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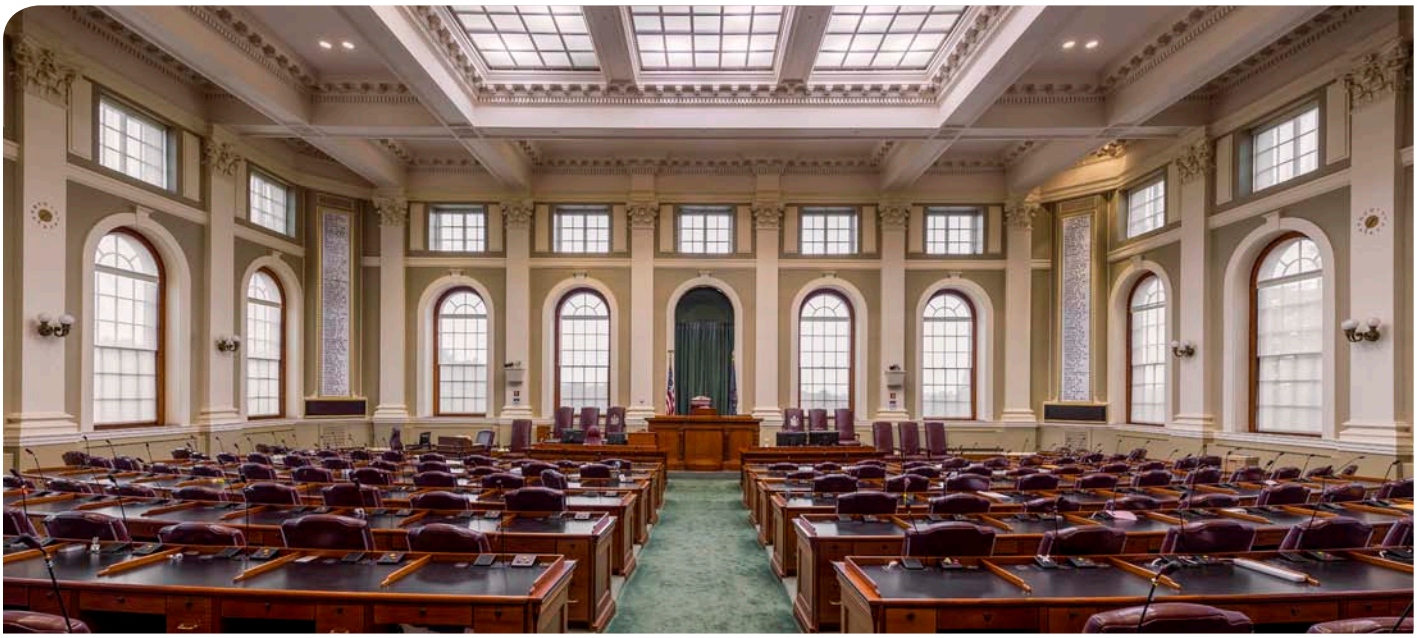
Comprehensive Medicaid Tobacco Cessation Coverage in Maine: A Case Study in Legislative Action to Improve Health



Introduction

Helping smokers quit saves lives and money. And yet, nationally the outlook for comprehensive Medicaid tobacco cessation coverage looks grim. States seem to be increasing barriers to access, such as co-pays, prior authorization requirements, and coverage limitations, at the same time they are expanding coverage.[1] However, there are a few states that are successfully expanding access to comprehensive tobacco cessation benefits free of barriers for all Medicaid enrollees. Let's look at how one of these states, Maine, used strategic legislative action to improve the health of its Medicaid enrollees.

The story began on September 1, 2012 when Maine Gov. Paul LePage canceled coverage for all smoking cessation medications under MaineCare,[2] the state Medicaid program. This applied to all MaineCare enrollees, with the exception of pregnant women, who by federal law, must be covered. In response, tobacco control advocates, together with an expanded coalition of partners, mounted a groundbreaking effort to pass legislation, LD 386, which would implement near-comprehensive coverage of tobacco cessation in MaineCare and eliminate most barriers to receiving quit-smoking treatments.

In 2013, the Maine state legislature passed LD 386 with overwhelming, bipartisan support. However, on January 10, 2014, Governor LePage vetoed this legislation. In his veto message,[3] LePage objected particularly to the elimination of cost sharing for MaineCare enrollees seeking help quitting tobacco. Later in January, the legislature overrode the governor's veto again with strong bipartisan support. This legislation positions Maine to implement one of the best tobacco cessation Medicaid benefits in the country and can serve as a potential model for other states looking to improve cessation coverage for Medicaid enrollees.

How did the tobacco control advocates succeed in the face of strong opposition from the governor? Several strategies proved crucial:

- The strategic selection of the bill's sponsor;
- a deliberate and carefully planned media strategy;
- engagement of the "right" people to deliver economic and scientific arguments for the bill; and
- an intentional bipartisan approach.

More details will be shared about these specific strategies later on in this case study.

GUIDE TO THE READER

Purpose

This case study aims to document Maine's real-world experience of passing a near-comprehensive tobacco cessation benefit for Medicaid enrollees, and to give an insider's view of the environment, key players and strategies that both enhanced and challenged success. Effective strategies, tactics, and lessons learned are highlighted throughout to help people in other states who may be considering a legislative strategy to work toward comprehensive tobacco cessation coverage under Medicaid.

Audience

The case study's primary audiences are tobacco control advocates and state department of health and Medicaid agency staff—critical allies in moving this type of initiative forward. Secondary audiences include the greater public health community, health care systems, and policymakers.

Methodology

The case study is built upon extensive review of key documents and testimony during the legislative process, as well as articles recounting the process appearing online in Maine newspapers. Sources for data on Medicaid include the Kaiser Family Foundation website and key published articles related to the Medicaid population and tobacco use. Key-informant interviews were conducted with relevant state legislators in Maine and representatives from the American Cancer Society-Cancer Action Network, the American Heart Association, Maine Public Health Association, Maine Medical Association and the American Lung Association in Maine.

BACKGROUND

The importance of supporting Medicaid smokers in quitting is well documented. Not only are their rates of smoking much higher than those of the general population (30.1 percent versus 18.1 percent)[4] they are, by definition, low-income and therefore less able to pay for tobacco cessation treatments themselves. However, there are critical cost-savings to be realized by covering evidence-based treatments for this population of smokers, in addition to ample public health and social justice evidence for Medicaid cessation coverage.

Medicaid expenditures attributable to smoking total nearly $22 billion annually, representing 11 percent of all expenditures.[5] Smoking-related diseases cost Medicaid programs an average of $833 million per state in 2013.[6] A study by the American Legacy Foundation in 2007 found that if all smokers enrolled in Medicaid stopped smoking, the Medicaid program would save $9.7 billion after five years.[7] Surprisingly, despite these and other compelling data, most state Medicaid plans do not cover all treatments proven effective in helping smokers quit and all states have at least one policy in place that makes it harder for a Medicaid enrollee trying to quit to access treatments that are covered.[8] Only two states, Indiana and Massachusetts, provide comprehensive coverage—all seven FDA-approved medications and all three forms of counseling—for all Medicaid enrollees.[9]

In Maine, smoking rates are higher among lower-income residents. Approximately 43 percent of individuals enrolled in MaineCare smoke, compared to 18 percent of Maine adults who are not enrolled in MaineCare.[10] While 19 percent of Maine pregnant women smoked during pregnancy, 43 percent of pregnant women with an income of less than $15,000 reported smoking during pregnancy.[11]

Smoking costs Maine approximately $811 million each year in direct medical costs and $647 million from productivity losses due to premature death.[12] For MaineCare, 10.6 percent of its expenditures, equivalent to $261.6 million, can be attributed to tobacco use.[13] The good news is that 76 percent of MaineCare tobacco users have a desire to quit smoking or using other tobacco products, and 97 percent of these tobacco users were seriously considering quitting in the next six months.[14]

Common Barriers to Accessing Tobacco Cessation Treatments

- Required Co-payments
- Prior Authorization Requirements
- Limits on Duration of Treatment
- Annual Limits on Quit Attempts
- Lifetime Limits on Quit Attempts
- Stepped Care Therapy Requirements
- Requirements for Cessation Counseling

Source: American Lung Association, Helping Smokers Quit, 2014

SETTING THE STAGE FOR POLICY CHANGE

The Patient Protection and Affordable Care Act (ACA) was passed in March 2010, and many of its major provisions have been implemented over the last four years, culminating in new insurance coverage to many Americans on January 1, 2014. In addition to strengthening and expanding health care coverage for those privately insured, the ACA made several changes to benefits provided to those enrolled in Medicaid. Some of these changes directly impact enrollees who smoke and want to quit by expanding coverage of tobacco cessation treatments and improving access to these treatments.

One critical ACA provision focused on improving the health and birth outcomes of pregnant women on Medicaid: as of October 1, 2010, all state Medicaid programs are required to cover a comprehensive cessation benefit for pregnant women without cost sharing.[15] Until just recently, coverage for tobacco cessation treatments for individuals enrolled in Medicaid who

are not pregnant was optional for states. However, also as a result of the ACA, as of January 1, 2014, coverage of prescription and over-the-counter tobacco cessation medications is no longer optional for states that provide a prescription drug plan to those enrolled in either fee-for-service or managed care Medicaid plans.[16] The extent to which states implement this requirement, and/or promote the coverage to enrollees, remains to be seen. There is evidence that points to the impact of the provision being directly linked to how thoroughly states implement it, including whether or not barriers to accessing these medications are removed.[17]

In addition to the major changes in the national and Medicaid health care coverage environments since 2010, the political landscape at the national and state levels have also seen dramatic changes. In 2010, all three of Maine's branches of government went from being Democratic-controlled to Republican-controlled. Paul LePage, a conservative Republican, won the governorship in a three-way race with 38.2 percent of the vote.[18] According to Gov. LePage, the key goals of his governorship were cutting taxes, environmental and labor regulations, welfare services, and public spending.[19]

IMPACT OF PARTISAN LANDSCAPE ON MEDICAID CESSATION POLICY ADVOCACY IN MAINE

According to three of the advocates interviewed, there was an almost-complete lack of trust of the tobacco control advocacy community among some legislators at the start of the 125th Legislative Session. There were a large number of freshman lawmakers, many of whom were aligned with Governor LePage initially, who did not yet know who to trust. The issue of tobacco control had been a non-partisan one until 2010 and it quickly became clear to advocates that public health issues would now be viewed less favorably.

It was no secret that MaineCare was going to be a major focus of budgetary and policy scrutiny. Prior to the LePage administration, the tobacco control advocacy community, in collaboration with the Partnership for a Tobacco-Free Maine[20] and MaineCare, had made progress toward crafting a managed care approach to MaineCare (which prior to 2010 was fee-for-service only) and defining what tobacco cessation coverage would look like under a managed care system. In addition, prior to 2010, the Legislature had been working on legislation to improve service delivery and benefit coverage by increasing coordination between MaineCare and the Maine Center for Disease Control and Prevention (Maine CDC). In 2006, Massachusetts passed its health reform law that included expansion of tobacco cessation coverage for all state Medicaid (MassHealth) enrollees. Collaboration and partnership was required between MassHealth and the Department of Public Health to implement and promote the benefit. Advocates in Maine hoped to use Massachusetts' experience as a model.

Prior to 2011, Maine had gone beyond many states' Medicaid programs by providing health coverage to childless adults and parents of enrolled children. However, the 2011-2012 two-year budget proposed by the governor eliminated MaineCare eligibility for non-citizen immigrants, increased cost-sharing by enrollees and cut off enrollment of parents who earn more than 133 percent of the federal poverty level.[21] This budget also cut nearly $50 million from the MaineCare budget and eliminated programs within the Fund

for a Healthy Maine,[22] a collection of public health programs created with tobacco Master Settlement Agreement (MSA) funds. In previous legislative sessions there had been attempt by legislators to divert some MSA funds away from the Fund for a Healthy Maine. However, it was becoming clear to public health advocates that efforts to build comprehensive cessation coverage in MaineCare would require them to play more defense than offense.

Upon her appointment, Commissioner Mary Mayhew put the brakes on plans for managed care and began cutting optional Medicaid services. Advocates, who at one time sat side-by-side with the Partnership for a Tobacco-Free Maine to improve the administration of benefits to MaineCare enrollees, no longer felt they had a place at the table. Staff within MaineCare who were favorable towards providing tobacco cessation coverage started leaving their positions and all avenues for progress toward comprehensive tobacco cessation coverage for MaineCare enrollees seemed to be closing. A compelling need to control costs in the short term started to take precedence over developing health care coverage policy based on evidence.

LD 386's JOURNEY TO PASSAGE

On September 1, 2012, Gov. LePage canceled coverage for all smoking cessation medications under MaineCare,[23] for everyone other than pregnant women (effective October 1, 2012). This purported cost-cutting measure reflected Gov. LePage's stated commitment to ensure that MaineCare not pay for anything other than services required by the federal government. This resulted in a cut of about $430,000 to MaineCare's budget for cessation medications. In addition, these cuts resulted in the loss of $750,000 in federal matching funds, amounting to a $1.2 million cut over the 2012 and 2013 fiscal years.

In response to canceling coverage of cessation for MaineCare smokers, the tobacco control advocacy community, led by the Maine Public Health Association (MPHA), American Cancer Society Cancer Action Network (ACS CAN), American Lung Association in Maine (ALA), American Heart Association (AHA), Maine Medical Association (MMA) and the Osteopathic Association, immediately went to work developing a strategic response.

"Over time, tobacco control in Maine had become apathetic—the legs had been cut out of the public coalitions doing tobacco [control] work. As advocates, we were focused on mundane issues like rule changes. No one gets excited about that. However, when there were cuts made to the Fund for Healthy Maine and cessation medications coverage, people got motivated again and paid attention to what we were doing. They were engaged in a way that they hadn't been when all we were doing was technical legislation or paying attention to where Master Settlement Agreement (MSA) dollars were going."

— Advocate

A Supportive Building Block

The MaineCare Redesign Task Force was created by legislative mandate in 2012 and charged with developing recommended redesign strategies for the MaineCare program that would provide $5.25 million in state savings in State Fiscal Year 2013. The nine-member task force, including the Commissioner of Health and Human Services who served as chair, included MaineCare members and providers with expertise in public health, finance and state fiscal and economic policy.[24] The Task Force studied state and national trends in Medicaid cost containment strategies and identified short-, mid-, and long-term recommendations. One mid-term strategy recommended by the Task Force in their Recommendations Report published in December 2012, was that restoration of smoking cessation services be referred to the Legislature for action considering the significant health impact and costs associated with smoking in the MaineCare population. This recommendation was exactly opposite what the LePage administration had done three months prior to the report's release.[25]

One strategy could have been to simply restore the benefit in the budget, but advocates quickly realized that doing so under the current administration would be tenuous, and likely unsustainable approach. Rather than focusing on legislation that would merely restore a not-so-comprehensive benefit that was cut, advocates began thinking about not only reinstating the medications benefit, but proposing the very best benefit possible. They reviewed the Public Health Service Clinical Practice Guideline, ***Treating Tobacco Use and Dependence: 2008 Update***[26] and while they wanted the statute to reflect the evidence and remove access barriers, they also understood that clinical evidence changes over time, which meant the benefit needed to be somewhat flexible. Their strategy was to use this as an opportunity to improve coverage and to open dialogue about the evidence—most notably the 2012 study that showed an investment in comprehensive tobacco cessation coverage results in substantial savings for Medicaid programs.[27] The final strategy, perhaps the most challenging, was to convince legislators that a near-comprehensive benefit for MaineCare would serve as an investment and not an expense.

Summary of LD 386: An Act to Reduce Tobacco-related Illness and Lower Health Care Costs in MaineCare

Provides comprehensive, evidence-based coverage for tobacco cessation services and medications to all adult MaineCare members:

- All cessation medications approved by FDA or recommended as effective by United States Public Health Service Task Force Clinical Practice Guideline
- Individual AND group counseling
- No copays, deductibles or cost-sharing
- No annual or lifetime limits on quit attempt limits
- Cannot require counseling to receive medications
- Must maximize all available federal funding

Public Law, Chapter 444—Law enacted when Legislature overrode Governor's veto

"As soon as coverage was cut and we knew what we were going to do, we immediately started working lawmakers and educating them! We were all over them."

— Advocate

To ensure successful passage of near-comprehensive coverage in the current fiscal and political climate, advocates needed the right sponsor for this legislation—a critical step according to one advocate. They found that sponsor in Democratic Rep. Linda Sanborn, a retired family physician, first elected in 2008, and trusted legislator among Democrats and Republicans alike. She is a champion of public health, had served on the Health and Human Services (HHS) Committee since the 2009-2010 legislative session and in the 2013-2014 legislative session moved to the Appropriations and Financial Affairs Committee. These were two key committees that the legislation needed to go through to be passed into law.

Once the bill was introduced in the HHS Committee, advocates ramped up education efforts. Advocates aligned themselves with the three other physicians then serving in the state legislature and pushed the results of Massachusetts' experience implementing a comprehensive cessation benefit under its state Medicaid program, MassHealth. These positive results included decreased rates of smoking, high utilization of the benefit, improved health outcomes and, most critically, for every dollar expended on the cessation program, there was a $3.12 return on investment within three years.[28] Simply stated, advocates had to do all they could to convince legislators that the bill would pay for itself.

A Supportive Building Block

During the very early phase of the campaign, a valuable tactic utilized by advocates was the identification of Republican legislators who were supportive of public health. Advocates began to build working relationships with them, expanding the conversation from benefit coverage to taxation of other tobacco products, and slowly they began to have Republican champions in critical positions.

"We did this through lots of one-on-one conversations about a variety of public health bills. Once we identified someone as being interested in public health issues, we would continue to go back to them. Collectively, we had worked on bills related to prohibiting tanning bed use for minors, smokefree college campuses, protecting Maine's seat belt laws, and some other issues, so we knew who had supported these issues. We used multiple bills and issues to identify and work with champions and then we asked them to talk to their friends."

—Advocate

In addition to, finding the right sponsor of the bill and conducting face-to-face education of individual lawmakers, advocates also worked to find the right funding mechanism for the bill. Republicans on the HHS Committee wanted to be sure that funding for the bill came out of the Fund for a Healthy Maine (Master Settlement Agreement funds) and Rep. Sanborn agreed. In December 2011, a commission established by the legislature, the Commission to Study Allocations of the Fund for a Healthy Maine, released its final recommendations on the alignment of allocations from the Fund, including a recognition of "the importance of investments in public health and prevention" and "that the original intent of the funding should be maintained and efforts be made to eliminate health disparities."[29]

Before agreeing to link the bill with the Fund, advocates met with Friends for a Healthy Maine, a coalition convened by the MPHA and committed to protecting the Fund, to determine if they supported its use to cover costs associated with the bill. The coalition agreed that it was a good use of funds and soon there was unanimous committee support for a fiscally prudent bill with a funding mechanism that followed the Commission recommendations.

Under normal circumstances, advocates "fight a good amount in the media" or in other words try to generate earned media to advance the policy issue being worked on. When a bill is working its way through the Legislature there

"She [Representative Sanborn] is well-respected across the aisle. Most importantly, because we had so much education to do, she could carry her own weight with this bill. She knew the issue. There was no hand-holding required like in other cases."

— Advocate

are often press conferences, letter to the editor campaigns and email alerts to encourage the public to engage with their legislators and the governor and rally support for passage. However, due to numerous accounts of Gov. LePage's public attacks on individuals opposed to his policies, tobacco control advocates felt they needed to fly under the radar with this particular piece of legislation. The agreed-upon tactic was to purposefully get through the Legislature without getting any attention from the media or the governor.

On June 27, 2013, the Legislature passed LD 386, a bill implementing near-comprehensive coverage of tobacco cessation in MaineCare, with critical bipartisan support. The Senate and House of Representatives had shifted back to Democratic control in the November 2012 state elections, and advocates agreed that they were in a better place politically than when the initial cuts to the benefit in September 2012 were made. Success had occurred in a tough budget climate due to carefully crafted efforts to make the case that the benefit would save the state money in both the short and long-term. Making this case depended heavily on the published study of Massachusetts' return-on-investment success.

> *"The cessation benefit fell into the same pot as other "optional" Medicaid benefits that were cut by the LePage administration simply because it would save money in the 1-year-budget-paper sense, but not in the long run. Legislators who might not otherwise have supported an "expanded" smoking cessation benefit certainly saw the need for people on Medicaid—who have one of the highest smoking rates—to have some assistance in quitting. While many Republican legislators generally had trouble breaking with the LePage administration, this was one area where we could gain some support."*
>
> — Advocate

Due to a clerical error at the close of the legislative session, LD 386 and six other bills were not sent to the governor's desk for signature. Advocates were not aware of this error until they came back to the statehouse for Veto Day and learned that the governor had not yet signed the bill. As a result, he would have until after the start of the next legislative session to either sign or veto the bill. The wait from June to January as this bill and others were stalled was a painful one for advocates who felt paralyzed. They did not want to prompt a veto from Governor LePage, so again made the hard decision to stay out of the media. Some advocates would come to regret this decision after the fact, as they also remained quiet on other critical public health issues until January for the same reason.

On January 10, 2014, Gov. LePage did veto LD 386, stating that the elimination of co-pays for MaineCare enrollees who seek help in quitting tobacco expands "welfare unchecked and does nothing to move us in the direction of a sound fiscal house."[30]

Advocates immediately kicked in to lobbying-mode by contacting every single legislator to determine the level of support for a veto override. They focused their efforts with those legislators that they believed were on the fence. Although they felt confident, based on the lack of debate on the bill initially, they did not stop contacting legislators until the veto override vote. They sent action alerts to encourage the public to contact their legislators and spent time tracking results of meetings with individual lawmakers. Advocates understood that there would be some lawmakers who would align with the governor simply because they did not want to go against him—even though they may have supported original passage of the bill.

> *"This is when it got fun! It was a frantic few days—calling legislators, getting allies working their contacts, engaging the grassroots coalitions. We ramped it up. A contract lobbyist developed a whip sheet on Google docs and started working every rank and file. We put ourselves outside of committee rooms and met with every single person."*
>
> — Advocate

Later that month, the Legislature did override the governor's veto, highlighting strong bipartisan opposition to the governor's action on the bill. The House vote was 131 to 10 and the Senate vote was 31-4. Advocates felt relief and extreme pride. This model bill, as well as the overwhelming bipartisan support it received, positions Maine to implement one of the best tobacco cessation Medicaid benefits in the country. Maine now has one of the country's only laws requiring Medicaid coverage of all tobacco cessation medications and individual and group counseling. The law also prohibits most barriers to treatment—thus making MaineCare's coverage for tobacco cessation near-comprehensive, as well as easy to access. Coverage for cessation must be provided without copayments or cost sharing; annual or lifetime dollar limits or limits on attempts to quit; and patients are not required to enroll in counseling in order to access medications.[31]

BUILDING BLOCKS

Strong Savings

In the current political environment advocates understood the need to focus on the bill's fiscal impact on the state Medicaid budget. This was a key message that helped advocates achieve bipartisan support for the legislation. The public health message resonated far less than the message of cost savings, so developing talking points highlighting successful quit attempts, lowered prevalence and decreased death and disease were of less importance overall.

Strong Partnerships

It was clear from the start of this effort that the critical partners (ACS CAN, ALA, AHA, and MPHA) had to be on the same page strategically and that they needed to have a presence in the statehouse every day. This meant honest conversations about internal and external priorities and capacity from the onset.

As a deliberate tactic, advocates agreed to prioritize this particular bill over others but it was certainly not easy to do. They pulled in known supporters who were not currently active, including the Maine Hospital Association and other systems that engage providers who serve MaineCare enrollees. Advocates who work on behalf of low income residents were encouraged to be vocal in support of the bill after being educated on its benefits to the Medicaid population. Susan Lamb, Executive Director of the Maine Chapter of the National Association of Social Workers, provided public testimony on the bill noting that "helping low income Mainers to quit smoking will not only improve their overall health, it will also put money in their pockets."[32] There was great success in pulling in supporters who were not necessarily active in the coalition up to that point and their combined efforts contributed greatly to success.

Strong Evidence Delivered by the Right People

According to one advocate, explaining the rationale for, and cost-savings of cessation coverage for MaineCare enrollees is not a one-minute conversation. However, showing the financial benefit is the most important information to communicate clearly. The fact that passing this bill would be a financial win for the state had to be emphasized with legislators. Finding enough of their time and their attention to make this case was a challenge. Advocates recommend finding people or organizations who are trusted by the Legislature to deliver economic messages and not spending a great amount of time trying to convince lawmakers that have in the past voted "no" on increasing benefits to low income people.

It is important to note that in the end, many lawmakers who typically vote "no" on increasing benefits to low income people did vote to override the Governor's veto. Clearly, the time advocates spent talking about return on investment and cost savings paid off. In addition, LD 386 was the first bill the Governor vetoed at the start of the 2014 legislative session and many legislators were angered that he did not simply let the bill go into law without his signature (as he supposedly promised an ally he would do). Lawmakers felt that vetoing this particular bill was not a smart way for the Governor to start the session.

"Once we gained some traction with Republicans, the momentum grew, and the rest is history."

— Advocate

As noted earlier, this effort relied heavily on what has become commonly known as "the Massachusetts study." The study, published in 2012, examined the cost implications for the state's Medicaid agency from reducing hospital admissions for heart attacks and coronary heart disease. Authors found that for every dollar invested in helping Medicaid smokers quit, the program yielded $3.12 in savings for cardiovascular-related hospital admissions alone—a net annual savings of approximately $14.7 million. Authors note that savings were reported conservatively, as they did not include long-term savings, savings occurring outside of the Medicaid program, or savings beyond hospital admissions.[33] The Massachusetts study resonated with Maine legislators because:

- The major conclusion of the study was that state policy actions to cover and promote comprehensive cessation coverage in Medicaid are cost-effective approaches to improving health outcomes for low-income populations;

- unlike many other studies showing impact and ROI of tobacco cessation coverage, this study was independent and the authors were health economists;
- savings reported in the study came in little more than a year after the smoking-cessation benefits were used, demonstrating that states can realize immediate budget gains from helping Medicaid beneficiaries quit; and
- it was a specific state example, rather than a study reporting results from national Medicaid administrative data or a compilation of multiple state data.

Strong Sponsor

Advocates spent a great deal of time strategically selecting the right sponsor for LD 386. Critical characteristics they identified in Rep. Linda Sanborn were:

- *Principled and trusted*
  Rep. Sanborn is a retired family physician who has served in the Legislature since the 2009 legislative session. She is a well-trusted member by both Democrats and Republicans and known as a champion of public health. As a retired physician, her passion for public health is not simply a political value, but is attributed to her 25 years as a family doctor.

> *"To be truthful, it was hard for me to know just where to start with this testimony, as every piece of evidence-based data proves that tobacco cessation is one of the most effective clinical preventative services (second only to childhood immunization) that we have available. It is good health policy and it is good fiscal policy."*
>
> — testimony, Rep. Sanborn

Source: http://www.mainelegislature.org/legis/bills/getTestimonyDoc.asp?id=1960

- *Critical connections in critical committees*
  Rep. Sanborn served on the HHS Committee for her first four years in office, and while she was no longer a member of that committee when LD 386 was introduced, she still had many allies on the committee and understood potential challenges that might arise with particular legislators sitting on that committee. In addition, at the time the bill was working its way through the legislature, Rep. Sanborn was a member of the Appropriations & Financial Affairs Committee—a committee that advocates knew would be critical to passage. To have an ally on this committee who also understood the tobacco cessation evidence base was of great importance.
- *Understands the importance of championing a bill*
  Multiple advocates noted that due to the amount of face-to-face lobbying needed on this bill, it was important that the bill's sponsor knew the topic and was able to effectively champion the bill from inside the legislature.

The co-sponsor for LD 386 was Sen. Brian Langley, a well-respected Republican who lives in a district with a strong Healthy Maine partnership, Healthy Acadia. It was important to Rep. Sanborn that the bill have a Republican co-sponsor and he agreed to sign on as cosponsor based on

> *"Determining who would be the best sponsor was certainly part of our legislative strategy. She [Representative Sanborn] had strong allies and a quiet strength that we knew we would need. We approached her. We sought her out."*
>
> — Advocate

the health merits of the bill, as well as his trust in Rep. Sanborn as a retired physician. One advocate noted that his name on the bill likely helped encourage support from those questioning whether or not they should support it.

CHALLENGES TO SUCCESS

Are these savings really real?

There is a perception among some legislators and public administrators that there is not a lot that can be done to control state Medicaid program costs. Despite the evidence base, the state-specific return on investment data compiled by advocates, and the MaineCare Redesign Task Force recommendations, advocates still found it difficult to communicate in a convincing way how extending cessation benefits to MaineCare enrollees would help to control costs and save the state money. Every day, lobbyists try to convince legislators that they have built a better mousetrap. The result, unfortunately, is that words like "cost savings" "ROI" and "short-term investment for long-term gain" lose power and significance over time—unless great time and effort are spent educating legislators face to face using information that is tailored to their specific concerns, questions and doubts.

"There is skepticism about if the savings are real. You speculate, but no one is really tracking. This is why utilization tracking is key."

— Senator (R)

How can we craft a bipartisan policy?

The political environment in Maine had become laser-focused on making state government smaller. Therefore, it was difficult for advocates and supportive legislators alike to determine the most effective strategies to address this trend when working on LD 386. One advocate noted that it remains difficult to convince people to support adding benefits to MaineCare when many of the conversations at the time were about excluding people from MaineCare.

Historically speaking, tobacco control policy had not been a partisan issue in Maine and LD 386 represented an opportunity to return to a bipartisan approach to tobacco control policy efforts.

Will they stand with us on override?

Assessing where Republican legislators stood on the veto override vote was a key concern for advocates during the days between the governor's veto and when the override vote occurred in January 2014. Simply stated, they needed Republican support to override this veto.

Advocates continued to talk to rank and file legislators during this time—to make certain that legislators knew that people still cared about this particular bill. There were many action alerts to supporters encouraging them to call their legislators and a lot of face-to-face lobbying. It was all hands on deck and it paid off.

"This had been an eye opener for me. I had been so used to presenting arguments where the presentation of solid evidence would be sufficient to move people… What became clear with the cutting of cessation medications, and then the veto of LD 386, was that the administration was simply not going allow any extra features of Medicaid—just those required by the feds. My facts weren't speaking to the right issue. Even though tobacco is such a small piece of Medicaid, offering the benefit was viewed as Medicaid "expansion." I had to find a way to get people to understand that approving this benefit was not approving expansion."

— Advocate

LESSONS SHARED

Think big!

By the time Governor LePage cut cessation coverage for MaineCare enrollees, advocates understood that policy decisions were being made by looking at immediate cost-cutting results. They had gotten used to playing defense and thankfully, the coalition of advocates had historical strength. They were working within a system that was looking everywhere to make cuts and did not understand the value of public health.

The cut to cessation coverage was an opportunity for advocates and they realized this quickly and collaboratively. Recognizing that the legislative process is much better at shrinking things than growing them, they decided to think big and create a bill that represented a gold standard for cessation coverage. They took a temporary cut and out-smarted and out-maneuvered opposition by refusing to compromise on, or narrow their vision of what they knew to be right.

A legislative approach opens the issue to public dialogue.

According to one Republican Senator and one Democratic Representative, the 126th Legislature knew that there was support from the HHS Committee to restore the benefit, but the need for a law on cessation coverage was still clear to many. While the administrative approach may be easier in some ways, a legislative approach opens the issue up to public dialogue and encourages a base of grassroots and advocacy support that then helps to promote new coverage or expanded coverage down the road.

> *"Get it out of the bureaucracy and make it public. If it is left up to the administration, and there isn't money to do it, or personnel to do it, it doesn't get done."*
>
> — Senator (R)

Develop solid talking points for every occasion.

Advocates agree that taking time to develop talking points "for the three minutes you may have with a legislator in the hallway of the Statehouse or the 10 minute conversation you might have at a local coffee shop" is time well spent. Making certain that talking points focus on financial arguments in support of a bill is imperative. Examples from the LD 386 effort included:

- 42 percent of adult MaineCare members smoke—more than twice the rate of non-members—and 76 percent of MaineCare smokers report wanting to quit. LD 386 provides the tools to assist them in making a good health decision and reduces one of the cost drivers in the Medicaid program.
- Maine taxpayers pay an estimated $216 million annually to treat tobacco related disease in Medicaid members—this is 100 percent preventable and avoidable.
- A comprehensive benefit has been implemented in Massachusetts and results there demonstrate a substantial 3:1 return on investment in reducing costs in their Medicaid program. The results are irrefutable—

> *When faced with a veto override vote, I ask myself, "How did I vote originally on this bill?" Then I determine what the committee chair wants. Typically, if I vote for a bill, I will vote to override a veto of it."*
>
> — Senator (R)

a 26 percent decline in beneficiary smoking rates, 46 percent fewer hospitalizations for heart attacks and a 17 percent decline in ER visits for asthma symptoms in the first year of the comprehensive benefit.

- The bill's fiscal note is minimal and could be covered with unspent tobacco settlement dollars.

Source: Hilary Schneider, American Cancer Society Cancer Action Network

WHAT COMES NEXT?

As of September 2015, the Office of MaineCare Services[34] had released all of the rule updates needed to fully enact LD 386. The Office of MaineCare Services did provide retroactive coverage of the new benefit while the rules were being promulgated.

Aside from monitoring further implementation by the Office of MaineCare Services, partners are focused on promoting the new benefit to MaineCare enrollees and health care providers who serve them, and exploring collaborative opportunities with MaineCare to get the word out about the new benefit. The Partnership for Tobacco-Free Maine included educating the public and MaineCare members about the benefit in their federal funding proposal to the Centers for Disease Control and Prevention, Office on Smoking and Health, submitted in November 2014.

CLOSING REFLECTIONS

In 2015, Maine will implement one of the best tobacco cessation Medicaid benefits in the country. At the heart of this successful legislative approach to securing near-comprehensive coverage for Maine's most vulnerable population of smokers is a dynamic, lengthy and trusted partnership among tobacco control advocacy organizations and the individuals serving those organizations. They shared a vision for progress that dared to go beyond simply restoring a loss and tried and true advocacy tactics—working all angles and leveraging all possible information, data and relationships.

Despite federal and state efforts to bolster tobacco cessation coverage for Medicaid enrollees, only two states offer comprehensive tobacco cessation treatment for Medicaid enrollees and all states, regardless of the coverage offered, have at least one barrier that stands in the way of enrollees accessing help with quitting. Recognizing that tobacco control allies in many states are in the midst of fiscal challenges, political stalemates and unsupportive administrations, there is much to be learned from Maine's experience of securing almost barrier-free coverage within a similarly challenging fiscal and political climate. There is much to be learned as implementation, promotion and evaluation of this benefit moves forward.

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