

**AHA and ALA Webinar
Million Hearts® and Smoking Cessation -
Leveraging ACA Initiatives in States and Local Communities
Aug 27, 2014
2:00 – 3:00 pm ET**

Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen-only mode until the question and answer session of the call. To ask a question during that time, please press star and then 1. Today's conference is being recorded. If you have any objections, you may disconnect at this time. Now I'd like to turn over the meeting to Jill Birnbaum, Vice President State Advocacy and Public Health at the American Heart Association.

Jill Birnbaum: Great. Thank you and good afternoon, everybody, in cooperation with our partner at the American Lung Association. American Heart Association is very pleased to present Million Hearts and Smoking Cessation. We can leverage the Affordable Care Act Initiatives in states and local communities.

As the operator says, my name is Jill Birnbaum and I'm the vice president of State Advocacy and Public Health with the American Heart Association and I'm pleased to welcome you all to today's webinar. Before we begin, I'd like to share with you some options with my meetings which is the service that we're using to conduct this meeting. You can review and download the slides and handouts that will be shared during this meeting.

You go up to the top right-hand corner where you see an image that looks like three piece of a paper. If you click on that icon, you can download the presentation and the handouts. We'll have some time at the end for question and answers and you could submit those questions online. Just go to that question - Q&A tab and type in your questions and we'll be answering those questions at the end.

I'm going to start off this presentation a little bit with an overview of Million Hearts which is what brings us all here today and start off first with giving you a little bit of background on the initiative. The national risk initiative that was launched in January of 2012 by the US Department of Health and Human Services and it's co-led by CDC and CMS and focuses the efforts of federal agencies, states, regions, communities and individuals on a common goal which is to prevent 1 million heart attacks and strokes by 2017.

This goal is audacious and achievable but only with the collective efforts of each of us as individuals and as members of our communities, our work places and organizations. As I'm sure many of you know while we've seen a gradual decline in mortality from cardiovascular disease over the last 40 years, it remains the nation's leading cause of death for men and women. Each year, more than 1.5 million people will have heart attack or stroke and in addition, it's a leading cause of racial disparities and in terms of life expectancy.

In 2010, life expectancy for black populations was 3.8 year shorter than that of white population but heart disease mortality being the single cause of death accounts for most of that disparity. It's also a leading contributor in terms of cost. The US economy is - cost to the US economy of 315.4 billion every day that's nearly 1 billion for each day in medical cost and lost productivity.

In addition, heart disease remains something that is very preventable at the same time. More than half of preventable deaths happen to people under the age of 65 and these deaths could be prevented through changes in health habits such as stopping smoking, (unintelligible), less salt in the diet. We need changes to create healthier living spaces such as safe places to exercise as well as something that we'll talk about today which are smoke-free areas as well.

This table provides an overview of the Million Hearts population goals and clinical targets for the ABCs and for those of you who may not be as familiar as with the ABCs, these are the ABCs of clinical care when it comes to cardiovascular disease including aspirin when appropriate, blood pressure control, cholesterol management, and as we're talking about today, smoking cessation and assessment.

Well for 20 years, it taught us a comprehensive tobacco control programs can bring down smoking rates and death. Comprehensive programs such as media campaigns highlighted today in this slide are tips from former Smokers Campaign which is a great example of an effective media campaign that's really driving people onto Quit Lines across the country.

Well we know we have set very ambitious goals with Million Hearts. There is good evidence that these goals are achievable. This slide shows one city's dramatic drop in adult smoking -- New York City -- using a multi-prong comprehensive tobacco effort including tax increases, workplace smoke-free policies, free cessation programs and media campaign shown by the Purple Arrows.

Before 2002, the prevalent smoking was at 21% for a decade in New York City but by 2010, the prevalence fell by more than a third to 14% which

represents 450,000 fewer smokers in New York City and the rate for smokers under 18 parallels that adult curb.

In addition, Million Hearts focuses in the area of - clinical quality care and in this case highlighted here are the clinical quality measures that helps us measure and track our performance when it comes to the ABCs. Million Hearts focuses really on the alignment of measures and you see here the specific measure related to tobacco use, screening and cessation.

State and local governments and I know that we have many of on today representing state and local governments to really play a critical role in terms of our success when it comes to Million Hearts. (Unintelligible) an engaging government, healthcare providers, consumer and other groups which is really going to be very vital of the ability to really convene state and local stakeholders in a variety of different sectors and listed here are some specific actions steps that you may want to consider to take back to your state or city everything from - some steps around state and local governments having the healthcare systems, having both clinicians and the work, payers and as well as employers.

And with that, that's a quick overview of Million Hearts and now, I want to turn the program over to our speakers who will provide you with some ideas when it comes to the role of tobacco cessation can play in helping us achieve our goals of Million Hearts.

I'm going to start off first by introducing them both . The first is Jennifer Singletary who she was the director of National Health Policy at the American Lung Association. She's the primary author of the report, "Helping Smokers Quit" tobacco cessation coverage and manages the American Lung

Association cessation policy project in state tobacco control coverage database.

That database is the most comprehensive source of information on tobacco cessation coverage policy available. In addition, we're joined by (Chris Sherwin) who's the director of Tobacco Policy at the American Heart Association. At the association, he oversees the (unintelligible) of National Tobacco team and provides strategic consulting services to AHA government relations staff on tobacco policy issues.

With that, I will turn it over to Jennifer Singletary.

Jennifer Singletary: Great. Thanks, Jill. Can everyone hear me?

Jill Birnbaum: Yes.

Jennifer Singletary: Okay. Great. All right thanks for that introduction, Jill, and I'm happy to be here and share this information with you all. I'm going to trust that the folks on the webinar already have some background in what the Affordable Care Act is and what it does with my allotted time. I don't have time to get into the real background on so I'm going to go straight to tobacco cessation and then I will give you essentially kind of a tour through the Affordable Care Act and where the issues of tobacco cessation come up and where the ACA, you know, cause change on tobacco cessation coverage.

But before I get to the different types of insurance in the ACA, I just wanted to get everyone on the same page as, you know, some of the terms I used, you'll hear me saying a comprehensive cessation benefit so this slide defines what I mean when I say that and so the one association considers the comprehensive cessation benefit to include all seven medications and three

types of counseling recommended in the public health service guidelines on treating tobacco use and dependents.

So this comprehensive benefit definition comes right from that guideline which is based on a lot of evidence, a compendium of the evidence on helping smokers quit. So comprehensive benefit means all the nicotine replacement therapies -- bupropion and varenicline -- and then individual group and phone counseling and also cessation benefit should be easy to access and have a few limits if possible so that's the other thing to think of when you're going through all this information on cessation coverage policy.

So think about what treatments are actually covered and then the next slide what policies that insurance plan have that might restrict the access or make it harder for smokers to use the treatment and these are the most common barriers listed on this slide. Cost sharing is co-pays, co-insurance any money that the smoker has to pay upfront at the pharmacy or at the place where they're getting counseling to get the treatment. Prior authorization is when the doctor or the patient has to contact the insurance company before they can get the treatment, duration limits and yearly or lifetime limits.

Lifetime limits are particularly restricting because we all...we know that it often takes smokers more than one time to quit. If the process, many of them have to try several times before they're successful and so limiting a benefit per lifetime really well, you know, potentially stop a smoker from trying again if they ever relapse.

Daily limits are self-explanatory. Stepped-care therapy is a policy where the smoker has to try one treatment before they can try a different one. It's usually trying a cheaper treatment before they can move on to a more expensive one and generally, it's required, you know, they have to fail on the first treatment

before moving on to the next one and a policy that requires failure and quitting is never going to be a good thing.

And the last barrier that we see a lot is policies that require the smoker to enroll in a counseling program in order for them to get the medications. We know that pairing counseling and medications together is in fact the best way to quit but we also know that counseling can be a real barrier for some people and so they should be encouraged but not required.

So that's some background on tobacco cessation policy and the things to think about when you're delving into all of these policies on tobacco cessation. So now, I'm going to get into the Affordable Care Act or the ACA. And before I get into each type of insurance specifically, I wanted to explain kind of more broader concept that throughout the ACA which is the preventive services requirement and we've had some recent development on that which I'll share.

So in the Affordable Care Act, there is a requirement that many plans -- and I'll detail which one - which plans in a second -- but many plans have to cover preventive services given in A or B recommendations by the US Preventive Services Task Force. So the USPSTF which is the worst acronym ever is an independent volunteer panel of national experts in prevention and evidence-based medicine.

They make recommendations based on the evidence for - essentially for clinicians the recommendations are written for clinicians and doctors and they assign each recommendation, letter grade based on the strength of the evidence so A, B, C, D or I, I meaning Incomplete. There isn't enough evidence to judge one way or the other.

So they issued these grades. These recommendations were - are for clinicians and they existed before the Affordable Care Act but the Affordable Care Act requirement, you know, tied it to these recommendations and now, they're really important. They were important before and they're even more important. So what's the requirement in the ACA?

So this preventive services requirement applies to a lot of plans. It applies to private plans or you can think of those as, you know, the kind of plan that most of us probably have and that, you know, it's sponsored by our employer. Our employer provides our health insurance. It applies to all of those plans as long as they're not grandfathered. There are still a few plans that were in existence before the ACA went into effects and have managed to not lose their grandfather status so there are some grandfather plans out there that this does not apply to but most important sponsored plans this is going to apply to.

It's also applying to plans in the state exchanges so sold through the state health insurance marketplace in every state. It also applies to small group and individual plans that are sold outside of the exchange so those - there are still some plans that are doing business outside of the official marketplace and it would apply to these plans as well. This requirement also applies to Medicaid expansion plans so, however, the states that are expanding Medicaid have decided to implement that.

The plans that they're offering to the newly eligible population, the Medicaid expansion population, are supposed to also have these preventive services covered and all the preventive services are supposed to be covered with no cost-sharing which means co-pays, co-insurance and deductible. So what does this mean for us?

The USPSTF has recommendations for many different kinds of preventive services as put a smothering of them on this slide including lots of cancer screening including a new recommendation for lung cancer screening which the Lung Association obviously follows closely -- immunizations, blood pressure screening of cholesterol, you know, sexually transmitted infection, counseling, et cetera.

So this is somewhat a selection of the kind of recommendations and services that are included in this requirements and tobacco cessation is also included. There are actually three recommendations related to tobacco cessation. There is an A grade for counseling and intervention so interventions can include medications.

For - there is one recommendation for adults ages 18 and above and then the other recommendation is for pregnant women of any age and so they're both in A grade so they're included in this requirement. There is also a recommendation with B grade for education and brief counseling for prevention so not cessation but prevention in school age children and adolescent.

I'm not going to spend any more time talking about that but just so you're aware that it's there but we'll be talking about the A grade for tobacco cessation counseling and interventions. So I mentioned before that the - these recommendations from the preventive taskforce were written for clinicians and that has caused some problems when we're translating them into insurance policy because they weren't written as insurance policy.

So for the last four years, the lung association, the heart association and all of other partners in tobacco cessation has been asking the Department of Health and Human Services to work - to clarify and to define the requirement for

tobacco cessation because unlike some other treatments that are pretty cut and dry like if it says you have to cover a mammogram, you know, or if it says, you know, a mammogram is recommended for this age group while then the insurance company has to cover a mammogram for this age group.

For tobacco cessation, there are, you know, ten different treatments that I have on that previous slide that are evidence-based for tobacco cessation but the recommendation did not go into detail and so it doesn't say this means you must cover X, Y, Z. It just says tobacco cessation gets an A. So we've been asking for this clarification for four years and finally in - on May 2, 2014, the three agencies who are implementing the Affordable Care Act -- the Health and Human Services, Treasury and Department of Labor -- released a joint FAQ, frequently asked questions, document that included a clarification on the tobacco cessation requirement.

So this is what was in the FAQ. It basically said, when we say that tobacco cessation is required for all these different plans, we mean the requirement to be four sessions of individual group or phone counseling, 90 days, at least 90 days of one of the FDA approved smoking cessation medications. No cost-sharing and no prior authorizations and at least - coverage for at least (unintelligible) attempts per year.

If that seemed - sounds familiar, it's pretty close to that slide I had originally for a comprehensive tobacco cessation benefit. It's a great definition. We were very happy that they came out with this clarification in May. The question is now, what is everyone going to do with it. There are some - it's somewhat open to interpretation as to how closely planned actually have to follow this guidance and the other big question is who and who is going to enforce it and will anyone enforce it with the plan?

And I'll get into that more as we go through the presentation but there are lots of questions, you know, for HHS, we asked them clarify something for four years and they do it and then we just have more questions but that's what happened. So some states are taking action to basically make the FAQ a requirement in their state because there are some questions about whether they really have to follow it to the letter.

Meaning they - all the plans have to cover all the medications and all the types of counseling. Some plans are interpreting it as, yes, this is a requirement and we're going to cover everything. Other plans don't think they have to, at least that's what we're hearing anecdotally.

So some state policy makers and regulators have taken the authority that they're given and the guidance have basically said we are going to enforce this to the letter and make sure that you're covering all of these treatments and there has been some action. Illinois the insurance commissioner sent out a bulletin telling the plans, you know, we expect you to follow this and we'll be looking for it in your submissions for 2015.

The Kansas Health commissioner actually sent a press release out to consumers. Rather than communicating with the plans, they sent it out to consumers saying your plan should be covering this comprehensive benefit and we encourage you to quit and here's the number to call if your plan isn't doing what it's supposed to be doing. So that was an interesting approach.

The state of Washington we've also - we also know is planning to use the guidance to work with the plans out there submitting their bids essentially for the coming years so some good work is going on. I'm hoping to be able to add more states to this list as the year goes on as people become aware of this guidance and what it means.

So now, we'll get into each of the types of insurance because I think it's the most helpful to just go through each one and to talk about the coverage requirements for tobacco cessation and I'll be referring back to this preventive service requirement a lot which is why I started with it. So we'll start with Medicaid expansion so 1 of the types of insurance - kind of types of insurance that which created in the Affordable Care Act.

It created a new population of people eligible for Medicaid. This is a map from the Kaiser Family Foundation which shows which states have expanded Medicaid. The orange are states that have not expanded. The light blue is states that may be in progress. They've - I know Indiana and Pennsylvania both have state plan amendments pending with DMS and that the question of whether they're going to be approved.

And then the dark blue are states that are implementing an expansion or have - they all have implemented expansion at this point. So what are the requirements for Medicaid expansion plans related to tobacco cessation? The Medicaid expansion plans have to cover the essential health benefits and I'm not going to get into all the intricacies of the essential health benefits but just know that that means that they have to cover - these plans have to cover the A and B preventive services which is what I just talked about.

There's also a separate requirements for prescription drug coverage in this plans and the plans that the state chooses to cover the Medicaid expansion population have to cover at least one drug per category of drugs and smoking cessation is its own category so if the plan decides not to follow the FAQ guidance that I just talked about they would still at least have to cover one drug - one smoking cessation drug and, of course, hopefully they would cover more.

What are the states doing on Medicaid expansion? It's too early for me to say definitively. We're actually going through these data right now to see what's going on and confirming things but I can preliminarily say that most states seem to be simply incorporating their expansion population into their traditional Medicaid population so the Medicaid system they've already got setup.

They are just sending the new expansion people into that existing system which frankly makes the most sense and it's the simplest way to do it. So that means that the cessation coverage being offered to the extension population is going to be the same coverage as to the, you know, regular existing Medicaid population which means that there's a ton of variance and I will talk about that when I get to Medicaid.

When states are integrating their Medicaid expansion with the traditional Medicaid, they should be removing those co-pays because for the Medicaid expansion population, they're supposed to be covering preventive services with no co-pays and that's something to watch for because some states don't seemed to be doing that so we're trying to get the word out about that.

So what can you do if you are able to advocate in a state that does that have Medicaid expansion? I would suggest that you advocate for expanding Medicaid, find out how your state has or will implement expansion. It's important to understand how those, you know, where those people are being sent to get their coverage as they're being sent to the exchanges which is the case in a couple of states or if they're being sent to traditional Medicaid and just being integrated that way.

You know, push Medicaid to remove barriers as they're integrating benefits. It's a great time to talk about this with Medicaid stuff because they're already pulling apart their benefits and figuring out what to do with everything so it's a great time to ask for change and then, you know, promote cessation to the newly enrolled. A lot of these folks who are now able to enroll in Medicaid were perhaps uninsured before and so they didn't have access to a cessation benefit so it's important to get the word out and encourage them to quit smoking.

Now moving onto the state exchanges. This is a map again from Kaiser showing which states - well all the states have exchanges but some of them are opting to run their own versus letting the feds run it but it doesn't really matter when it comes to actual coverage requirements because the requirements are the same across the boards.

Plans offered in the exchanges also have to cover the essential health benefit which means that they have to cover preventive services so the same thing I was just talking about before and, once again, there is a separate prescription drug requirement and this one for plans in the exchange that these plans have to cover at least one truck per category or as many as the benchmark plan so some benchmark plans cover more than one drug and so then the exchange plan would have to meet that number of covered drugs.

What are states doing? I don't know. Data coming out of the - it's plans and the exchange is really hard to get and we are not the only organization having this problem. There is a lot of transparency issues right now so I don't know what tobacco cessation benefits are being covered through the exchanges. I do know that if a state regulator, insurance commissioner is saying that they're going to enforce strictly the FAQ, that the cessation FAQ so the preventative services requirement.

That would apply to plans in the exchange but I really don't know what's going on right now. I suggest you find out for your state for you those of you who are working in the local and state areas. So what can you do? Find out what the benchmark plan covers for tobacco cessation and then see if you can do a survey or go into documents and, you know, find it yourself. To find out what plans in your state exchange are covering for tobacco cessation and I always encourage folks that when they find this information to make it public.

Providers need this information. Consumers need it. it's also a great way of call attention to any deficiencies in the coverage so I always encourage to make people and make things public whether it's actually publishing it in a journal or more appropriate probably most of the time it's just, you know, put out fact sheet or whatever. Just make it public information.

You can also reach out to exchange plans and do outreach to the plans and also to the health insurance commissioner regarding the cessation FAQ and some, you know, here's this great guidance. You should follow it and here's why. For employer-sponsored insurance so this is not talking about the exchanges but this is private health insurance.

I already explained grandfathering but - so non-grandfathered plans. They've actually been required to cover the preventive services since 2010 and this was how we knew that plans were not all interpreting the tobacco cessation requirement the same way because coverage was all over the board. So this requirement has been in place for them since 2010. Now, we have this guidance in 2014 so it will be interesting to see what plans do with the guidance and how closely they follow it.

So what are plans doing? Again, national level data it's pretty hard. In fact, they're impossible to get because there are so many employer-sponsored plans in different products out there so we can't track it but we have seen, you know, anecdotal evidence showing that coverage is being offered is not comprehensive and not uniformed.

So plans are doing all kinds of different things. They're not - they obviously did not all think the same way when they saw the tobacco cessation requirements. So what can you do? Again, find out what the plans in your states or your area are covering for tobacco cessation. Do some sort of formal survey if you have the means to do that, means or staff resources to do it.

And even if you can't do all of the plans in the state or your area, you could, you know, you could start with some major employers or some major health insurance plans that have a lot of enrollees in your area to see what they're covering for tobacco cessation.

Again you can reach out to the plans and the employers about the cessation guidance and the preventative service requirement especially some smaller employers who maybe don't have a large HR staff and they're not following - they're not able to follow all the requirements in the Affordable Care Act. They can really use some outreach on tobacco cessation as well as doing some education and outreach to healthcare providers.

So now unto traditional Medicaid. It seems kind of in a weird order but it's because those three types of plans I just talked about all have the preventive service requirements in them so we're now on plans that don't have the preventive service requirement but the Affordable Care Act does add some requirements around tobacco cessation for traditional Medicaid.

The first one from 2010 was at a comprehensive cessation benefit is required for pregnant women in traditional Medicaid with no cost-sharing again. And then as of January 1, 2014, these are no longer able to exclude tobacco cessation medications from coverage and notice that's a double negative and that's intentional on my part because that's how the law is written and I don't know if a double negative means a positive that this is another thing that we're still waiting to see what happens in implementation.

Just because the state can't exclude a medication does not mean that it ends up automatically on their preferred drug list and that is crucial if you've ever tried to get a drug that is not on your plans preferred drug list. It's quite difficult so we're watching and seeing what happens with this requirement in the ACA.

So what are states doing? So as we know right now, only two states cover a comprehensive benefit for traditional Medicaid and so that means all seven medications and all three types of counseling so including phone counseling. So those states are Indiana and Massachusetts. Seven more cover everything except phone counseling. Phone counseling is a little special because, you know, every state has a Quit Line so that's a little different but there are still ways for Medicaid program to cover phone counseling through the Quit Line so we don't count on this comprehensive unless they also cover phone counseling.

So you got about nine states that are doing pretty much everything they should as far as coverage but one thing to know is that all states even the ones on the slide that are doing pretty have some sort of barrier to the coverage so they have a co-pay, they have prior authorization. They limit treatment to, you know, twice or once per year that kind of thing.

So no state is perfect every state can improve and there's a lot of difference, you know, it's not a uniformed thing across the country. So what can you do? Find out what your state covers for tobacco cessation and Medicaid and for this one, I actually have a resource for you. It's (unintelligible) cessation coverage, the one cessation tracks this information. we're hoping to add Medicaid expansion information this year.

So you can click on that link and find out what's happening in your state or at least what we know is happening. You know, ask if - again if you're able to advocate, advocate for a better benefit and the removal of barriers. It's one thing to get a good coverage benefit in place and it's another thing to make it easy to access so both of those are important.

Work with Medicaid to make the benefit easy to understand. That's really important. You don't want your Medicaid enrollees sifting through a bunch of complicated information to try to figure out how they can quit smoking with their Medicaid plan. It should be really easy for them to figure it out and easy for providers. Promote the benefit to Medicaid enrollees. Do, you know, media campaigns and educational campaigns, enrollees and then again provider education and outreach is always helpful.

Providers often have a hard time getting a handle on what is covered for their patient. I wanted to mention Medicare briefly even though it's a more - it's a federal thing but it's also very relevant here. A lot of people get insurance through Medicare. Individual counseling and prescription medications are covered for tobacco cessation and that was pre the Affordable Care Act. That benefit has been there for a while.

The Affordable Care Act added a prevention visit which is a place that could be a starting off point for tobacco cessation counseling and treatment so that

was a positive. Medicare does not have the preventive services requirement but the law does say that if Medicare is offering a preventive service, they have to offer it with no cost sharing so essentially the ACA did not add any new benefits but it did say that they have to take away the cost sharing and the deductible for any preventive services that Medicare is covering.

The last thing I wanted to quickly address was tobacco surcharges. These are variations in insurance premiums based on tobacco use of the policy holder so it's when plans are charging, tobacco users more for their health insurance than non-tobacco users. They come with various different names including discounts, not a discount. You're charging some people more.

And the ACA allows surcharges of up to 50% for tobacco use and small in individual markets. The Lung Association is opposed to the use of tobacco surcharges because punitive measures have not been proven effective in getting smokers to quit or even getting them to try to quit and we're concerned that surcharges will make insurance unaffordable for tobacco users and their families making insurance unaffordable for the adults and the family can definitely have effects on the children.

So that's important to remember and no one wants tobacco users to uninsured. We all know the effects - health effects and we don't want these folks to go uninsured and I can't speak for the Heart Association but I believe they have a similar position on surcharges. So what are states doing? States can actually prohibit or limit tobacco surcharges to smaller than the 50% in these markets.

Eleven states have done this and as far as what are plans doing, how are they responding to this change in the ACA, one study -- this is very anecdotal -- but one study that came out recently showed that most plans thankfully are not charging the full 50% surcharge amount so that's good but a lot - but a lot of

them are charging surcharges in states where they're allowed to so that continues to concern the Lung Association.

What can you do? Encourage state policy makers to prohibit surcharges as you're able to advocate. Reach out to our health insurance commissioner and find out what is being charged in your state or your area. You can also find out some of this information just by playing around on healthcare.gov and pretending that you want to enroll in a plan and figuring out what the premiums are and reach out to plans and employers encouraging them not to use surcharges or if they're going to at least cover a comprehensive cessation benefit like I just talked about if they do use surcharges.

All right. That is the end of my presentation and I think I'll be turning it over to (Chris).

(Chris Sherwin): Great. Thanks so much, Jennifer. So what I'll do for just a few minutes here is provide you all with a very brief overview of the larger picture of tobacco policy work that the AHA is engaged in and really this mirrors the work that are being done by our partners at the national level, at the local level and for those of you who are familiar with tobacco policy work, a lot of this may be very familiar but we wanted to make sure that you all understood how abdicating for expected coverage of tobacco cessation fits into the larger picture of tobacco control efforts.

As you all know, in January, the 50th anniversary of the attorney general's report on smoking health was released and this was really a landmark report 50 years after, of course, the primary landmark initial report in 1964, numerous findings from that report that I won't go into but it really reaffirmed that the incredible health consequences caused by tobacco, you know, more

deeply and reaffirmed the solutions that we all know are available to us to reduce tobacco use.

Now, we have come a long way since 1964 in terms of the prevalence of tobacco use. Back then, it was very high, around 42%. And as of 2013, we're about 19% of adult population that is smoking but there's another one to look through that is not quite as good. When you look at the actual number of smokers back in '64, it was 15 million. Now, it's about 43 million. Now, of course, the difference is we have a much larger population.

So we still have a lot of way too many people who are smoking. Granted those who are smoking are smoking a lot less than they did. So the actual consumption of cigarettes per capita has gone down a lot and even overall have gone down quite a bit but still, we have far too many people who are smoking.

So our work around tobacco policy, as I've said, really mirrors the agenda that a lot of other national and local partners have. When we really look at the effectiveness, proven effective ways to reduce tobacco use, as Jill had said earlier, it's really comprehensive approach of numerous policy intervention including clean our air campaigns, increasing the excise tax on tobacco, fully funding tobacco prevention and cessation programs, as (unintelligible) talking about coverage for tobacco cessation and we're really focusing on right now is the Medicaid population as an organization, that's where we see the greatest need.

We also do a lot of work around educating providers, patients and caregivers and I'll talk about that very briefly at the end of my presentation and through, of course, Million Hearts. Let me pause very quickly just to remind everybody that right after my presentation, there will be the Q&A and that is open to you

now to submit a question so if you'd like to submit a question, we can make sure that we're ready to provide those answers in the Q&A tab right at the top of your screen.

The benefits of - let me talk about smoke-free laws very quickly. (Unintelligible) but there's overwhelming evidence that smoke-free laws are a huge benefit in terms of improving cardiovascular health. Smoke-free laws can actually cause a significant drop in admissions to hospitals due to heart attacks very significant finding as well as reducing long-term impacts of the exposures to second-hand smoke. We've also - there's quite a bit of data showing that smoke-free laws have an effect on reducing smoking overall among the population.

This is a map that is created by our partners in American Nonsmokers' Rights showing where we are in the country as far as coverage of smoke-free laws. The darker blue ones have comprehensive policies covering all work places, restaurants and bars. Those that (unintelligible) cover restaurants and bars but some work place - other work places are left out and then all of the triangles (unintelligible) are all the local policies that are out there.

And like you saw earlier on the health disparity slides geographically, it's the southeast where we see still a great need to advance smoke-free policy and that's where we're really focusing a lot of our efforts. Unfortunately though, what we've seen in the last few years is a very significant slowdown in a number of statewide smoke-free laws. Back in 2010 we saw a larger number and that's slowed down quite a bit and really has to do with the fewer number of states available, the changing political clients and, unfortunately, kind of a perception that maybe the tobacco problem had been solved which has not - it's certainly not true.

Tobacco taxes, there's a very compelling number. If you look at the actual smoking cost, health cost, and lost productivity cost, per pack sold in USA and this is a very conservative estimates. That's about twice as much. We're talking over \$10 per pack so in the context of raising taxes, our overall taxes are far below the actual cost to society. The effectiveness of taxation is well documented and there's something about that raising the price of tobacco causes consumption to drop. This chart is only up to 2007 but certainly if you were to take it up the current time, we would see this trend continue.

Unfortunately, we haven't seen that many taxes recently but a clear correlation between the increase in price and the drop in consumption. And this shows the current taxation across the country. Right now, our national - our state averages are \$1.54 per pack. Unfortunately, if you look at the major tobacco states, it's only 48.5 cents per pack, largely concentrated in the southeast. And again, another place where we're seeing a significant slowdown of increases in the tobacco tax, many tax increases happened through 2010 and then (unintelligible) at 50 cents or higher in the last few years.

Tobacco prevention programs, another place where there's lots of documentation of well-funded programs that are in accordance with CDC best practice recommendations are effective in reducing tobacco use. Here's the example from Washington State where it was enormous mostly positive return on investments as well as in Arizona. Another great example of (unintelligible) this program.

But again, the trends are unfortunately not heading in the right direction. If you look at the total amount of state revenue available from all tobacco taxes and from the master settlement agreement with the tobacco companies, the total revenue is \$25.6 billion. If states were to fully fund at the CDC

recommended level for tobacco prevention programs, it's still just a fraction of the overall revenue states are getting at 3.7 billion.

The reality, unfortunately, is much lower than that. Currently, states only invest a total of about \$457 million on tobacco prevention program. So we continue to have a lot of work to do in this area.

And just to briefly mention, then we have also -- as I said earlier -- a program really a premiere effort to work with clinicians to ensure that they are providing high quality care for patients suffering from cardiovascular disease and stroke. It's on our Get With The Guidelines program and we provide doctors, nurses and emergency medical services in hospital teams with quality improvement tools and it's all based along on latest research and you may refer to some of these and (unintelligible) Get With The Guidelines, the Guideline Advantage, Mission Lifeline and hospital accreditation and certification.

Since 2001, we've impacted more than 5 million patients through these programs. And the reason it is so important for tobacco prevention is because both Get With The Guidelines Stroke and Heart Failure include measures for screening, counseling and smoking cessation, the Guideline Advantage which is our primary tool for primary care setting includes screening and tobacco use cessation intervention.

So again, I just want to provide a quick overview. If anybody is curious about what is happening in their states, what the priorities are in their states around tobacco control from an AHA perspective, we've uploaded our state advocacy director - government relations director contact list so you have access to that. Feel free to reach out to them if you want to inquire more about what's happening in your states.

And now, I'm going to turn it back over to Jill Birnbaum for facilitating the Q&A. Thank you.

Jill Birnbaum: Great. Thank you, both (Chris) and Jennifer, very much. And we have about 5 minutes for questions. I would ask for folks to submit any questions that they currently have. We have two in the queue and the first one is -- and I'll turn it over to both of you perhaps to consider a response -- which is a healthcare provider, what can I do to help in this area?

Jennifer Singletary: So this is Jennifer. I'll go first and then (Chris) can jump in if you like. I mean the first thing is to make sure you're asking your tobacco - asking your patients if they use tobacco and if they say, yes, then encouraging them to quit and if they say they want to quit, then providing them with treatment. So that's the first thing is the screening component.

And then the second thing is working on figuring out what your patients have coverage for through their health insurance plans so if your provider tends to see a lot of people from one plan or you're a Medicaid provider, that kind of thing, to be aware, fully aware of what is being covered in these plans for your patients and how the patients access them because there's all kinds of hoops that you sometimes have to jump through so being familiar with those policies and with that coverage, that's really important.

And then, just being very supportive of your patients as they're going through this process and being encouraging and hopefully helping them with counseling. I don't know if, (Chris), if you have anything to add.

(Chris Sherwin): Jennifer, I think you covered it very well. Another perspective to bring into (unintelligible) you have time is there are any efforts in your state for your

local community any advocacy efforts to pass them with the policies that I talked about whether they're taxes or smoke-free laws. We can only be successful with the engagement of volunteers and oftentimes, we have healthcare professionals, clinicians, doctors who are getting involved in those campaigns and really speak from the health impact voice that point of view.

So I definitely encourage you to get involved with any advocacy efforts as you're able.

Jill Birnbaum: Great. Now, I'll turn this one over to Jennifer. And we have - this is the last question we have right now. And again, if you have any additional, we still have time but we have one more in queue which is I work for a state public health agency and cannot lobby. Is there anything that we can be doing to make sure their state is covering cessation and implementing effectively?

Jennifer Singletary: Yes. Definitely. There are, you know, a lot of the - I had next step slides and - or, you know, what can you do slides in my presentation and feel free to go back and refer to them again. Many of the things I listed, you can do even if you can't lobby or advocate such as, you know, establishing a good relationship with the Medicaid department.

A lot of Medicaid folks don't - you know, don't hear from and don't work with the public health folks so keeping that good relationship and just figuring out what's going on even if you're not asking for change, just getting a handle on what is being covered, what does that smoker have to do to get treatment. Do they have to get prior authorization? Do they have to go to this specific program? Those kinds of things, figuring out the situation and seeing what the plans in your state are doing that's all totally, you know, not lobbying that advocacy, that's definitely within your capabilities.

And then the other thing I'll say is that a lot of these changes on cessation coverage do get made at the administrative level. They are not - you know, I often do not work with bills and state legislatures. It's just not the way these changes happen. They are more administrative. And sometimes, they are not even rule changes. Sometimes, it's just getting to the right bureaucrat in the Medicaid agency who, you know, who has the power to make this change and giving him the evidence saying, you know, these are the best practices, this is the evidence.

You know, evidence shows that this will get more people to quit and that person can often just make the decision and make it happen. So actually - but the world of tobacco cessation is less, you know, lobbying an advocacy had even some of the other areas that (Chris) has talked about. So there's a lot that folks that work for state and local health department and government can do in this area.

Jill Birnbaum: Great. Thank you, Jennifer and as a reminder, everybody, going to Jennifer's point about going back and reviewing the slides, as a reminder, you can review and download the slides (unintelligible) by going up to the top right-hand corner right now, now where you're seeing image that looks like three pieces of paper. You can click on that icon and download the presentation and handouts.

So with that, I want to thank again both (Chris) and Jennifer for the time today. I'm sure that they would respond to questions after this meeting as well so feel free to reach out to them directly or you can reach out to me as well. And finally, I want to thank Julie Harvill and (unintelligible) on our team here at AHA for all the work that they did in pulling this webinar together and finally thank all of you for joining us this afternoon and we look forward to

working with you in this important area of helping us achieve our goals around Million Hearts. Thanks, everybody. Have a good rest of your day.

Coordinator: Thank you for your participation in today's conference. Please disconnect at this time.

END