Testimony, Senate Bill SB 316
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Many thanks for hearing my testimony today. My testimony will be a mix of personal experience and research evidence. It is based on my experience as a health care professional, and my views don't necessarily reflect the views of my employer the University of Kansas Medical Center.

My mother and father both served in WWII, both started smoking during their service, and both died from tobacco-related illnesses – my mom from heart failure—she was never able to quit—and my father from COPD that caught up with him even though he had quit at the age of 50.

We know there's a strong genetic component to all addictions – including smoking—and both my sons experimented and went on to become daily smokers. One started while he was on a student exchange in Ecuador and the other started during his senior year of high school with cigarettes given to him by an older classmate. This was incredibly frightening, frustrating, and I have to admit a little humiliating – here I am director of a hospital tobacco treatment service that treats over a thousand smokers per year!

But I put those feelings aside and took an evidence-based approach to helping them. I basically gave them comprehensive, barrier free treatment just like what we are talking about for Medicaid patients here today. They weren't interested in quitting for a year or so but shortly they began to really regret what was happening – to their health – my older son has asthma – and also to their lives- they were caught in an addiction that was affecting every aspect of their social lives.

At that time our insurance didn't pay for any medications, but we had the resources to buy the medications and I felt it was pretty much a life or death issue, so we started down the path toward quitting. Each tried the nicotine patch, nicotine gum, lozenge, and one son tried bupropion and the nasal spray – which he made me try too – I wouldn't recommend it for never-smokers.

Each attempt they were able to stop for a while, cut down a bit more on the numbers of cigarettes they smoked per day, and learn more about the people, places, and things that triggered relapses. They've both been tobacco free for several years now. They are healthy – they rarely go to the doctor.

Every smoker–no matter their age or health status–gains years and quality of life when they quit. The younger they quit, the more they gain.[1] I am so grateful that I had the training/resources to help my children avoid dying the way my parents did.

Medications and support in quitting double smokers' odds of quitting on any given attempt.

Because tobacco is so addictive, withdrawal is so bad, it takes multiple quit attempts for most people to quit.

Maybe you have high blood pressure, or you know someone who does. What if your doctor had only one chance per year to treat your blood pressure? Instead of being able to prescribe a medication, see how it worked, increase the dose, change the medication, or even add another to make sure you have it under control – what if he or she just had one shot to get it right? That's where we are with smoking cessation benefits for Medicaid beneficiaries. And the evidence is clear—tobacco kills many more people per year—in many more ways –than hypertension.[2-3] Not just heart disease and stroke but also cancer, COPD, and other illnesses.

And tobacco treatment is more effective and *cost effective*—in terms of lives saved—as other important treatments like statins for heart disease or cervical cancer screening.[4] Medications and behavioral support like quitlines, counseling, or groups each double smokers' odds of quitting on any given quit attempt.[5] Combination pharmacotherapy—like the nicotine patch and nicotine lozenge—similar to the common practice of using two medications for controlling hypertension—is the most effective way to go.[5] But coverage for these medication combinations for treating tobacco dependence are specifically excluded under our current Kansas Medicaid policies.

In fact, there's so much uncertainty over what medications or counseling are covered, for who, and for how long that a lot of physicians aren't willing to go there with patients. And if the treatment they try is only partially successful—for example, a patient goes from 40 to 10 cigarettes per day--they can't change tactics to put the nail in the coffin, because Medicaid beneficiaries only are covered for one quit attempt per year.

It's important to know that smoking cessation medications – even when combined combination therapy –is a *very cheap regimen* compared to any other medical care you can name—but it's out of reach for most doctors and their patients with Medicaid.

Also, under the current policy, office visits for tobacco cessation are not covered for most Medicaid beneficiaries—only for pregnant smokers. So busy providers have a real dis-incentive to treat tobacco dependence because the time they spend treating it is not reimbursed.[6]

The bill you are considering will enable providers to tell patients – "lets' start down this road together. If what you first try doesn't work, we'll change tactics until we find the right combination of medications and support for you to be able to quit for good. No matter what happens, I've got your back." A number of state-wide studies have found that when you take this approach you save lives, reduce hospitalizations, and save dollars.[7-8]

Thanks for your attention.

References

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