Issue Brief

STATE GOVERNMENT AFFAIRS

Tobacco Cessation and Treatment Programs

Overview

Smoking costs the US over $300 billion per year in lost productivity, premature death, and health care expenditures. However, every dollar a state spends on smoking cessation will provide the state with a 26% return on investment. It is in a state's public health interest to ensure that individuals have access to comprehensive smoking cessation treatment.

Maximizing the use of all funding sources, substantial evidence exists to show that adult and adolescent tobacco users can successfully quit using tobacco with appropriate pharmacotherapy and counseling. Although more than half of high school students who use tobacco attempt to quit during high school, and the majority of parents who smoke report that they welcome tobacco cessation counseling from their child's pediatrician, many barriers limit the ability of a pediatrician to treat the tobacco addiction of adolescent patients or the tobacco addiction of parents that may cause or exacerbate many child health conditions.

A 2006 AAP Periodic Survey of Fellows found that many pediatricians cite barriers to parental tobacco cessation counseling that include time constraints during a well-child visit and unfamiliar billing practices. Often, adolescents who use tobacco do not inform their pediatrician about their tobacco use or seek medical treatment when trying to quit due to confidentiality concerns. Private and public insurers often do not include comprehensive tobacco cessation coverage which would include a wide-range of medication and individual and group cessation counseling sessions.

AAP Recommendations

To ensure that all youth and parents who seek tobacco cessation treatment receive access to appropriate care, the AAP Policy Statement – Tobacco Use: A Pediatric Disease recommends:

- Treatment of tobacco use and dependence should be available to patients and their families in both inpatient and outpatient settings. Children's hospitals and pediatric inpatient and outpatient facilities should specifically address the tobacco use of parents and other family members.
- Proactive enrollment in cessation programs such as quitlines should be implemented in every jurisdiction and be available through all clinical settings, including pediatric settings. The additional staff and resources needed to implement a proactive program should be supported, and practices should be encouraged to visibly post quitline phone numbers and provide referrals to access cessation services.
- Public and private employers should develop or provide access to tobacco use cessation programs for their employees and provide employee incentives for participation in these programs. Incentives, such as tax exemptions, should be offered to public and private employers who offer tobacco use cessation programs for their employees.
- All public and private health insurance should provide coverage for comprehensive tobacco cessation treatment, including counseling (individual and group) and medications (both prescription and over the counter) that have been shown to be effective. Health insurance should provide

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adequate reimbursement for services related to the treatment of tobacco use and secondhand tobacco-smoke (SHS) exposure of children and families, including behavioral modification treatments and FDA-approved pharmacotherapies.

Medicaid Coverage of Smoking Cessation Treatments

The population insured by Medicaid smokes at a rate of almost 14% higher than the general population, yet only 6 states (as outlined on page 3) currently provide comprehensive coverage for tobacco cessation treatment, which includes physician counseling visits and pharmacotherapies for cessation. Along with the scarcity of such coverage for Medicaid patients, other barriers exist.

The US Public Health Service (PHS) Clinical Practice Guideline for comprehensive tobacco cessation treatment consists of coverage for all 7 FDA-approved cessation medications and group, individual, and phone counseling. To be considered comprehensive, benefits must be provided to all Medicaid recipients. However, states that provide comprehensive tobacco cessation benefits within their Medicaid programs also include at least 1 limit to accessing this coverage. These limitations can include limits in the number of counseling sessions, copays for prescription medication and counseling sessions, and prior authorizations.

While the Patient Protection and Affordable Care Act (ACA) requires Medicaid to provide comprehensive cessation coverage for certain populations, not all smokers have access to such coverage. In October 2010, the ACA required Medicaid programs to provide this benefit to pregnant women with no cost-sharing. However, there is not yet mandatory cessation coverage for the remaining Medicaid population, meaning that adults not of child-bearing age, the disabled, and parents whose children are exposed to secondhand smoke do not have access to a comprehensive cessation benefit. Beginning in 2014, Medicaid may no longer exclude tobacco cessation drugs from covered benefits. Additionally, Medicaid coverage for adults under 133% of the federal poverty level (FPL) must include an Essential Health Benefits package, which is still undefined, but may include coverage for tobacco cessation treatments and services. Ultimately, a number of individuals enrolled in Medicaid remain without tobacco cessation benefits now and into the foreseeable future.

Private Insurance Coverage of Smoking Cessation Treatment

As of September 23, 2010, the ACA required new private health plans to cover tobacco cessation treatment with no cost-sharing on the part of the enrollee. Plans existing before the enactment of the ACA, however, are granted grandfathered status exempting them from the requirement until the plan significantly changes coverage or premiums. Beginning on January 1, 2014, like Medicaid, insurance plans offered through a Health Insurance Exchange must cover an Essential Health Benefit. Again, this leaves a number of individuals without tobacco cessation benefits for the time being since the Essential Health Benefit package has yet to be determined.

Currently, most people receive their health insurance through their employers or purchase it on their own. Until the US Department of Health and Human Services (HHS) more clearly defines the smoking cessation requirement for private health insurance plans, coverage is likely to differ among plans.

State Smoking Cessation Quitlines and the Uninsured

Like the population insured by Medicaid, the uninsured smoke at rates much higher than the general population, but unlike those insured by Medicaid, the uninsured lack access to tobacco cessation services through benefits packages. In most cases, the only tobacco cessation program offered to uninsured smokers is a nationwide network of state quitlines created to help all smokers quit smoking, regardless of insurance status. Smoking cessation quitlines provide smokers with easy access to treatment whether or not they can access or pay for other means of treatment. Accordingly, state quitlines reach a diverse population of smokers. As of 2008, 54% were either Medicaid enrollees or uninsured; 10% were enrolled in Medicare; and 32% were covered by private insurance.

State-run tobacco quitlines and web services vary from state to state. Some state-run quitlines offer proactive services where a counselor calls the smoker to initialize counseling through clinician referral or self-referral through Web-based systems. Other quitlines are reactive, meaning that the smoker initiates calls and follow-ups. Quitlines can also offer callers other options, such as self-help materials, counseling, medications, and referrals. Many quitlines also provide free or discounted cessation medication to uninsured callers or callers who are insured, but without cessation medication coverage. Some quitlines have provided easy access to parents referred from pediatric care settings and have addressed secondhand smoke reduction goals, but most do not.

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Unfortunately, the majority of state quitlines are underfunded. Quitlines that are adequately funded provide the means for states to offer at least some free tobacco cessation medications to callers. Thirty-seven (37) states offer 1 or more over-the-counter medications to callers and 5 states offer prescription medications to callers. The Centers for Disease Control and Prevention (CDC) recommends that quitlines be funded at $10.53 per smoker. However, funding per smoker averages only $3.46 as of 2010, falling far short of the CDC's recommendations.

State Activity

Medicaid

Currently, only 6 states (**Indiana**, **Massachusetts**, **Minnesota**, **Nevada**, **Oregon**, and **Pennsylvania**) include both comprehensive FDA-approved cessation medication and group and individual counseling to Medicaid enrollees. Five (5) states (**Alabama**, **Connecticut**, **Georgia**, **Missouri**, and **Tennessee**) provide no cessation coverage for Medicaid enrollees, except for pregnant women as required under the ACA. Medicaid programs in 7 states (**Arizona**, **Colorado**, **Idaho**, **Illinois**, **Mississippi**, **Nevada**, **Ohio**, and **Vermont**) provide for only the 7 types of medications recommended by the PHS. Most other states (ie, 32 states) provide limited amounts of coverage under their Medicaid programs. In 2011, **Connecticut** introduced a bill to provide coverage for smoking cessation under Medicaid, but this bill failed to pass.

Private Insurers

In absence of a clearly defined standard for comprehensive tobacco cessation treatment, 8 states (**Colorado**, **Maryland**, **New Jersey**, **New Mexico**, **North Dakota**, **Oregon**, **Rhode Island**, and **Vermont**) have implemented laws requiring a certain level of tobacco cessation coverage in insurance plans. Some of these states require only prescription drug coverage; others cover both prescription drugs and counseling for a specified period of time; and other states fail to clearly describe the components of smoking cessation treatment. In 2011, bills in 8 more states (**Alaska**, **Illinois**, **Iowa**, **Massachusetts**, **Nevada**, **Pennsylvania**, **South Carolina**, and **Washington**) sought to mandate some form of smoking cessation coverage or reimbursement in private insurance plans. **Illinois** enacted a law that requires that every new insurance policy offered by employers offer optional tobacco cessation coverage of up to $500 for people 18 and older. None of the other bills were enacted.

State Employee Health Plans

Some states have also included tobacco cessation coverage for state employees. Currently, 5 states (**Illinois**, **Maine**, **Nevada**, **New Mexico**, and **North Dakota**) provide both tobacco cessation medication and group and individual counseling for state employees. Three (3) states (**Arizona**, **Kansas**, and **West Virginia**) provide all 7 medication treatments, while 3 other states (**Tennessee**, **Vermont**, and **West Virginia**) provide all 7 medication treatments plus either group or individual counseling. In 2011, **Massachusetts** and **Texas** introduced bills to cover tobacco cessation treatment for public employees; however, neither bill was enacted.

Smoking Cessation Quitlines

Though most state quitlines are funded through a blending of federal and state funds and private grants, some state quitlines rely solely on federal funding. In times of state budget crises, tobacco quitlines are easy targets for states to cut. Currently, only 11 state quitlines have just half the funding that the CDC recommends. **North Dakota** and **South Dakota** are the only states that fund most of their quitlines above the CDC-recommended level.

Federal Activity

Medicare

In addition to new requirements under the ACA for both Medicaid programs and private insurance plans, the US Department of Health and Human Services announced on August 25, 2010 that it would provide tobacco cessation counseling to all Medicare Part B enrollees, without cost sharing. Previously, these counseling services were only available to those who had established tobacco-related diseases. This coverage is important to pediatricians because, while children are typically not covered under Medicare, children's overall secondhand smoke exposure will decline if adults covered under Medicare (eg, grandparents) quit smoking. Additionally, Medicare often acts as a national standard for coverage decisions, meaning if Medicare covers a certain treatment, state Medicaid programs may be more likely to cover that treatment as well. More information on federal tobacco activities is available from the AAP Department of Federal Affairs.

Advocacy Considerations

- **Smoking cessation saves lives and saves states money.** Because smoking costs the US over $300 billion per year, the $1.26 return on investment per dollar spent on smoking cessation treatment will reduce the costs of lost productivity, premature death, and health care costs.

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Additionally, research has shown that an estimated 42,000 lives would be saved if use of cessation treatments increased to 90%.

- **Raising tobacco taxes increases the public demand for quitline and web-based cessation services.** Because adolescents have limited financial resources, they are especially price sensitive when the price of tobacco products rises. As states increase tobacco taxes (and adolescents become more likely to quit using tobacco), states should ensure that quitlines and web-based cessation services are available and that there are enough resources to handle an increased call volume.
- **Actively promoting quitlines and web-based cessation services through a variety of channels allows those without access to other types of cessation services to receive treatment.** Quitlines are an effective treatment for smoking cessation. In at least 1 study, quitlines have been shown to increase smoking abstinence by at least 30%. Because quitlines provide low-cost treatment to a broader population, they should be promoted through the media and in clinical settings, including pediatric settings.
- **Pediatricians and partners in medicine and public health can work with state tobacco control agencies to increase demand for effective cessation programs via mass media and public education programs.** Information about cessation benefits in insurance plans should be easy to find and understand, and should be promoted to both plan members and plan clinicians. For example, pediatricians can refer youth to counseling for tobacco cessation programs, which can be promoted in public education and media campaigns.

Resources:

AAP Julius B. Richmond Center of Excellence
http://www2.aap.org/richmondcenter/index.html

AAP Policy Statement: Tobacco: A Pediatric Disease
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;124/5/1474

AAP Tobacco Policy Tool
http://www2.aap.org/richmondcenter/TobaccoPreventionPolicyTool/index.html

American Lung Association – State Cessation Coverage 2010: Helping Smokers Quit
www.lungusa.org/assets/documents/publications/smoking-cessation/helping-smokers-quit2010.pdf

American Lung Association: States Should Provide Cessation Coverage to Medicaid Enrollees
www.lungusa.org/assets/documents/state-cessation-coverage-medicaid.pdf

Campaign for Tobacco-Free Kids: Quitlines Help Smokers Quit
www.tobaccofreekids.org/research/factsheets/pdf/0326.pdf

Campaign for Tobacco-Free Kids – Tobacco Cessation Works: An Overview of Best Practices and State Experiences
www.tobaccofreekids.org/research/factsheets/pdf/0245.pdf

Institute of Medicine Report – Ending the Tobacco Problem: A Blueprint for the Nation (2007)
www.iom.edu/Reports/2007/Ending-the-Tobacco-Problem-A-Blueprint-for-the-Nation.aspx

US Public Health Service - Clinical Practice Guideline: Treating Tobacco Use and Dependence 2008 Update
www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf

NOTE: Issue Briefs provide AAP chapters with an introduction to state government issues and additional background information that can be used when communicating with legislators or other public officials. While they are not intended as a presentation for, or to be distributed to, legislators, the media, or the general public, excerpts of nonstrategic information may be utilized in your advocacy work.

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