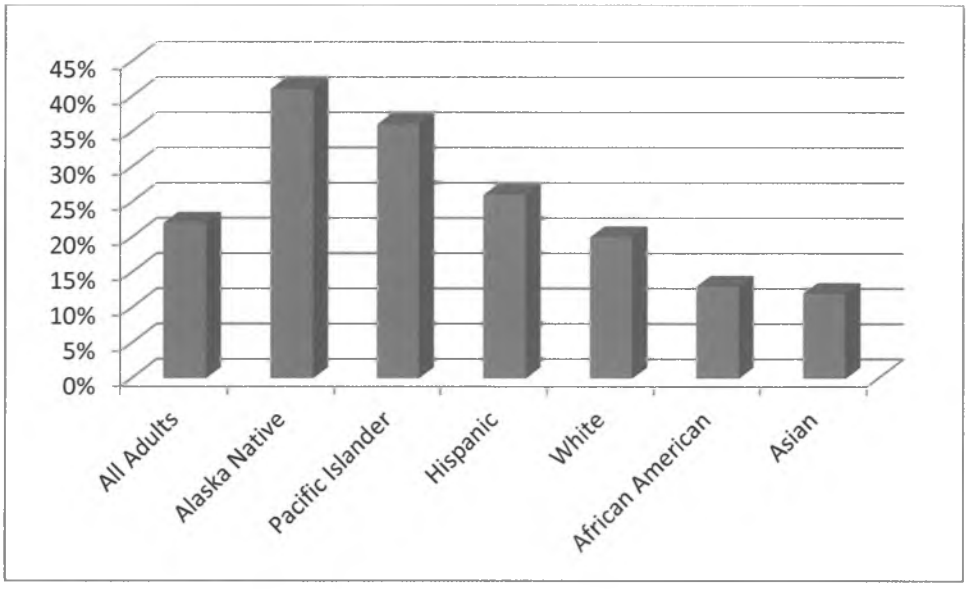
[1] Alaska Tobacco Facts, 2009 Update. September, 2009
http://www.hss.state.ak.us/DPH/chronic/tobacco/alaska_tobacco_facts.pdf

SUPPORTING DATA

- A recent article in the Associated Press outlines findings that more people smoke and die young in Alaska than the rest of America. The percentage of people who smoke nationally is estimated at 15%; however in Anchorage the percentage of people who smoke is 19%.[1]
- In 2007, tobacco use cost Alaskans $314 million in direct medical expenditures and an additional $177 million in lost productivity due to tobacco-related deaths[2]
- Alaskan Native adults are twice as likely to smoke as non-native adults
- Alaskans with less education, with lower incomes, and who live in rural areas of the state also smoke more than their peers
- The majority of Alaskan adults who currently smoke want to quit; three out of five tried to quit in the last 12 months
- Tobacco addiction kills more people in Alaska per year than suicide, motor vehicle crashes, chronic liver disease and cirrhosis, homicide, and HIV/AIDS combined
- An additional estimated 120 Alaskans die each year from lung cancer and heart disease caused by exposure to secondhand smoke
- In total, $491 million is lost due an estimated $314 million annually in direct medical expenditures and an additional $177 million annually in lost productivity due to tobacco-related deaths. (Lost productivity due to tobacco-related illness and costs due to second-and smoke exposure related illness or death are not included)

Percentage of Smokers by Race



[1] "Report: Smoking, drinking more common in Alaska." *The Associated Press.* 30 March 2011. http://juneauempire.com/state/2011-03-30/report-smoking-drinking-more-common-alaska

[2] Alaska Tobacco Facts, 2009 Update. September, 2009 http://www.hss.state.ak.us/DPH/chronic/tobacco/alaska_tobacco_facts.pdf

- Alaskan natives are twice as likely to smoke as non-natives
- Smoking prevalence has remained relatively stable among Alaska natives over the past decade; among non-Native adults, there has been a small but significant decrease in smoking from 1996 to 2007

Percentage of Smokers by Region

Region	Percentage
North/Interior	36%
Southwest	34%
Mat-Su Borough	26%
Fairbanks	22%
Gulf Coast	20%
Anchorage Borough	20%
Southeast	19%
All Adults	22%

Regional Definitions:

- Anchorage Borough
- Mat-Su Borough
- Gulf-Coast – Kenai, Kodiak, and Valdez Cordova Boroughs and Census Areas (as well as part of Denali)
- Southeast – Yakutat, Skagway, Juneau, Sitka, Haines, Wrangell-Petersberg, Ketchikan Gateway Boroughs and Census Areas
- Fairbanks – (North Star) – Fairbanks North Star Borough
- North/Interior – Nome, Northwest Arctic, North Slope, Yukon-Koyukuk, Southwest Fairbanks, and Denali Boroughs and Census areas
- Southwest – Bristol Bay, East Aleutians, West Aleutians, Dillingham, Lake and Peninsula, Bethel, and Wade Hampton Boroughs and Census Areas (plus part of Yukon-Koyukuk)

Percentage of Adults Who Smoke, by Socio-Economic Status and Race, Alaska, 2005-2007[3,4]

SES Status*	Alaska natives	Alaska Non-Natives	Total
Lower	48%	34%	38%
Higher	33%	16%	18%
All Adults	41%	20%	22%

*Lower SES is calculated as those persons with less than a high school or less than 185% of the Alaska Poverty Level Guideline

[3] Alaska Tobacco Facts, 2009 Update. September, 2009
http://www.hss.state.ak.us/DPH/chronic/tobacco/alaska_tobacco_facts.pdf

[4] Source: Alaska Behavioral Risk Factor Surveillance System, combined Modified and Standard BRFSS Surveys

- Nearly half (42%) of adult smokers live in households earning less than 185% of the Alaska Poverty Level Guideline
- Although unemployed adults and those who are unable to compromise about 11% of the overall adult population, they are disproportionately likely to smoke; 43% of unemployed adults and 46% of those who are unable to work are smokers, compared to 20% of employed adults who smoke

Alaskans Covered by Percentage[5]

Based on health coverage of the Alaskan population, approximately 49% of Alaskan's would be affected by the passage of this mandate. Per statistics provided by the Division of Insurance, approximately 34% of Alaskans are self-insured, and 15% of Alaskans are insured through state regulations. Remaining Alaskans are covered by Medicaid, Medicare, IHS, the military, or are uninsured. Those Alaskans who are self-insured or are insured through state regulated insurance may be affected by this mandate and would therefore have access to tobacco cessation treatment.

[5] A chart showing the health care coverage of the Alaskan population is available upon request. The origins of these statistics are from the Division of Insurance and were obtained through Premera in 2010.

HOUSE BILL NO. 209

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES HERRON, Kerttula

Introduced: 3/25/11
Referred: Health and Social Services, Labor and Commerce

provide a policy

A BILL

FOR AN ACT ENTITLED

"An Act requiring a health care insurer to provide coverage for tobacco cessation treatment."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.420. Coverage for tobacco cessation treatment. (a) A health care insurer that offers, issues for delivery, delivers, or renews a health care insurance plan in the state shall provide coverage for a minimum of two courses of tobacco cessation treatment during each plan year.

(b) Coverage for a course of tobacco cessation treatment must include the cost of

(1) not less than four tobacco cessation counseling sessions provided by a qualified counselor, which may be provided by telephone or in person in a group or individual setting, and which must last not less than 10 minutes a session; and

(2) over-the-counter medication or prescribed medication approved by

other mandates do same coverage?

SUBSTANCE ABUSE coverage

the United States Food and Drug Administration for tobacco cessation treatment.

(c) Coverage for tobacco cessation treatment may not

(1) require an insured individual to obtain preauthorization from the health care insurer before receiving treatment;

(2) ~~require a referral~~ from a health care provider to participate in tobacco cessation treatment;

(3) require an individual to participate in a counseling session in order to receive coverage for medication;

(4) include treatment or financial requirements that are more restrictive than the financial limitations or conditions applicable to the medical or surgical ~~benefits~~ under the policy, including limitations on payments, deductible, or copayment amounts.

*** Sec. 2.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. AS 21.42.420, enacted by sec. 1 of this Act, applies to a health care insurance plan offered, issued for delivery, delivered, or renewed after the effective date of this Act.

HOUSE BILL NO. 209

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES HERRON, Kerttula

Introduced: 3/25/11
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Online Services / t real- Chantex # -

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— when did we start to pay for over the counter Drugs ? — for bad — to start this

New Text Underlined [DELETED TEXT BRACKETED]

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27-LS0620\A.1
Bailey
2/13/12

AMENDMENT

OFFERED IN THE HOUSE

TO: HB 209

Page 1, line 1:

Delete "**provide**"

Insert "**offer**"

Page 1, line 7:

Delete "provide"

Insert "offer"

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

Bill Version: **HB 209**
Fiscal Note Number:
() Publish Date:

Identifier (file name): HB209-DCCED-INS-12-28-11
Title: Insurance Coverage for Tobacco Cessation
Sponsor: Representative Herron
Requester: House Health and Social Services

Dept. Affected: DCCED
Appropriation: Insurance
Allocation: Insurance
OMB Component Number: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Commodities	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts							
1003	GF Match							
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
TOTAL		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Initial version updated on new form for the 2012 Legislative Session.

Prepared by: Linda S. Hall, Director — Phone: 907-465-2560
Division: Insurance — Date/Time: 12/28/11 10:00 AM
Approved by: Susan K. Bell, Commissioner — Date: 1/5/2012
Commerce, Community, and Economic Development

(Revised 11/28/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. HB 209

Analysis

HB 209 requires that a health care insurer who offers, issues for deliver, delivers, or renews health care insurance in the state shall provide coverage for a minimum of two courses of tobacco cessation treatment during each plan year.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number
Bill Version **HB 209**
() Publish Date

Identifier (file name) HB209-DCED-INS-04-06-11
Title Insurance Coverage for Tobacco Cessation
Sponsor Representative Herron
Requester House Health and Social Services

Dept. Affected DCCED
Appropriation Insurance
Allocation Insurance
OMB Component Number 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version

Initial Version

Prepared by Linda S. Hall, Director
Division Insurance
Approved by Susan K. Bell
Commerce, Community, and Economic Development

Phone 269-7900
Date/Time 4/6/11 2:18 PM
Date 4/7/2011

(Revised 12/29/2010 OMB)

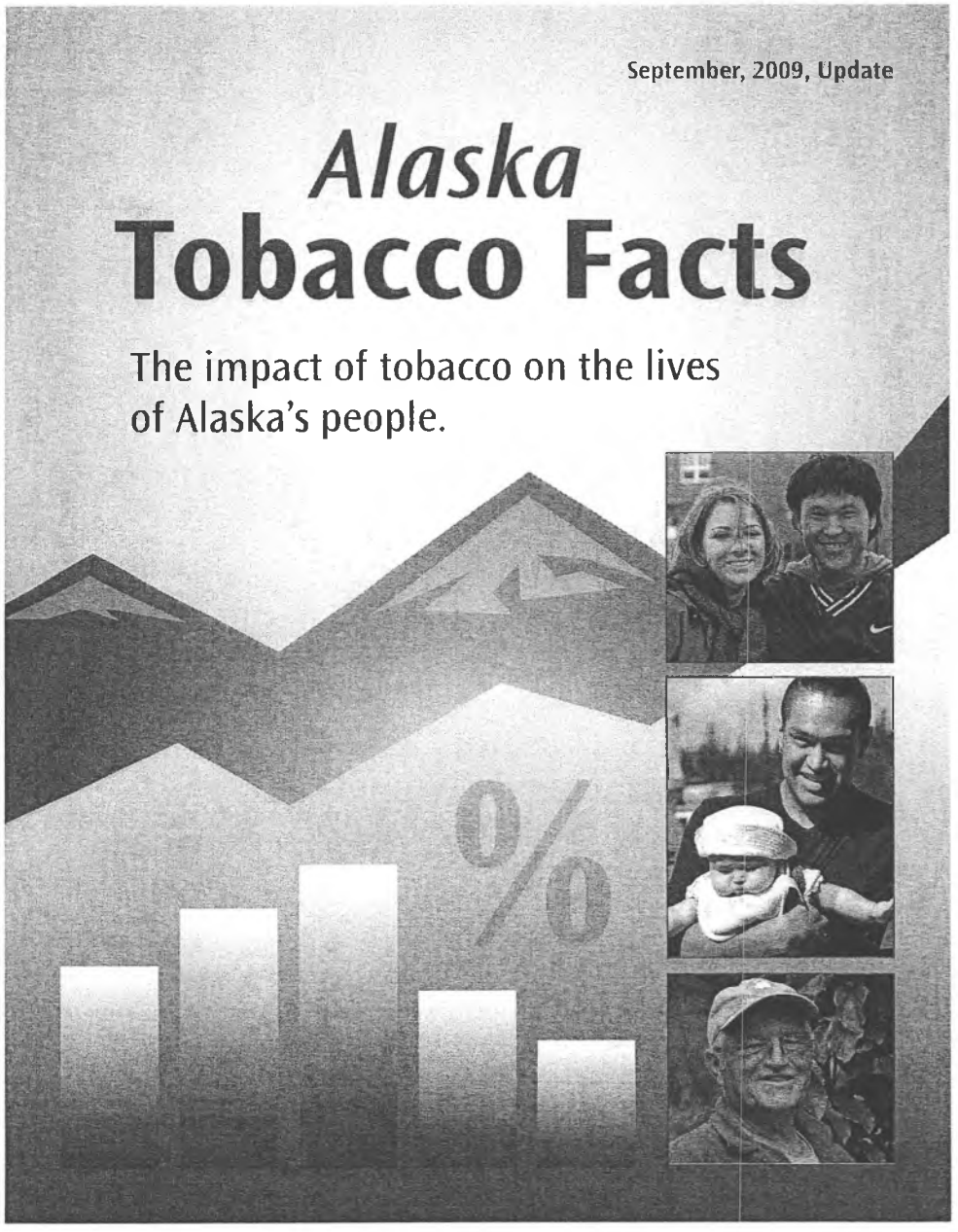
FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. HB 209

Analysis

HB 209 requires that a health care insurer who offers, issues for deliver, delivers, or renews health care insurance in the state shall provide coverage for a minimum of two courses of tobacco cessation treatment during each plan year.



Alaska Tobacco Facts

2009 Update

Sean Parnell, Governor
William H. Hogan, MS, Commissioner, Department of Health and Social Services
Deborah L. Erickson, Acting Director, Division of Public Health
Kathy Alleiy, MPH, Section Chief, Chronic Disease Prevention & Health Promotion

Suggested Citation:
http://www.hss.state.ak.us/DPH/chronic/tobacco/alaska_tobacco_facts.pdf

Alaska Tobacco Facts, 2009 Update

Acknowledgements

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We would like to acknowledge the following individuals and organizations for their contributions to this report:

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Section of Women's, Children's, and Family Health
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Bureau of Vital Statistics
Phillip Mitchell, MS, Section Chief

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Joe Darnell, Chief Investigator, Tobacco Enforcement and Youth Education

Alaska Department of Revenue
Tax Division
Johanna Bales, CPA, Revenue Audit Supervisor
Janis Hales, BA, Tax Auditor

Table of Contents

1. Introduction

In 2004, the Alaska Division of Public Health produced *Tobacco in the Great Land* (www.epi.hss.state.ak.us/pubs/tobaccofeb04.pdf), a monograph intended to provide the reader with a comprehensive review of data related to tobacco use and its consequences in Alaska. *Alaska Tobacco Facts* is designed to be a brief, annual update to *Tobacco in the Great Land* that can be used to educate Alaskans about the toll that tobacco continues to take on the health and well-being of our citizens.

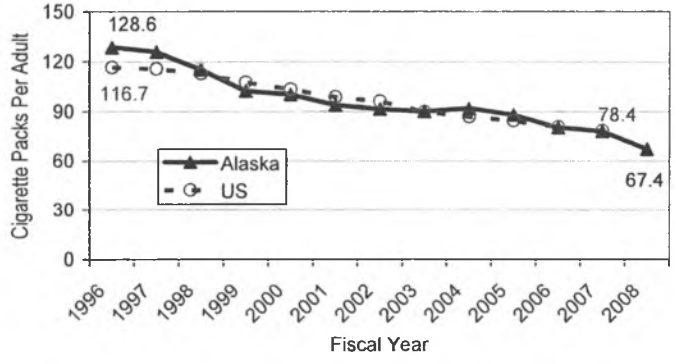
Trends in tobacco use are measured from the baseline year of 1996, prior to two early events in tobacco prevention and control in Alaska: the tobacco tax increase in 1997 and Alaska's decision to join in the national multi-state Tobacco Master Settlement Agreement in 1998. Differences are noted where there is statistical significance ($p < .05$).

The following are highlights from *Alaska Tobacco Facts, 2009 Update*:

- Per adult cigarette consumption declined 48% from State Fiscal Year (SFY) 1996 to SFY 2008; ***405 million fewer cigarettes*** were sold in 2008 compared to 1996.
- In 2007, tobacco use cost Alaskans $314 million in direct medical expenditures and an additional $177 million in lost productivity due to tobacco-related deaths.
- ***The percentage of adult smokers in Alaska has declined*** by one-fifth since 1996 to 21.5 percent in 2007, a statistically significant decrease.
- Alaska Native adults are twice as likely to smoke as non-Native adults.
- Alaskans with less education, with lower incomes, and who live in rural areas of the state also smoke more than their peers.
- The majority of Alaskan adults who currently smoke want to quit; three out of five tried to quit in the last 12 months.
- Smoking among high school students has dropped from 36.5% in 1995 to 17.8% in 2007.
- Although they are still more than twice as likely to smoke as students of other racial backgrounds, Alaska Native high school students were also the only group to show a decrease in smoking between 2003 (44.2%) and 2007 (31.7%).
- Eight out of ten smokers believe that secondhand smoke is harmful and nearly as many agree that people should be protected from secondhand smoke.

2. Cigarette Consumption

Annual Per Adult Sales of Cigarette Packs, By Fiscal Year, Alaska and US (minus Alaska), 1996-2008

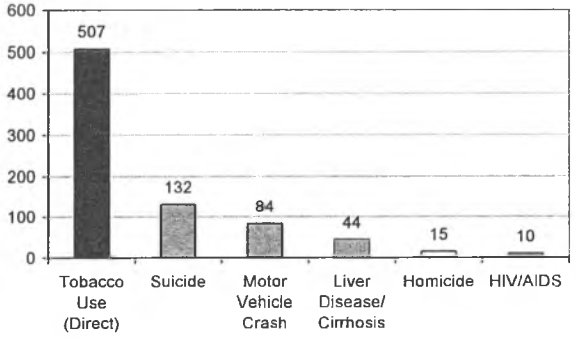


Sources: Alaska Department of Revenue, Tax Division FY08 Reports; Orzechowski & Walker, *The Tax Burden on Tobacco*, 2007.

- Between State Fiscal Years (SFY) 1996 and 2008, the per adult number of cigarette packs sold in Alaska dropped 48%, from 128.6 packs to 67.4 packs per adult.
- This drop in cigarette sales translates to 405 million fewer cigarettes sold in Alaska in 2008 compared to 1996.

3. Tobacco-Related Deaths and Economic Costs

Number of Deaths Due to Selected Causes, Alaska, 2006



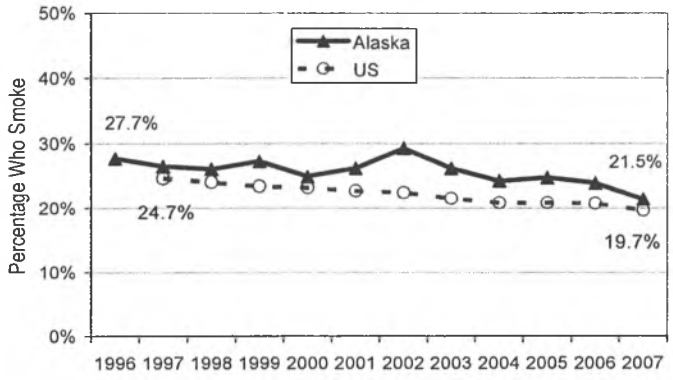
Sources: Alaska Bureau of Vital Statistics (2006 deaths); Alaska Behavioral Risk Factor Surveillance System (smoking prevalence); CDC, Smoking Attributable Morbidity, Mortality, and Economic Costs.*

- More Alaskans die annually from the effects of tobacco use than from suicide, motor vehicle crashes, chronic liver disease and cirrhosis, homicide, and HIV/AIDS combined.
- An additional estimated 120 Alaskans die each year from lung cancer and heart disease caused by exposure to secondhand smoke.*
- In 2007, tobacco use cost Alaskans an estimated $314 million annually in direct medical expenditures and an additional $177 million annually in lost productivity due to tobacco-related deaths.
- This sums to an astounding $491 million; yet it underestimates total costs; lost productivity from tobacco-related illness and costs due to second-hand smoke exposure-related illness or death are not included.

* See Section 13: Data Sources, pp 48-49 for information on how smoking-attributable and secondhand smoke-attributable deaths were estimated.

4. Adult Smoking

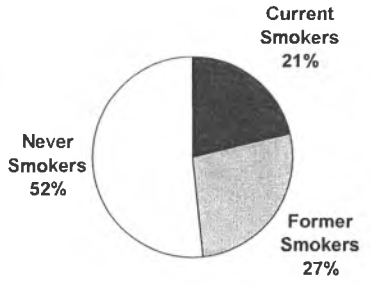
Percentage of Adults Who Smoke, by Year Alaska and US, 1996-2007



Sources: Alaska Behavioral Risk Factor Surveillance System, Standard BRFSS Survey (1996-2003), combined Modified and Standard BRFSS Surveys (2004-2007); National Health Interview Survey

- Smoking prevalence has declined significantly from 27.7% in 1996 to 21.5% in 2007.
- Among women, the proportion of smokers decreased significantly from 24.2% in 1996 to 18.9% in 2007.
- Among men, the decline in smoking was not significant.
- Men continue to be significantly more likely than women to be smokers; in 2007, 24.0% of Alaskan men vs. 18.9% of Alaskan women were current smokers.

Smoking Status of Adults, Alaska, 2007

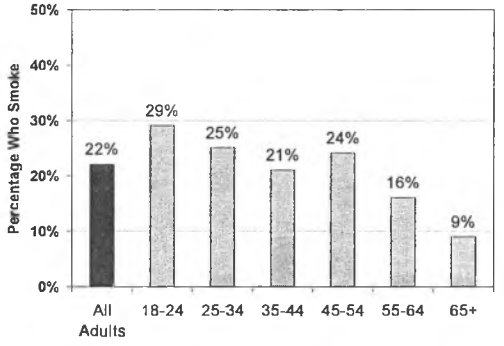


Source: Alaska Behavioral Risk Factor Surveillance System, combined Modified and Standard BRFSS Surveys

- As the proportion of smokers decreases, the proportion of Alaskans who have never been smokers has increased from 46.3% in 1996 to 51.7% in 2007.
- Although proportion of former smokers among all Alaskan adults has remained at about a quarter of the population, among Alaskans who have ever been smokers, the proportion of former smokers increased from 48.4% in 1996 to 55.5% in 2007.
- Being able to stay quit for 3 or more months greatly increases the chances of quitting tobacco for life. Among recent smokers–those who smoked in the past year, the proportion that have successfully remained quit for 3 or more months has increased from 5.5% in 2001 to 9.1% in 2007.

Note: Questions in the Alaska Behavioral Risk Factor Surveillance System about when former smokers last smoked changed in 2001, and data from earlier years are not comparable.

Percentage of Adults Who Smoke, by Age Group, Alaska, 2007



Note. Throughout this report percentages are rounded to the nearest whole number in graphs and tables in which at least one category's prevalence estimate is based on fewer than 500 responses (per national BRFSS guidelines).

Source: Alaska Behavioral Risk Factor Surveillance System, combined Modified and Standard BRFSS Surveys

- Among Alaskans between the ages of 40 to 59, smoking decreased significantly from 28.7% in 1996 to 21.6% in 2007.
- Younger adults between the ages of 18 and 34 are the most likely to be smokers (27%).
- More than half of all current smokers (57%) were smoking by the time they were 17 years old.

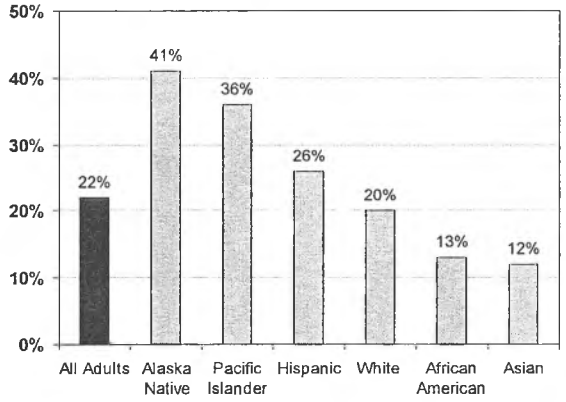
Percentage of Adults Who Smoke, by Region, Alaska, 2007

Region	Percentage
North/Interior	36%
Southwest	34%
Mat-Su Borough	26%
Fairbanks (North Star)	22%
Gulf Coast	20%
Anchorage Borough	20%
Southeast	19%
All Adults	22%

Source: Alaska Behavioral Risk Factor Surveillance System, combined Modified and Standard BRFSS Surveys

- Residents of more rural regions in Alaska – Southwest and North/Interior Regions – are more likely than residents of other regions of Alaska to smoke.
- Between 1996 and 2007, adult smoking prevalence decreased in three regions of Alaska: Anchorage (23% to 17%), Gulf Coast (29% to 20%), and Southeast (28% to 19%).
- Regional groupings include:
  - Anchorage Borough
  - Mat-Su Borough
  - Gulf Coast – Kenai, Kodiak, and Valdez Cordova Boroughs and Census Areas (plus part of Denali)
  - Southeast – Yakutat, Skagway, Juneau, Sitka, Haines, Wrangell-Petersburg, Ketchikan, and Ketchikan Gateway Boroughs and Census Areas
  - Fairbanks (North Star) – Fairbanks North Star Borough
  - North/Interior – Nome, Northwest Arctic, North Slope, Yukon-Koyukuk, Southeast Fairbanks, and Denali Boroughs and Census Areas
  - Southwest – Bristol Bay, East Aleutians, West Aleutians, Dillingham, Lake & Peninsula, Bethel, and Wade Hampton Boroughs and Census Areas (plus part of Yukon-Koyukuk)

Percentage of Adults Who Smoke, by Race/Ethnicity, Alaska, 2005-2007



Note: The race categories of Alaska Native, African American, Asian, Pacific Islander, and White do not include respondents of Hispanic ethnicity.

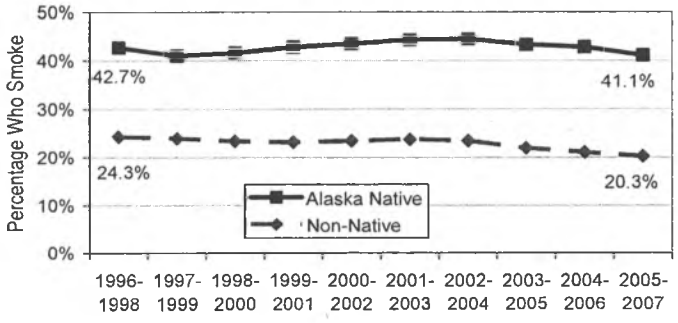
Source: Alaska Behavioral Risk Factor Surveillance System, combined Modified and Standard BRFSS Surveys

- In Alaska, African American adults and Asian adults are significantly less likely to smoke than adults from all other race/ethnicity groups.
- Alaska Native adults are more likely to be smokers than Hispanic, White, African American, or Asian adults.
- Alaskans of Native Hawaiian or Pacific Islander heritage are more likely to be smokers than are White, African American, or Asian adults.
- There is no significant difference in smoking prevalence between White and Hispanic adults.

Percentage of Adults Who Smoke, by Year

Alaska Natives and Non-Natives, 1996-2007

(3-year moving averages)



Source: Alaska Behavioral Risk Factor Surveillance System, combined Modified and Standard BRFSS Surveys

- Smoking prevalence has remained relatively stable among Alaska Natives over the past decade; among non-Native adults, there has been a small but significant decrease in smoking from 1996 to 2007.
- Alaska Native adults are currently twice as likely to smoke as non-Native Alaskan adults.

Percentage of Adults Who Smoke, by Socio-Economic Status and Race, Alaska, 2005-2007

SES Status*	Alaska Natives	Alaska Non-Natives	Total
Lower	48%	34%	38%
Higher	33%	16%	18%
All Adults	41%	20%	22%

Source: Alaska Behavioral Risk Factor Surveillance System, combined Modified and Standard BRFSS Surveys

*Lower SES is calculated as those persons with less than a High School education or less than 185% of the Alaska Poverty Level Guideline.

- Nearly half (42%) of adult smokers live in households earning less than 185% of the Alaska Poverty Level Guideline.

Source: Alaska Behavioral Risk Factor Surveillance System, combined Modified and Standard BRFSS Surveys, 2007

- Although unemployed adults and those who are unable to work comprise about 11% of the overall adult population, they are disproportionately likely to smoke; 43% of unemployed adults and 46% of those who are unable to work are smokers, compared to 20% of employed adults who smoke.

Source: Alaska Behavioral Risk Factor Surveillance System, combined Modified and Standard BRFSS Surveys, 2007

Percentage of Adults Who Smoke, by Education and Race, Alaska, 2005-2007

Education Level	Alaska Natives	Alaska Non-Natives	Total
Less than high school graduate	45%	45%	45%
High school graduate or GED	45%	29%	33%
Some college	36%	21%	23%
College graduate	27%	9%	10%
All Adults	41%	20%	23%

Source: Alaska Behavioral Risk Factor Surveillance System, combined Modified and Standard BRFSS Surveys

Percentage of Adults Who Smoke, by Income and Race, Alaska, 2005-2007

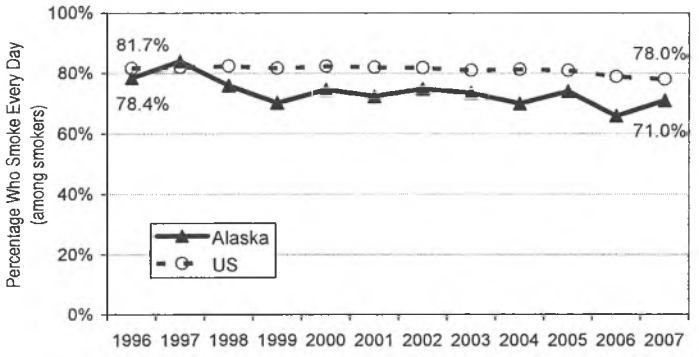
Household Income Level	Alaska Natives	Alaska Non-Natives	Total
Less than $15,000	49%	39%	43%
$15,000 - $24,999	49%	31%	35%
$25,000 - $49,000	45%	25%	28%
$50,000 - $74,000	37%	17%	18%
$75,000 or more	21%	13%	14%
All Adults	42%	20%	23%

Source: Alaska Behavioral Risk Factor Surveillance System, combined Modified and Standard BRFSS Surveys

- Alaskans with fewer years of education and/or lower household income are more likely to be smokers; this pattern is true for both Alaska Native and non-Native adults.

Source: Alaska Behavioral Risk Factor Surveillance System, combined Modified and Standard BRFSS Surveys, 2005-2007

Percentage of Adult Smokers Who Smoke Every Day, by Year Alaska and United States, 1996-2007



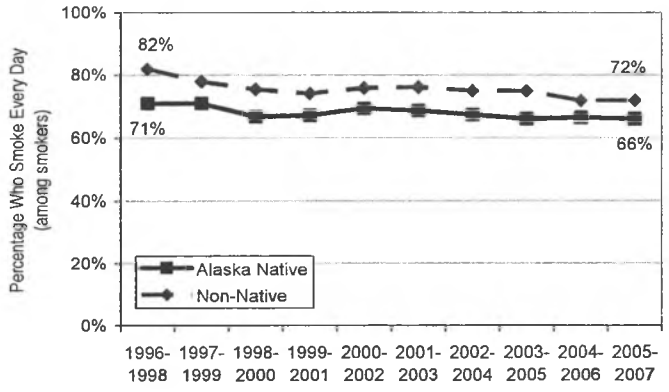
Sources: Alaska Behavioral Risk Factor Surveillance System, Standard Survey (1996-2003), combined Modified and Standard BRFSS Surveys (2004-2007); National Health Interview Survey

- The proportion of Alaskan smokers who smoke every day has remained about the same since 1996; roughly 7 out of 10 smoke daily.

Percentage of Adult Smokers Who Smoke Every Day, by Year

Alaska Natives and Non-Natives, 1996-2007

(3-Year moving averages)

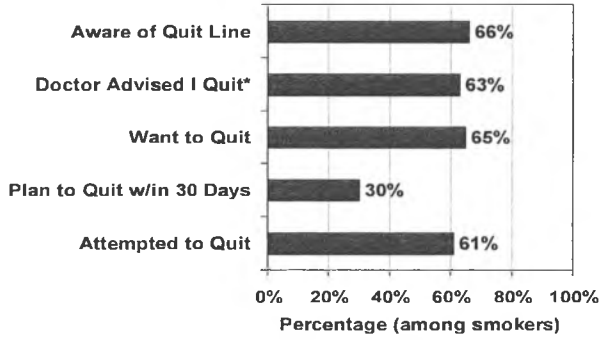


Source: Alaska Behavioral Risk Factor Surveillance System, Standard Survey (1996-2003), combined Modified and Standard BRFSS Surveys (2004-2007)

- Compared to non-Native adult smokers in Alaska, Alaska Native adult smokers have consistently been less likely to smoke every day.
- The proportion of non-Native adult smokers who smoke daily has significantly decreased since 2007.

Percentage of Adult Smokers Endorsing Key Cessation Variables

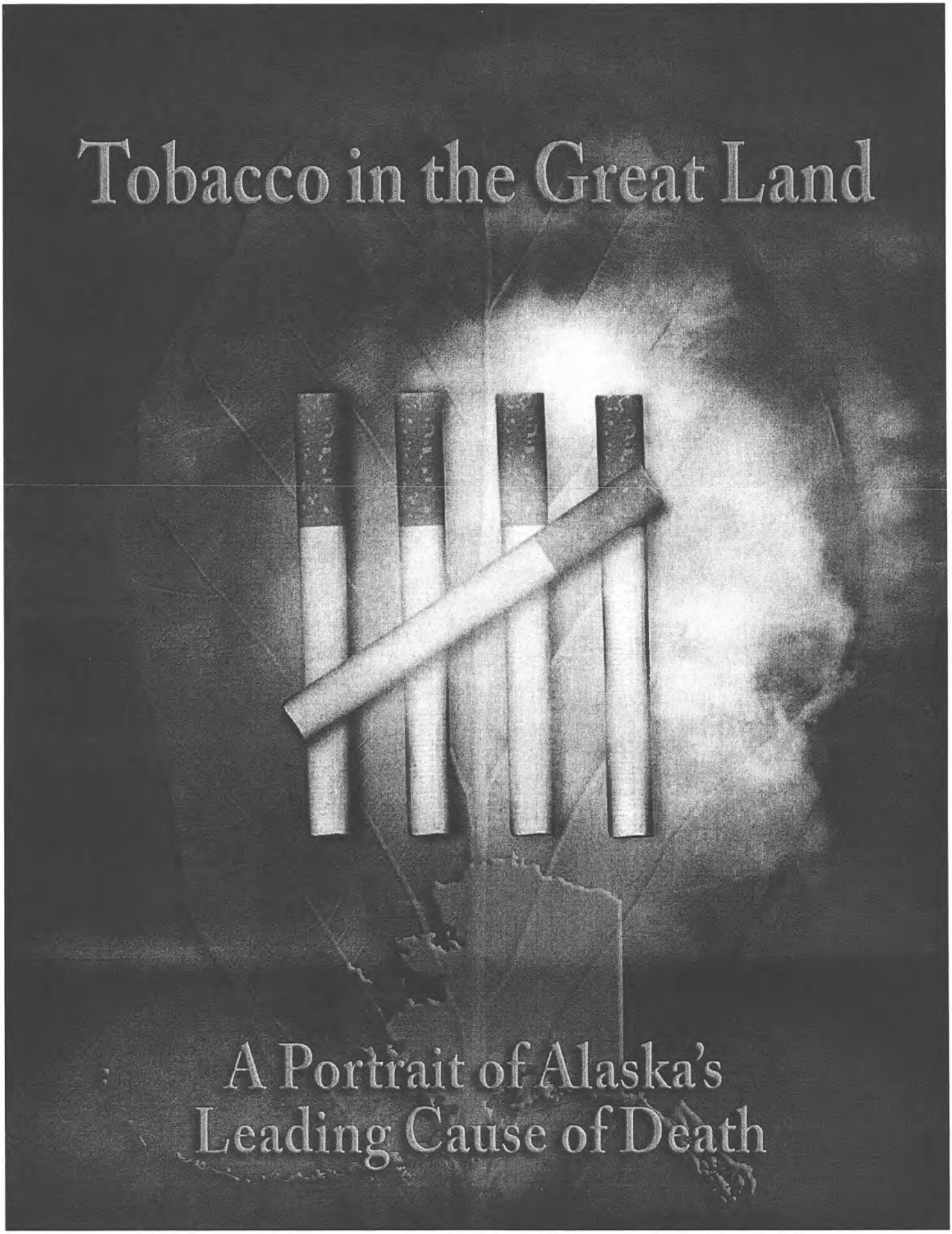
Alaska, 2007



Sources: Alaska Behavioral Risk Factor Surveillance System, Modified Survey (except for 'Attempted to Quit' which was based on data from combined Modified and Standard BRFSS Surveys)
*Among current smokers who had a health care visit in the past 12 months.

- Two thirds of Alaskans who currently smoke (65%) want to quit.
- Three out of five current smokers (61%) have attempted to quit in the past 12 months; quit attempts were made by over half of those who smoke every day (55%) and three quarters of those who smoke some days (74%).
- Quit attempts among Alaska Native people who currently smoke have increased from 59% in 2001 to 70% in 2007.
- The proportion of Alaskan smokers who had a health care visit in the past 12 months and received advice from their health care provider to quit has decreased from 73% in 2001 to 63% in 2007.

Tobacco in the Great Land



A Portrait of Alaska's Leading Cause of Death

Tobacco in the Great Land

A Portrait of Alaska's Leading Cause of Death

February 2004

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Section of Epidemiology
Division of Public Health
Department of Health and Social Services
State of Alaska

Suggested Citation:

Peterson E, Fenaughty A, Eberhart-Phillips JE, Tobacco in the Great Land, A Portrait of Alaska's Leading Cause of Death

Anchorage, AK: Section of Epidemiology, Division of Public Health, Alaska Department of Health and Social Services, 2004.

Executive Summary

Tobacco use is Alaska's number-one public health problem. In terms of deaths, chronic illness and disability, no other underlying cause comes close. Tobacco cuts short the lives of more Alaskans than all infectious diseases combined. It leads to more deaths than all environmental toxins combined, more deaths than all other drug and alcohol use, and more deaths than all injuries – intentional or non-intentional – combined. The single best thing that Alaskans who use tobacco can do to improve their health is to quit smoking or chewing tobacco products. The single best thing that young people can do to improve their odds for a long and healthy life is never to use tobacco.

Control of the deadly tobacco epidemic in Alaska involves a partnership between state and local governments, voluntary associations, clinicians, and enlightened citizens who are mobilizing for change at the community level. The success of this partnership depends on access to complete and accurate information on the use of tobacco throughout our state. Many surveys have recently been conducted in Alaska to understand better who is using tobacco products, who is exposed involuntarily to tobacco smoke, and who is ready to accept and act on anti-tobacco public health messages. These surveys, which have added significantly to our understanding of tobacco use in Alaska, include:

- The Adult Tobacco Survey of approximately 2,500 randomly selected Alaskans aged 18 and older (2003)
- The Youth Risk Behavior Survey of approximately 1,500 randomly selected Alaskan high school students (1995 & 2003)
- The Behavioral Risk Factor Surveillance System, an annual survey of approximately 2,500 randomly selected Alaskan adults (1991-2002)
- The Pregnancy Risk Assessment Monitoring System, an annual survey of approximately 1,900 randomly selected Alaskan women who recently gave birth (1991-2000)
- The Health Care Provider Survey of 384 Alaskan clinicians, who shared how they approach patients on reducing tobacco use (2003)

In addition, ongoing data are available from the Alaska Department of Revenue on tobacco consumption in the state. There have also been privately funded surveys of tobacco media awareness in various Alaskan media markets by Hellenthal and Associates (2001-2003). Finally, data on the impact of tobacco on mortality, and the economic costs of fatal tobacco-related diseases, can be estimated for Alaska using a data system known as Smoking-Attributable Morbidity, Mortality and Economic Costs (SAMMEC).

Gathering useful data from each of these sources could be cumbersome for any Alaskans seeking a comprehensive overview of the tobacco problem in this state. This monograph is meant to

simplify that task, by collecting all that is known about tobacco use in Alaska into one easy-to-use resource. Data from the various streams have been pooled and arranged into three large groupings: adult data, youth data and environmental tobacco smoke (ETS) data. Results are presented graphically, along with insightful interpretations that put the numbers into perspective and take into account possible sources of bias and confounding factors.

The picture that emerges from this wide-ranging undertaking is of a state whose social and economic health is under severe threat from tobacco use. The toll of tobacco use in Alaska – past, present and future – is staggering. Unless smoking is vastly reduced, tens of thousands of Alaskans will die prematurely in the next 50 years because of tobacco. But tobacco's burden is not being borne evenly throughout the state's population. Alaska Natives, rural Alaskans and economically disadvantaged Alaskans stand to suffer more from tobacco use and its consequences than their non-native, urban and more advantaged counterparts. Even non-smokers are at risk of tobacco-related diseases, as shown by the widespread exposure to secondhand smoke reported by Alaskan adults and youth alike. A sharp cut in smoking by high school youth since 1995 provides the most hopeful sign that Alaska's grim present reality may one day be followed by a smoke-free future.

Important findings emerging from this monograph are numerous, and cannot all be listed here. This monograph highlights the health and economic burden of tobacco use in Alaska, including the following:

- Tobacco is the single largest killer of Alaskans, claiming nearly 500 lives per year directly, and an additional 120 lives through secondhand smoke.
- Tobacco-related deaths in Alaska exceed the combined total from motor vehicle crashes, suicides, homicides and air transport accidents.
- The impact of tobacco on mortality in Alaska is more than double that of alcohol.
- The annual economic cost of tobacco-related mortality exceeds $260 million in Alaska. This is more than 50 times the amount the state spends on tobacco control and prevention activities.

Other key findings from this monograph are arranged here in the same groupings that comprise the main chapters: youth, adult and secondhand smoke. For high school youth, the essential findings in this monograph include the following:

- Smoking among high school youth in Alaska has been cut in half since 1995, with only 19 percent reporting that they have smoked at least one cigarette in the past month.
- Frequent smoking, in which students report using cigarettes on at least 20 days in the previous month, has fallen in Alaska from 21 percent in 1995 to just 8 percent.
- Nearly half of high school students in Alaska have never taken a single puff of a cigarette. Only 28 percent of students reported that in 1995.
- Alaska Native youth are three to four times as likely to smoke as non-native youth.

- Approximately 11 percent of Alaskan high school youth report using smokeless tobacco in the past month. Smokeless tobacco use is particularly high among Alaska Native youth, with rates of 32 percent among males and 18 percent among females.

- Alaskan students who report that their parents never talk to them about school are almost twice as likely to smoke as students whose parents do talk with them about school.

- Alaskan students who get mostly C's or worse in school are four times as likely to smoke as those who get mostly A's.

- Alaskan students who do not participate in after-school activities are almost twice as likely to smoke as students who participate in one or more such activities per week.

- Alaskan students older than 16 years of age who smoke are twice as likely to have used alcohol in the past month, and are four times as likely to have used marijuana during that time, compared to those who do not smoke.

- Alaskan students older than 16 years of age who smoke are three times as likely to have ever used inhalants, and four times as likely to have ever tried cocaine, heroin, methamphetamine or ecstasy, compared to those who do not smoke.

- Alaskan students older than 16 years of age who smoke are almost twice as likely to have had sex in the previous three months, compared to those who do not smoke.

- Alaskan students who smoke are twice as likely to have been in a physical fight in the past year, and four times as likely to have been driving while intoxicated during the past 30 days, compared to those who do not smoke.

For adults, the essential findings in this monograph include the following:

- Per capita cigarette consumption has dropped by 30 percent since introduction of a state wide excise tax in 1997.

- One in four Alaskan adults currently smokes cigarettes

- Among adults, Alaska Native smoking prevalence is nearly double that of Non-Natives.

- The average number of cigarettes that Alaskan adults are smoking appears to be decreasing.

- Smoking is markedly increased in Alaskan adults with low incomes and less educational attainment. It is also more common in younger adults, in the unemployed and in those living in rural parts of the state.

- Alaskan adults who smoke are more likely than nonsmokers to be physically inactive and to engage in binge drinking.

- More than 80 percent of Alaskan adults who smoke want to quit, with approximately half reporting that they have quit temporarily for at least one day in the past year.
- Smokers who have quit smoking permanently now outnumber smoking adults in Alaska.
- 86% of adult smokers in Alaska who have seen a health care provider in the last year were advised to quit smoking.
- Approximately 4 percent of Alaskan adults use smokeless tobacco, 7 percent of males and 1 percent of females. Among Alaska Natives the prevalence is 21 percent among males and 5 percent among females.
- Approximately 17 percent of new mothers in Alaska report that they smoked cigarettes during the last three months of pregnancy.

Regarding exposures and beliefs about environmental tobacco smoke, the essential findings in this monograph include the following:

- Approximately 1 in 6 Alaskan adults who do not smoke live with one or more smokers.
- Approximately 7 percent of Alaskan adults who hold jobs and do not smoke are exposed to secondhand smoke at work.
- Nearly three-quarters of Alaskan adults believe that smoking should not be allowed at all in restaurants. This includes nearly half of smokers.
- Nearly one-third of Alaskan adults say they would eat in restaurants more often if smoking were not permitted there. Only 8 percent say they would eat out less often.
- Nearly 90 percent of Alaskan adults believe that people should be protected from other people's cigarette smoke. This includes three-quarters of smokers.
- Nearly 50 percent of Alaskan high school youth who do not smoke say they have been exposed in the past week to secondhand smoke inside of buildings or cars.
- More than 95 percent of Alaskan high school youth say they believe that secondhand smoke is harmful. This view was even expressed by 89 percent of those youth who smoke.

These important results, and many others, await the reader in the pages that follow. Taken all together, the charts and tables in this monograph document the scope of the tobacco problem in Alaska, establish baselines for measuring future progress and identify areas to target new public health approaches.

Funding for tobacco prevention and control programs in Alaska falls short of the $8.1 million recommended by the CDC as the minimum amount necessary to implement a comprehensive tobacco prevention and control program. The maximum amount of tobacco prevention and control funding in Alaska to date totals $6.1 million, an amount that does not even begin to

approach the CDC recommended maximum of $16.5 million.

Despite funding limitations, Alaska has established the foundation for a comprehensive tobacco prevention and control program. Current tobacco prevention and control efforts thrive on a strong partnership between state government and the Alaska Tobacco Control Alliance, whose members include the Alaska Native Health Board, the American Cancer Society, the American Heart Association, and the American Lung Association of Alaska. Components of the state tobacco program include an aggressive anti-tobacco media campaign aimed especially at preventing the uptake of tobacco by youth and promoting cessation among adults who smoke. The state also supports community-based advocacy programs that discourage the initiation of tobacco use by youth and advance the enactment of local ordinances that reduce environmental tobacco smoke exposure.

This monograph is dedicated to all those have joined the struggle against tobacco-related disease because they care deeply about the health of Alaska's people. We hope this monograph will become a trusted sword in their daily battles against the scourge of tobacco use in this great state.

The Honorable Wes Keller, Chair
House Health and Social Services Committee
State Capitol, Room 432
Juneau, AK 99801-1182

April 7, 2011

Dear Chair Keller and HSS Committee Members:

The American Cancer Society Cancer Action Network (ACS CAN) supports HB209, Insurance Coverage for Tobacco Cessation.

ACS CAN commends the legislature on its investment in tobacco prevention efforts in Alaska over the past decade. Together, we have seen significant reductions in both youth and adult smoking rates, but there is more work to do.

Tobacco use remains Alaska's number one source of preventable illness and death. For employers, it is also the single greatest cause of excess health care spending and productivity losses. Tobacco cessation coverage is among the most cost-effective health insurance benefits available.

We know that quitting a tobacco addiction is difficult, which is why we work so hard to keep kids from ever starting to use tobacco. Across the nation, more than 70% of smokers want to quit and attempt to do so each year, but without help, most fail. Smoking cessation counseling and medicines are proven to help and improve quit rates.

HB209 moves Alaska forward towards the standard of care documented in the national Clinical Practice Guideline for Treating Tobacco Use and Dependence.

Thank you for your support of tobacco prevention in Alaska. HB209 is one more important piece of Alaska's tobacco prevention and cessation efforts. ACS CAN urges your support of this legislation.

Sincerely,

Emily Nenon
Alaska Government Relations Director

3851 Piper Street, Suite U240 • Anchorage, AK • 99508
Phone 907.277.8696 • Fax 907.273.2073

NFIB

The Voice of Small Business®

ALASKA

April 4, 2011

The Honorable Bob Heron
Alaska House of Representatives
State Capitol Building
Juneau, Alaska 99801-1182

RE: House Bill 209

Dear Representative Heron,

On behalf of the National Federation of Independent Business/Alaska, I wish to express our opposition to House Bill 209. The National Federation of Independent Business is the largest small-business advocacy group in Alaska.

For many small employers in Alaska insurance premiums for small groups or single coverage have increased by more than 82 percent since 2000, a jaw-dropping statistic. This is completely unsustainable over the long-term. Much of the increase is driven by the additions to coverage by state mandates.

Unfortunately HB 209 mandates coverage for tobacco cessation treatment that may not fit employee's needs but for which small employers providing health insurance bear the cost. Increased mandates force employers to consider whether they can afford to continue coverage or are forced by increased prices to eliminate health insurance for their employees. Mandates prevent small employers from providing affordable insurance programs tailored to its specific work force.

HB 209 is discriminatory against small employers as the mandate applies only to those who provide coverage regulated by state insurance statutes, estimated to be only 15% of Alaska's population. It does not cover programs offered by the state and other governmental entities, unions, or large employers who typically offer ERISA programs – about 70% of our population. Thus, it creates a less fair business environment for Alaska's small employers and favors outside business interests.

Even with this legislative mandate and its heavy negative impact on small businesses, only 15% of the population will be affected and 85% will not. The probability is that the 15% covered by state regulated insurance will decrease as the increases in premiums caused by legislative mandates make health insurance unaffordable for more small businesses and individuals.

Sincerely yours,

Dennis L. DeWitt
Alaska State Director

cc: Health and Social Services Committee

Denny DeWitt -

Spoke T Rep Herron About HB209 -

Denny said that the Sm. business groups would accept A "mandated Offering" That it was up to the Employer if they chose that plan -

I believe Rep. Herron will Amend His current bill —Janet—

Janet Ogan

From: Laughlin, Wilda J (HSS) <wilda.laughlin@alaska.gov>
Sent: Tuesday, February 14, 2012 5:36 PM
To: Janet Ogan; Rep. Charisse Millett; Liz Clement; Rep. Bob Herron
Cc: Hurlburt, Ward B (HSS); Lewis, Jill (HSS)
Subject: FW: rotavirus vaccine efficacy (CDC)

Follow Up Flag: Follow up
Flag Status: Flagged

Rep. Millett, below is a response to the question you asked in today's House HSS hearing. Let me know if you need anything else on this.

Janet, I trust you will get to the other committee members.
w.

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From: McLaughlin, Joseph B (HSS)
Sent: Tuesday, February 14, 2012 4:42 PM
To: Hurlburt, Ward B (HSS); Lewis, Jill (HSS)
Subject: rotavirus vaccine efficacy (CDC)

How well does rotavirus vaccine work to prevent rotavirus disease?

Efficacy studies have demonstrated that rotavirus vaccine is 85%-98% protective against severe rotavirus disease and 74%-87% protective against rotavirus disease of any severity in the first year after vaccination.

http://www.cdc.gov/vaccines/vpd-vac/rotavirus/vac-faqs.htm

CDC

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