

*Testimony: HB 2129*  
*House Insurance and Pensions Committee*  
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Chair Johnson and members of the Committee:

Thank you for the opportunity to provide testimony in support of HB 2129. My testimony is based on my experience as an expert in health economics and my views do not necessarily reflect the views of my employer the University of Kansas Medical Center

Expanding tobacco cessation benefits for private insurance plans and the State Employee Health Plan (SEHP) makes economic sense. As an economist, I always question why policies that have positive economic returns do not naturally develop in the healthcare market. In this case, the net economic gains are estimated to be positive for each insurer, but likely only if all insurers expand benefits. This is because the benefits of expanded coverage do not offset the costs until the fourth year and the cumulative costs are not offset until year seven. Without consistent coverage across insurance plans, an insurer that expands services might see those benefits accrue to another provider as patients switch employers and insurance plans.

These estimates are based on a study of the costs and benefits of expanding tobacco cessation coverage from two attempts with counseling to four attempts with counseling per year.[1] Actual prescription use patterns and costs were used to estimate the cost of a quit attempt for each individual using prescription medication [2, 3] and, to be conservative, the counseling sessions were assumed to be reimbursed at just over the Medicare rate for intensive counseling. We used estimated quit rates from the literature and accounted for a relapse rate among successful quitters of 4.4%.[3] Medical cost savings were estimated as the difference between average spending for current and former smokers in private insurance plans and were calculated separately for male and female smokers and by age group.[4]

Overall, we find that insurance plans will have higher expenditures for smoking cessation in the expanded coverage scenario that are not yet offset by savings in medical spending for the first three years. For example, net costs are higher in the first year by \$26 per smoker. By year five, the economic gain from expanded coverage outpaces costs resulting in net savings of \$10 per smoker over the lower coverage level. These savings grow over time so that by year 10, the expanded coverage results in a savings of about \$100 per smoker. For a plan with 10,000 smokers, that amounts to a net savings of \$1 million in the tenth year. Covering two quit attempts per year yields economic benefits, but the cumulative savings are much higher, about double at the 10 year mark for the expanded coverage of four quit attempts per year.

I note that these estimates likely undervalue the total social benefit of expanding smoking cessation services. We only included costs paid by insurers, not travel or out-of-pocket costs for patients and only the medical cost savings for insurers, not the out-of-pocket savings for patients or any gains in quality of life. We also did not account for any spillover benefits. For example, more people successfully quitting could mean that a child is less likely to start smoking or a friend or family member is more likely to succeed in quitting.

**Summary:** We estimated that expanding smoking cessation coverage for private insurance plans and the State Employee Health Plan (SEHP) from two attempts per year to four attempts per year yields economic savings for these insurance plans through reduced future medical spending.

#### References

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2. Babb S, M.A., Schauer G, Asman K, Jamal A, *Quitting Smoking Among Adults — United States, 2000–2015*. MMWR Morb Mortal Wkly Rep 2017. **65**(52): p. 1457–1464.
3. Baker, C.L., et al., *A cost–benefit analysis of smoking cessation prescription coverage from a US payer perspective*. ClinicoEconomics and outcomes research: CEOR, 2018. **10**: p. 359.
4. Maciosek, M.V., et al., *Smoking-attributable medical expenditures by age, sex, and smoking status estimated using a relative risk approach*. Preventive medicine, 2015. **77**: p. 162-167.