AMERICAN LUNG ASSOCIATION®
Fighting for Air

State Cessation Coverage 2010

Helping Smokers Quit

Helping Smokers Quit

Introduction

Every year 443,000 people die from tobacco-related illnesses and secondhand smoke exposure. Children lose parents, spouses lose partners, and friends lose loved ones. There is also an economic element: employers lose employees, states lose taxpayers and productive citizens, and everyone pays higher health care costs.

Even more tragically, these losses are preventable. Kids can be prevented from starting to smoke, and current smokers can quit. Unfortunately, the U.S. has done very little to help smokers quit their powerful addiction to nicotine. Although most smokers want to quit, they often struggle and sometimes fail to quit for good. One of the reasons many smokers fail to quit is a lack of access to proven and effective treatments.

The American Lung Association believes that with the passage of health care reform, there is a historic opportunity to ensure that all smokers have access to treatments that can help them quit. State policymakers must take action to extend cessation coverage benefits even further as they implement provisions from the Patient Protection and Affordable Care Act. Demand for assistance in quitting is also likely to increase, as more smokers are faced with an increasing number of smokefree laws and higher tobacco prices. Giving all smokers access to a comprehensive cessation benefit now is the right thing to do, and it is also the smart thing to do.

What's New in Helping Smokers Quit 2010

- All data updated to October 2010 (unless otherwise noted)
- 2010 trends and changes to coverage policies
- Information on how health care reform and other recent federal initiatives help smokers quit
- Now featuring trends and state-by-state data on cessation quitlines

The Benefits of Helping Smokers Quit

Ask any smoker if they want to quit, and chances are they will say yes. Surveys show that over 70 percent of tobacco users want to give up tobacco.[1] The health effects of smoking are well known to most everyone—smoking increases a person's chances of suffering from chronic diseases like chronic obstructive pulmonary disease (COPD), heart disease and lung and other cancers. Studies show that smokers' lives are over 13 years shorter than nonsmokers'.[2]

Quitting smoking also has economic benefits. Studies indicate that helping smokers quit saves thousands of dollars in health care expenditures per smoker.[3,4] These savings in medical expenses benefit smokers, insurance companies, employers, and governments. In fact, a recent study conducted by Penn State University and released by the American Lung Association showed that states could save an average of $1.26 per every dollar spent on providing cessation treatments (see side-bar).[5] Also, the money that a smoker spends on buying cigarettes can be spent on other things after the smoker quits.

Smoking Cessation Coverage Saves Money

In September 2010, the American Lung Association released a study conducted by researchers at Penn State University called *Smoking Cessation: the Economic Benefits*. The study compared the costs of a state providing cessation treatments to the benefits to society when smokers quit using these treatments. The national findings were as follows:

- Smoking costs the nation over $300 billion yearly in lost productivity, premature death, and health care expenditures.
- The average retail price of a pack of cigarettes in the U.S. is $5.51. The *actual* cost of that pack in lost productivity, premature death and health care expenditures is a whopping $18.05.
- For every dollar a state spends on smoking cessation treatments, on average, it will get back $1.26. That's a 26 percent return on investment.

For more information, please visit www.LungUSA.org/cessationbenefits

The odds are also very good that any smoker who wants to quit will also tell you he or she has tried to quit before. In 2009, 47 percent of smokers reported trying to quit in the last year.[6] Because the addiction to smoking is extremely powerful, only 4 to7 percent of smokers are successful each year in quitting.[7] Many need to try multiple times to stop using tobacco products for good. Many also need help quitting—going "cold turkey" does not work for most people.

Fortunately, smokers can get help to quit. Seven treatments—both over-the-counter and prescription medications—have been approved by the U.S. Food and Drug Administration. They are most effective when used with group, individual and phone counseling. However, policymakers at the federal and state level need to make sure that the right policies are in place for smokers to get all the help they need to quit.

What Is a Comprehensive Cessation Benefit?

In the U.S. Public Health Service's Clinical Practice Guideline called *Treating Tobacco Use and Dependence*,[8] it recommends seven medications and three types of counseling that are scientifically-proven to be effective in helping smokers quit. The Guideline, updated in 2008, is a review of decades of research on tobacco cessation, and is widely regarded as the definitive report on effective methods of treating tobacco users.

Cessation Benefits Should Include ALL of These:

Nicotine-Replacement-Therapies

- ✔ Gum
  Available over-the-counter
- ✔ Patch
  Available over-the-counter & by prescription
- ✔ Lozenge
  Available over-the-counter
- ✔ Nasal Spray
  Available by prescription
- ✔ Inhaler
  Available by prescription

Non-Nicotine Medications

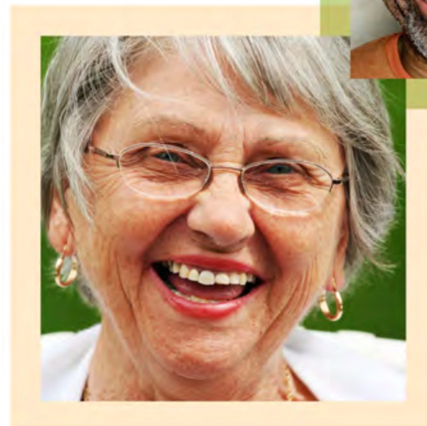
- ✔ Bupropion
  Available generic & name-brand (Zyban®); by prescription
- ✔ Varenicline
  Available name-brand (Chantix®); by prescription

Counseling

- ✔ Individual Counseling
- ✔ Group Counseling
- ✔ Phone Counseling

The medications listed in the box to the left are all recommended in the Guideline to fight the physical aspect of the tobacco addiction. The Guideline also states that these medications are most effective when paired with counseling, which helps smokers overcome the social and behavioral aspects. Counseling is the only treatment option for some smokers who should not take cessation medications (like some pregnant women or people with medical contraindications), and is effective on its own or paired with medication. The Guideline recommends three types of intensive counseling: individual (face-to-face), group, and phone. Effective cessation counseling incorporates social support and addresses practical coping and problem-solving skills.

Individual counseling can be delivered by a physician, dentist, nurse, or other clinician, as well as tobacco treatment specialist. Group counseling can and does occur in many different settings—often clinics or classes are run out of large physician practices, hospitals, community centers, religious institutions or workplaces. Phone counseling is provided in every state through state quitlines (reachable through 1-800-QUIT-NOW). Additionally several national organizations operate quitlines for smokers across the country (including the American Lung Association's Lung Helpline, 1-800-LUNG-USA). Some employers and insurance companies provide other phone counseling services to their employees and members.



In addition to the intensive counseling methods described above, the Guideline also recommends brief intervention methods for physicians and other clinicians who do not have the time or expertise to engage in intensive counseling training. These brief interventions are important, as more than 60 percent of tobacco users visit a physician and 51

percent visit a dentist each year.[9] Clinicians have an opportunity to help a lot of smokers by taking a few minutes to ask about tobacco use and briefly counseling patients to quit. The Guideline recommends that clinicians follow the "Five A's" when delivering brief cessation counseling: **Ask** about tobacco use, **Advise** in creating a quit plan, **Assess** willingness to make a quit attempt, **Assist** in quit attempt, **Arrange** follow-up.

The Guideline states that treatment with medication is effective by itself, as is counseling. However, smokers who are treated with both medications and counseling are even more likely to quit than smokers just using one form of treatment. Therefore, smokers should be encouraged—but not required—to combine these forms of treatment.

Increasing Access to Cessation Treatments Through Insurance Coverage

Tobacco dependence is a medical condition just like any other addiction, and its treatment needs to be covered by insurance plans. One of the main ways some smokers currently receive access to these proven treatments is through their health insurance coverage. Health care providers are a logical place for smokers to look for help quitting. Clinicians should be able to prescribe medications and counseling covered by patients' health insurance that will help them. It is crucial that all smokers with all types of insurance have access to medications and counseling that will help them quit. Public programs like Medicare and Medicaid provide health care to some of the most physically and economically vulnerable populations. Lower health care costs in public insurance programs means spending fewer taxpayer dollars. Private insurance plans also insure many smokers who need access to these treatments through their plans as well.

Insurance companies, program administrators and employers should ensure that they cover a comprehensive tobacco cessation benefit, which includes all seven FDA-approved medications and individual, group and phone counseling. Treatment for smoking cessation is not one-size-fits-all, everyone responds to treatment differently. Some patients also might not be able to take one or more cessation medications because of other medical conditions they have. For all these reasons, patients need to have the full range of treatment options available to them when they want to quit.

Cessation treatments must also be as easy for smokers to use as possible, so as to further encourage them to quit. Some health plans cover a treatment, but make it so hard for smokers to use the treatment that it might as well not be covered in the first place. Low-income patients, like Medicaid enrollees, are especially vulnerable to these barriers, as they are less able to afford treatment on their own.

The most common barriers found in insurance plans are listed to the right. All of these barriers should be avoided where possible to make it easier for smokers to quit.

Barriers to Avoid:

- ✖ Required Co-payments
- ✖ Prior Authorization Requirements
- ✖ Limits on Treatment Duration
- ✖ Yearly or Lifetime Limits
- ✖ Dollar Limits
- ✖ "Stepped Care" Therapy (requiring the use of one treatment before another)
- ✖ Counseling Required for Medications

American Lung Association Smoking Cessation Programs

The American Lung Association provides several programs that help tens of thousands of smokers quit every year. *Freedom From Smoking®* is considered to be the gold standard of smoking cessation programs and *Not-On-Tobacco®* is the country's most widely used teen smoking cessation program. All of these programs include components of the intensive counseling interventions recommended in the Guideline. More information about these programs can be found at www.LungUSA.org.

Freedom From Smoking®

AMERICAN LUNG ASSOCIATION. Freedom FROM SMOKING®

The *Freedom From Smoking®* program has been helping smokers quit for over two decades. The program is offered in three different formats. It began in 1980 as a self-help manual, which is still available today. The program is also offered as an eight-session group clinic in many areas of the country. Additionally, the American Lung Association offers *Freedom From Smoking®* Online (www.ffsonline.org), which takes smokers through the same recommendations online and provides interaction with other smokers from across the country. All *Freedom From Smoking®* products are regularly reviewed and updated to make sure the program remains "America's gold standard in smoking cessation programs."

Participants in *Freedom From Smoking®* develop a personalized step-by-step plan to quit smoking. Each session uses a positive behavior change approach and encourages participants to work through the problems and process of quitting individually as well as in a group.

Evidence has shown that *Freedom From Smoking®* is very effective at helping smokers quit.[10, 11]

N-O-T® NOT ON TOBACCO

Not-On-Tobacco®

This program for teens aged 14-19 was developed by the American Lung Association and West Virginia University. Introduced in 1997, it is now the most widely available teen tobacco cessation program in the country.

The program includes 10 sessions conducted in small groups. N-O-T is a voluntary (non-punitive) program that offers participants support, guidance, and instruction on understanding the reasons they started smoking, preparing to quit, and preventing a relapse once they have quit.

Not-On-Tobacco has proven to be effective in helping teens quit smoking.[12, 13]

Lung HelpLine (1-800-LUNGUSA)

The Lung HelpLine is a valuable resource to anyone interested in and affected by lung health. The HelpLine is staffed by registered nurses, respiratory therapists and smoking cessation counselors. Callers can ask about a variety of lung-related topics—but around 70 percent of calls are related to tobacco cessation.

The Lung HelpLine can help callers quit smoking, and refer them to local programs and treatments that will also help. The nurses and therapists at the Helpline also answer questions submitted through the American Lung Association website.

The Federal Government Weighs In

The federal government is an important player in providing access to comprehensive cessation benefits. It is able to set national standards for cessation coverage and provide funding. The federal policies enacted in the last two years, including the American Recovery and Reinvestment Act of 2009 (ARRA) and the Patient Protection and Affordable Care Act of 2010 (PPACA), have taken important first steps in helping all smokers quit.

Stimulus Funding

Enacted in February 2009, ARRA was intended to jump-start the U.S. economy by saving and creating jobs, investing in long-term growth, and fostering transparency in government.[14] An investment in tobacco cessation can help accomplish all of these goals. The money invested in tobacco cessation helps to save jobs in the public health and health care industries. It also is a smart investment in long-term growth, as reducing tobacco use increases productivity in a society, and saves money. These are some of the reasons tobacco cessation services have been declared one of the most cost- and health-effective preventive services.[15]

Therefore it is no surprise that preventing and stopping tobacco use plays an important role in the Communities Putting Prevention to Work initiative (CPPW) under ARRA. The purpose of this initiative is to implement obesity, nutrition, physical activity and tobacco control strategies in states and communities across the country. All together, the CPPW initiative distributed over **$119 million** in grant funding for prevention activities to the states and territories.[16] The CPPW grants designated for tobacco use prevention are being used to implement evidence-based strategies and policies to prevent people from starting to smoke and help current smokers quit. This includes $44.4 million being used to maintain and expand quitline services in all 50 states and the District of Columbia.[17]

What is not clear is how funding will be sustained for these critical community investments after the two-year grants expire. Continuing the investment in tobacco prevention and cessation will ultimately save millions of lives and billions of federal dollars, as fewer kids will start smoking and more smokers will get the help they need to quit.

Changes to Medicare

In 2005, the Centers for Medicare and Medicaid (CMS) began covering individual tobacco cessation counseling under Medicare Part B for patients who have a smoking-related illness or are taking medications affected by tobacco use. Since Medicare prescription drug coverage was implemented under Part D in 2006, Medicare patients are also provided with prescription cessation medications. While these were important steps, the coverage provided was not comprehensive, and not provided to everyone on Medicare.

In August 2010, CMS announced that the cessation counseling benefit under Medicare would be expanded to include all Medicare enrollees. While this is an important step forward, the coverage does not follow the Public Health Service Guidelines and only includes individual counseling—not group or phone.[18] Additionally, over-the-counter cessation medications are still not covered under Medicare Part D.

Health Care Reform

The Patient Protection and Affordable Care Act (PPACA), enacted in March of 2010, will have far-reaching consequences in U.S. health care. The law had several provisions related to tobacco use and effecting tobacco users' access to tobacco cessation treatments.[19]

Medicaid

- Prior to enactment of PPACA, there were no national requirements for tobacco cessation coverage in Medicaid for adults. Coverage decisions in this area were left up to the states, and states were allowed to exclude cessation treatment from coverage. Some states did just that.
- As of October 1, 2010, all state Medicaid programs are now required to cover a comprehensive cessation benefit for pregnant women with no cost-sharing. This benefit is to follow the recommendations of the U.S. Public Health Service Guideline. As of November 1st, CMS had not communicated to states what specifically they were required to cover.
- Congress did not include the rest of the Medicaid population in mandatory cessation coverage. This means many people on Medicaid still do not have access to a comprehensive cessation benefit. The adults left out of this provision include Americans not of child-bearing age, the disabled, and mothers and fathers whose children are affected by secondhand smoke.
- Beginning January 1, 2013, Medicaid programs that voluntarily cover all preventive services recommended with an 'A' or 'B' by the U.S. Preventive Services Task Force (USPSTF)[20] will receive a one percentage point increase in their federal matching rate for those services. Tobacco cessation services are given an 'A' by the USPSTF, so are included in this provision.
- Beginning January 1, 2014, state Medicaid programs will no longer be able to exclude tobacco cessation drugs from their prescription drug coverage. This provision will not guarantee coverage of all cessation drugs, however, and may not even guarantee placement on formularies or preferred drug lists.

Private Insurance

- Prior to enactment of PPACA, there were no national requirements for preventive services, including tobacco cessation, in private insurance.
- As of September 23, 2010, private group and individual health plans must cover all preventive services recommended with an 'A' or 'B' by the USPSTF with no cost-sharing. As previously mentioned, tobacco cessation is included as an 'A' recommendation, so private plans must cover some level of tobacco cessation treatment. More clarification is needed from the Department of Health and Human Services (HHS).
- The new preventive services requirements only apply to health plans in which an individual has enrolled since March 2010. Plans that were in existence before enactment of PPACA are "grandfathered" into the policy, and are therefore exempt from most of the requirements of health care reform. Only after a plan makes significant changes to coverage or premiums does

Leading by Example: Federal Government Employees Now Have Comprehensive Cessation Benefits

In April 2010, the U.S. Government Office of Personnel Management's Federal Employee Health Benefit (FEHB) program announced it would begin covering tobacco cessation treatments in 2011. Beginning January 1, 2011, federal employees and their families, no matter which health plan they choose, are guaranteed coverage of:

- At least four sessions of group, individual or phone counseling, lasting at least 30 minutes per session
- All FDA-approved cessation medications, including over-the-counter and prescription options
- Benefits provided with no copayments, coinsurance and are not subject to deductibles
- Coverage provided for two quit attempts per year
- The cost of treatments cannot be limited annually or by lifetime

By putting this new requirement into place, FEHB is leading by example, which is important because the benefits provided to federal employees are often looked upon as models for other insurance plans. FEHB is also saving the lives of its employees, and saving taxpayer money by investing in prevention.

For more information, see http://www.opm.gov/carrier/carrier_letters/2010/2010-12c.pdf

it lose its grandfathered status. Unfortunately, this provision leaves many Americans without the coverage of preventive services guaranteed in PPACA. In addition, a recent *Wall Street Journal* article detailed efforts by McDonald's and other retail employers that are seeking exemptions on a number of requirements.[21]

- Beginning January 1, 2014, each state must operate "exchanges" for individuals and small businesses in the insurance market. Each plan offered through these exchanges must cover an "essential health benefit" as defined by the Secretary of HHS. The American Lung Association has formally asked the Secretary of HHS to include a comprehensive cessation coverage in this essential health benefit.[22]
- Health plans offering coverage in the individual and small-group exchanges will be allowed to vary premiums based on tobacco use (sometimes called a "tobacco surcharge"). These plans are specifically allowed by the legislation to charge tobacco users premiums of up to 1.5 times that of non-tobacco users—this could mean tobacco users would be required to pay thousands of extra dollars in premiums. The American Lung Association considers tobacco surcharges to be punitive measures and barriers to obtaining health insurance coverage, and such measures have not been proven effective in encouraging smokers to quit.[23]

Public Health and Prevention Funding

- PPACA established a Prevention and Public Health Fund to support public health and wellness programs and activities authorized by the Public Health Service Act (including prevention research and health screenings). Funding for this initiative starts at $500 million in 2010, and incrementally increases to $2 billion by 2015.
- While this legislation is only six months old, this funding has already been attacked in the Senate. In August 2010, Senator Mike Johanns (R-NE) introduced an amendment to the Small Business Jobs Act that would remove most of the money in the Prevention and Public Health Fund. The amendment was defeated by a 46-52 vote. This was the first, but likely not the last, attempt to raid this funding. The public health community must be vigilant about educating members of Congress about the importance of this fund.

As this discussion shows, federal policymakers took several important steps toward bringing tobacco users in this country more access to cessation treatments. However, the American Lung Association encourages the federal government to continue its efforts to extend comprehensive cessation benefits to all Americans.

To-Do List
Federal Government

- Congress must ensure that tobacco users have access to affordable health care and the help they need to quit.
- Comprehensive cessation coverage benefits must be available to all Medicaid patients nationwide, not just pregnant women.
- The U.S. Department of Health and Human Services must clarify which tobacco cessation treatments are required for private insurance plans. The American Lung Association encourages the department to define this required benefit as all treatments recommended by the U.S. Public Health Service Guideline.
- The U.S. Department of Health and Human Services must include a comprehensive cessation benefit in its definition of the essential health benefit required of plans in state exchanges.
- Congress must maintain the Prevention and Public Health Fund established in the Patient Protection and Affordable Care Act.
- Congress must sustain the funding levels provided to states and communities to prevent and stop tobacco use as first provided in the federal stimulus bill.
- The Centers for Medicare and Medicaid must follow the U.S. Public Health Service Guideline and expand the cessation counseling benefit under Medicare Part B to include phone and group counseling. The cessation medications benefit under Medicare Part D also needs to be expanded to include over-the-counter cessation drugs.
- To provide more incentive for Medicaid programs to cover preventive services, Congress should increase the amount the federal government contributes to the cost of these services.
- The American Lung Association encourages the Centers for Medicare and Medicaid to allow dollars to go toward funding state quitlines.

States Can and Should Take Further Action

While the federal government has taken important steps in helping smokers quit in the last two years, there is still an important role for states to play in this policy area. The health care reform law does not provide cessation coverage for nonpregnant enrollees in Medicaid. States have a responsibility to fill this crucial gap and provide these treatments to some of their most vulnerable citizens. In addition, the current requirements for private insurance plans regarding tobacco cessation have not been defined in detail—and most plans are likely to implement coverage that is less than comprehensive if states do not step in and enact stronger requirements. States also have the ability to require plans that are grandfathered by the federal legislation to cover preventive services.

States are already making changes to their public and private health care systems while implementing PPACA. In many instances, it would be easier for states to implement and easier for tobacco users to get treatment if states required all insurance plans to cover the same comprehensive cessation benefit for everyone now, during this process.

It is also crucial to improve cessation coverage right now because the economic and social environments are changing in ways that make tobacco users more interested in quitting. As states continue to struggle with balancing budgets, more and more are turning to tobacco taxes to fill gaps. Increasing tobacco taxes is proven to lead to more people making quit attempts.[24] States and localities are also continuing to make more areas smoke-free, which also creates an environment that encourages quitting. It is crucial that these quitters be supported by their insurance plans and public health programs in the state.

To-Do List
State Governments

- States must direct all public insurance plans, including Medicaid and state employee health plans, to cover all quit smoking treatments recommended in the U.S. Public Health Service Guideline.
- Medicaid programs and state employee health plans must ensure that a comprehensive cessation benefit is specifically required in contracts with managed care organizations (MCOs) and health maintenance organizations (HMOs).
- States must require all private insurers to cover a comprehensive cessation benefit.
- States must require that all insurers provide tobacco cessation treatments that are easy to access. State policymakers can specify that plans not charge copayments, require prior authorization, limit benefits by treatment duration or by lifetime, require stepped care therapy, and require specific pairings of treatment.
- States must ensure that information about cessation benefits in all insurance plans is easy to find and understand, and that benefits are promoted to plan members and plan clinicians. States should also promote messages through media that encourage smokers to quit.
- State policymakers must fund state quitlines at the CDC-recommended level of $10.53 per smoker.

State policymakers have a golden opportunity here to save lives, create a more productive society, and save money; and they must seize it. Make no mistake—federal health care reform did not solve all the problems in this area. States still need to step in and ensure their citizens have access to help to quit.

Medicaid Coverage of Cessation Treatments

There is tremendous need for tobacco cessation benefits for the Medicaid population. People who receive Medicaid benefits smoke at higher rates than the general population (36.5 percent versus 22.7 percent for ages 18-65).[25] These Medicaid enrollees also, by definition, have low incomes and are less able to pay out-of-pocket for any cessation treatments. These are reasons enough to help people on Medicaid quit smoking. But providing this help has fiscal advantages as well. Smoking-related disease costs Medicaid programs millions of dollars every year—an average of $607 million per state in 2004.[26]

According to American Lung Association data for 2010, six state Medicaid programs provide comprehensive coverage for tobacco cessation treatments. These states give their Medicaid enrollees the best chances to quit by providing comprehensive coverage; that is, they provide all seven FDA-approved cessation medications and group and individual counseling to all Medicaid recipients.[i] While there has been some progress in Medicaid cessation coverage in the three years since the Lung Association began tracking these data, unfortunately, the number of states providing comprehensive coverage has not increased. More states need to follow these examples.

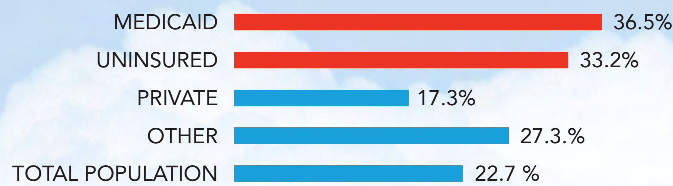
In 2010, 17 states came close to providing comprehensive coverage. These states covered all but one or two cessation treatments for all Medicaid enrollees. A common limitation among these states is the absence of coverage for counseling, despite coverage of all the recommended medications. Seven out of the 17 states have this specific gap in their coverage.

Five states provide NO coverage for cessation treatments to their entire Medicaid population in 2010. Requirements in the federal health care reform law have affected these states—they are now required to cover cessation treatments for pregnant women. But they are not required to provide them to anyone else, and do not provide any treatments to the *entire* Medicaid population.[27] While helping pregnant women quit smoking is very important, limiting counseling in this way unfairly and unwisely leaves out many other smokers.

In most states, the Medicaid program contracts with one or more managed care organizations (MCOs) or health maintenance organizations (HMOs) to provide health insurance to their enrollees. If cessation treatments are not required in the state's contract with the MCO/HMO as a covered service, decisions about this coverage are left up to the individual health plan. This often results in coverage that is less than comprehensive and varies by MCO/HMO. These differences between plans confuse Medicaid enrollees who are trying to get treatment, and unfairly penalize enrollees for choosing health plans that might otherwise have been best for them. To ensure all smokers in Medicaid get the same level of quality cessation coverage, the American Lung Association urges Medicaid plans to

i Some form of telephone counseling is provided to all state populations through state quitlines. Quitlines are discussed later in this report.

People on Medicaid and the Uninsured Smoke at Higher Rates than Others (Ages 18-65)



Source: Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey, provisional data. 2009.

require comprehensive cessation coverage in their contracts with managed care organizations.

Unfortunately, potential quitters encounter barriers to getting the help they need even in the states where Medicaid covers tobacco cessation treatments. One of the most common barriers is a copayment for medication or counseling sessions. Requiring these payments, especially of the low-income Medicaid population, discourages smokers from seeking treatment or refilling their prescriptions. The American Lung Association urges states to eliminate or dramatically reduce copayments.

Many Medicaid programs also limit how long quitters may take cessation medications, or how many counseling sessions they may attend. Some smokers take longer to quit than others because their addictions vary. Any arbitrary limit on length of treatment that does not follow FDA recommendations for the medication can discourage a smoker from continuing to try to quit or cause a relapse. Other barriers quitters encounter in their Medicaid coverage include lifetime, annual and dollar limits; prior authorization and stepped care requirements; and requiring the pairing of counseling with medications. For state-by-state information on coverage barriers, see Appendix C of this report.

While states have made changes in the right direction since last year's report was issued, the change has been incremental and has not gone far enough:

- In compliance with federal health care reform legislation, **Alabama**, **Connecticut** and **Tennessee** have begun covering medications and some counseling for pregnant women. The **Georgia** Medicaid program is also required to implement a benefit for pregnant women, and is in the process of doing so.
- In 2010, the **Missouri** legislature appropriated funds for helping pregnant tobacco users in the Medicaid program quit. Previously, the Medicaid program had not provided any treatments to help Medicaid enrollees quit. As of October, 2010, Medicaid enrollees who are pregnant or were pregnant within the last year will have access to a comprehensive cessation benefit, including all medications and counseling. Unfortunately, Missouri still does not provide treatment to its entire Medicaid population.
- After several years of having authorized a cessation benefit in the Medicaid program, but not funding it, the **Kentucky** state legislature finally funded this coverage in 2010. The benefit, implemented in October 2010, includes all cessation medica-

Six States Offer Comprehensive Cessation Benefits to All Medicaid Enrollees:

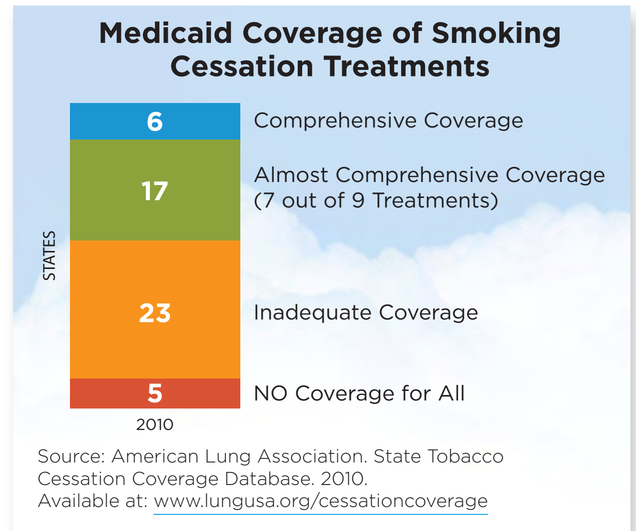
Indiana
Massachusetts
Minnesota
Nevada
Oregon
Pennsylvania

Five States Provide NO Cessation Coverage for All Medicaid Enrollees:

Alabama
Connecticut
Georgia
Missouri
Tennessee

tions and one individual counseling session with a clinician. Two quit attempts per year are covered.[28]

- The **Hawaii** Med-QUEST program took a big and important step this year. As of July 1, 2010, the program required all the managed care plans they contract with to cover all cessation medications and at least one type of counseling.[29] While this coverage is not completely comprehensive, and it does not affect the fee-for-service plan, this is an important step that will give many tobacco users access to treatment.



- Previous to this year, cessation counseling in the **New York** Medicaid program has only been provided to pregnant women. In January 2010, the plan expanded this coverage to include post-partum women (up to six months after giving birth).[30] This important step recognizes that a lot of women who quit during pregnancy relapse after they give birth. Unfortunately, counseling is still not available to those not pregnant or post-partum.

State Employee Health Plan Coverage of Smoking Cessation Treatments

Every state provides health insurance to its employees.[31] As state governments are often one of the largest employers in states, this coverage reaches a large number of people. Many state employee health plans also serve as examples for other health plans in the state. Therefore it is important for these health plans to cover cessation treatment for smokers—not only to create a healthier state workforce, but also to benefit others in the state. Furthermore, helping state employees quit will directly save state taxpayers money.[32]

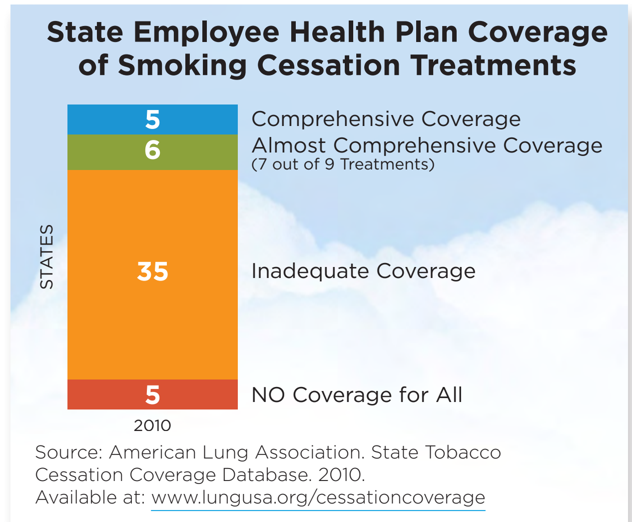
Coverage of cessation treatments for state employees varies widely state-to-state, according to data collected by the American Lung Association for 2010. Five states lead the way in providing comprehensive coverage to all state employees and dependents. A few more states (6) come close, providing all but two treatments for cessation.

Unfortunately, 35 states provide inadequate coverage and five states provide NO coverage for their employees and dependents who want to quit smoking.[33]

In some cases, the differences in coverage between managed care organizations (MCOs) create significant differences in the tobacco cessation treatments that are available to state employees. Just like Medicaid programs, state government benefit programs/administrators should specify in their contracts with MCOs that comprehensive cessation coverage is required, as well as offering it through self-insured plan options. Another way to guarantee coverage for all employees and dependents is to provide it through a state employee wellness program.

Encouragingly, several state employee health plans made positive changes to the cessation coverage they provide in 2010:

- The **Kansas** Health Policy Authority added coverage for the gum and patch for all state employees.[34]
- Previously, **Montana** provided no help to state employees who wanted to quit smoking. This year, the Montana Employee Benefits Bureau added a new cessation benefit that provides five of the seven medications and individual counseling. While this is an important step, there are still several barriers to employees accessing this benefit—the most onerous being it is only available once per lifetime.[35]
- **Nebraska** also added a new cessation benefit. Cessation treatment is now part of the new Wellness PPO plan, which is available to all employees if they agree to take a health assessment and participate in wellness activities. These kinds of requirements may present a barrier to coverage and may compromise employee privacy. Bupropion, varenicline, and the nicotine replacement therapy (NRT) patch are provided to members of the Wellness PPO, as well as individual counseling through the EMPOWERED Health Coach program.[36]



Source: American Lung Association. State Tobacco Cessation Coverage Database. 2010. Available at: www.lungusa.org/cessationcoverage

- Before 2010, tobacco cessation treatments available to **Ohio** state employees varied by which health plan they chose. This year, all Ohio employees and their families—regardless of health plan—have access to cessation treatment. The benefit covers phone or online counseling, along with five of the seven cessation medications. Two quit attempts per year are permitted.[37]
- In its FY 2011 budget legislation, the **Florida** state legislature required Florida state employee PPO and HMO plans to cover tobacco cessation medications.[38] While this requirement is not comprehensive, it is a significant improvement—prior to July 1, 2010, state employees and dependents had no access to cessation treatments through their employee benefits plan.
- Certain employees in **Texas** are now able to participate in a pilot program that provides prescription cessation medications in conjunction with the Texas Quitline. As the coverage is only available to employees in one section of government currently, the American Lung Association encourages the expansion of the program.

Five States Provide Comprehensive Cessation Treatment Coverage for All State Employees:

- Illinois
- Maine
- Nevada
- New Mexico
- North Dakota

Five States Provide NO Cessation Treatment Coverage for All State Employees:

- Georgia
- Maryland
- Louisiana
- New Jersey
- South Dakota

Unfortunately, there is also one case of bad news. State employees in **Georgia** no longer have access to help quitting. State employees who use tobacco are further penalized because tobacco users on the state employee health plan are charged a higher premium for health insurance.

Private Insurance Coverage of Smoking Cessation Treatments

Currently, the majority of Americans who have health insurance receive it through their non-government employer or buy it on the individual market. Many decisions about coverage and benefits for these privately-insured Americans are made by insurance companies and employers. This coverage varies widely state-by-state, employer-by-employer, and plan-by-plan. As previously discussed, the health care reform law requires these plans to cover tobacco cessation services, but the requirement has not been clearly defined. Therefore, coverage is likely to continue to vary widely.

Beyond the federal law, a few states have stepped in to ensure some level of cessation treatment coverage for privately-insured tobacco users in their states. Eight states currently have laws or insurance regulations that require cessation coverage in some or all private insurance plans in the state.

Each of these laws/regulations is different. Some have requirements for a "tobacco cessation program" or "interventions" to be covered, but do not specify which treatments must be covered. This means that insurance companies are left to determine what these programs or interventions entail, and they are rarely comprehensive—which leaves smokers with too few options. Colorado, New Jersey, North Dakota and Oregon have laws like this.

Other state provisions include more specific language, ensuring that certain medications or types of counseling are available for all applicable smokers. Maryland, New Mexico, Rhode Island and Vermont have these more specific laws.

Since the last edition of this report, only one state has enacted a law requiring coverage of cessation treatments. Vermont passed a law requiring all insurers in the state to cover all seven medications FDA-approved for smoking cessation. The law unfortunately does not require coverage of counseling.

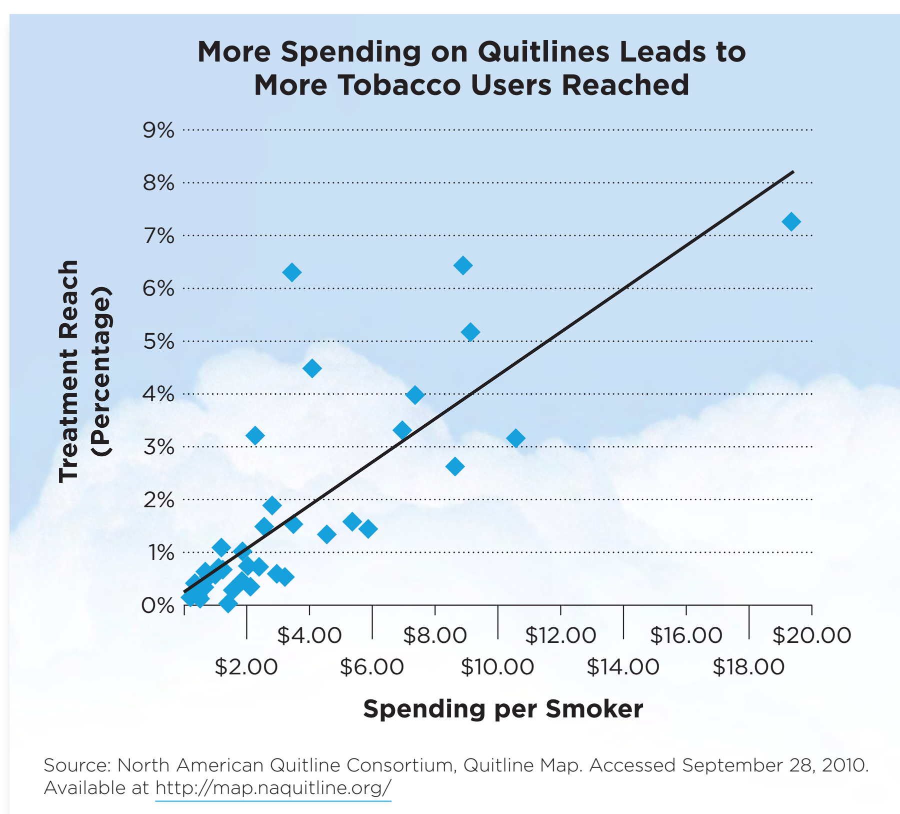
With laws and regulations like those discussed above, state governments can help smokers quit, and, ultimately, help save lives. Setting a standard that applies to the whole state is important; first and foremost, a standard coverage helps the largest number of smokers quit and be healthier. Enacting these standards also helps employers in the state. Helping workers quit improves their productivity and saves employers and employees money on life insurance premiums and health care costs. Employers and insurance plans could save up to $210 per year for every covered smoker who quits.[39]

Eight States Have Legislative or Regulatory Standards for Cessation Treatment Coverage:

- Colorado
- Maryland
- New Jersey
- New Mexico
- North Dakota
- Oregon
- Rhode Island
- Vermont

Smoking Cessation Quitlines

States can also reach and help smokers through their tobacco cessation quitlines, which provide one of the three forms of counseling recommended in the Guideline. In 2004, the U.S. Department of Health and Human Services launched the National Network of Tobacco Cessation Quitlines Initiative. Since then, every state in the U.S., the District of Columbia, and Puerto Rico has operated a cessation quitline. These quitlines are available to anyone, regardless of insurance status. However, the specific services available from a quitlines (including phone counseling sessions and sometimes free or discounted medications) can vary depending on the insurance status of the caller (more sessions or medications available to uninsured, for instance), as well as the age of the smoker and other eligibility requirements. All tobacco users can reach their state quitline by calling 1-800-QUIT-NOW. This is a national number that will route the call to the tobacco user's state.



Source: North American Quitline Consortium, Quitline Map. Accessed September 28, 2010. Available at http://map.naquitline.org/

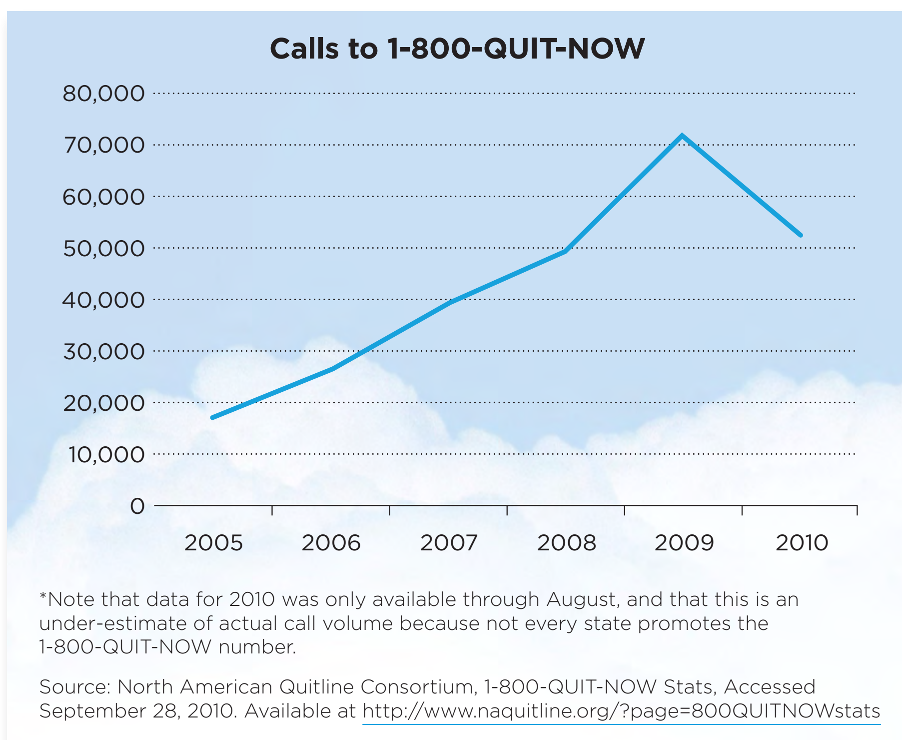
Each state's quitline is different, but they all have the same goal: to provide an evidence-based cessation treatment to smokers in an easily-accessible way. Quitlines are especially important for smokers who have no other way of accessing or paying for treatment. Based on data made available to the American Lung Association that appears in this report, it is clear that quitlines are dramatically underfunded.

In its document *Best Practices for Comprehensive Tobacco Control Programs*,[40] the U.S. Centers for Disease Control and Prevention (CDC) sets goals for state quitlines, which are achievable through adequate funding. According to the CDC, a well-funded quitline should:

1. Be available to all smokers wanting phone counseling;
2. Reach 8 percent of tobacco users in the state every year (measured by number of calls received from tobacco users);
3. Deliver services to 6 percent of tobacco users in the state every year (measured by number of tobacco users who receive treatment); and
4. Offer two weeks of free NRT to all tobacco users. Four weeks should be offered to uninsured or under-insured callers.

The North American Quitline Consortium, in conjunction with the CDC, has determined that in order to provide this level of service, quitlines must be funded at $10.53 per tobacco user.[41] Unfortunately, funding for most quitlines falls far short of this level. In FY 2010, the average funding per smoker was $3.46. This average is down 9 cents from FY 2009's average of $3.55. In fact, in FY 2010, only 11 state quitlines had even half the CDC-recommended funding. Only North Dakota and South Dakota fund their quitlines above the recommended levels.[42]

This lack of resources leads to quitlines not being able to reach tobacco users with treatment and help. While a well-funded quitline is supposed to treat 6 percent of tobacco-users in a state, quitlines on average were only able to treat 1.3 percent of the tobacco-using population in 2009.[43] The graph on the previous page illustrates how funding per smoker correlates with treatment reach. These data clearly show that if policymakers do not fund quitlines adequately, they are not able to help very many tobacco users. This results in fewer smokers quitting.



*Note that data for 2010 was only available through August, and that this is an under-estimate of actual call volume because not every state promotes the 1-800-QUIT-NOW number.

Source: North American Quitline Consortium, 1-800-QUIT-NOW Stats, Accessed September 28, 2010. Available at http://www.naquitline.org/?page=800QUITNOWstats

The CDC also determined that a well-funded quitline will be able to offer free medications to callers who want them. This is one goal that a majority of states are able to accomplish—37 states offer some form of free medications to callers. Most of these states offer one or more of the over-the-counter NRTs to callers. Five states are able to offer prescription medications. While the majority of quitlines are meeting this CDC goal, they do not necessarily meet it year-round. Again, because of underfunding, some quitlines can only provide medications at certain times of the year, or only while supplies last.[44]

This underfunding of quitlines comes at a critical time, when more and more tobacco users are interested in quitting. Calls to quitlines have steadily risen every year since 2005. Above is a graph showing the average monthly call volume to 1-800-QUIT-NOW for the last five years. Calls to the number spiked in 2009 due to the increase in the federal tobacco tax—further proving the point that when states increase tobacco taxes, they should make sure the quitlines are given enough resources to handle increased volume.

As state budgets are still extremely lean, many states will continue to look to new tobacco taxes for help in balancing budgets. States and communities are also continuing to pass smokefree workplace laws, recognizing the health and economic benefits. This means that demand for quitlines and other cessation services will continue to rise. Quitlines can and often do serve as the first and sometimes the only line of help for smokers

who want to quit. The American Lung Association urges state and federal policymakers to adequately fund this vital service to help the increasing number of smokers who want to quit.

Conclusions

The good news is that there are proven treatments available to help smokers quit (seven medications and three types of counseling), and there are many different ways to get these treatments to smokers (through public insurance, through private insurance, through all different levels of government, through quitlines, etc.). The bad news is that these treatments just are not getting to enough smokers. Federal, state and local governments all must play a role in helping smokers quit, as well as employers, insurers, health care professionals and smokers.

The data in this report show that the amount and kinds of help available to smokers varies widely—state-to-state, insurance plan-to-insurance plan, and smoker-to-smoker. This causes confusion, higher taxpayer costs, and illness and death. Helping smokers quit must become a higher priority in this country. No one can afford the economic and health consequences of failing to do so.

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Appendix A: Methodology

Data reported on pages 12-17 of this report are original, collected by staff of the American Lung Association (unless otherwise noted). These data were collected from June–November, 2010, and are intended to reflect coverage in effect as of November 1, 2010. Data were collected through extensive Internet and document searches, as well as through contact with relevant Medicaid and Department of Health staff in the states. Sources for data on Medicaid coverage of cessation treatments include state Medicaid websites, Medicaid handbooks, provider policy manuals, and regulations and legislation. Sources for data on cessation coverage in state employee health plans include state employee benefits websites, summary health plan documents and provider policy manuals. Sources for data on state mandates for coverage of cessation treatments include state legislation and regulations, obtained through the LexisNexis® database. Data on state quitlines was provided by the North American Quitline Consortium. For detailed information on coverage in each state and a specific state-by-state list of sources, please visit www.lungusa.org/cessationcoverage.

Appendix B:
Medicaid Coverage of Cessation Treatments

	NRT Gum	NRT Patch	NRT Nasal Spray	NRT Inhaler	NRT Lozenge	Varenicline (Chantix)	Bupropion (Zyban)	Group Counseling	Individual Counseling
Alabama	P	P	P	P	P	P	P	no	P
Alaska	yes	yes	yes	no	yes	yes	yes	no	yes
Arizona	yes	yes	yes	yes	yes	yes	yes	no	no
Arkansas	yes	yes	no	no	no	yes	yes	yes	yes
California	*	yes	*	*	*	*	yes	*	yes
Colorado	yes	yes	*	*	*	yes	yes	*	*
District of Columbia	*	*	no	no	*	*	*	*	*
Connecticut	P	P	P	P	P	P	P	P	P
Delaware	yes	yes	yes	yes	yes	yes	yes	no	no
Florida	*	*	*	*	*	*	*	*	yes
Georgia[#]	P	P	P	P	P	P	P	P	P
Hawaii	yes	yes	yes	yes	yes	yes	yes	*	*
Idaho	yes	yes	yes	yes	yes	yes	yes	no	no
Illinois	yes	yes	yes	yes	yes	yes	yes	no	no
Indiana	yes	yes	yes	yes	yes	yes	yes	yes	yes
Iowa	yes	yes	no	no	no	yes	yes	no	yes
Kansas	*	yes	no	no	no	*	*	*	no
Kentucky	yes	yes	yes	yes	yes	yes	yes	no	yes
Louisiana	yes	yes	yes	yes	no	yes	yes	no	no
Maine	yes	yes	yes	yes	yes	yes	yes	no	yes
Maryland	*	*	*	*	*	*	*	*	*
Massachusetts	yes	yes	yes	yes	yes	yes	yes	yes	yes
Michigan	yes	yes	*	*	*	*	yes	*	yes
Minnesota	yes	yes	yes	yes	yes	yes	yes	yes	yes
Mississippi	yes	yes	yes	yes	yes	yes	yes	P	P
Missouri[+]	P	P	P	P	P	P	P	P	P
Montana	yes	yes	yes	yes	yes	yes	yes	no	yes
Nebraska	yes	yes	no	no	no	yes	yes	no	yes
Nevada	yes	yes	yes	yes	yes	yes	yes	**	**
New Hampshire	yes	yes	yes	yes	no	yes	yes	P	yes
New Jersey	*	*	*	*	*	*	*	*	no
New Mexico	*	*	*	*	*	*	*	*	no
New York[+]	yes	yes	yes	yes	no	yes	yes	no	P
North Carolina	yes	yes	yes	yes	yes	yes	yes	no	yes
North Dakota	yes	yes	no	no	yes	yes	yes	no	no
Ohio	yes	yes	yes	yes	yes	yes	yes	no	no
Oklahoma	yes	yes	yes	yes	yes	yes	yes	no	yes
Oregon	yes	yes	yes	yes	yes	yes	yes	yes	yes
Pennsylvania	yes	yes	yes	yes	yes	yes	yes	yes	yes
Rhode Island	yes	yes	yes	yes	yes	yes	yes	I	I
South Carolina	yes	yes	*	*	*	*	*	no	no
South Dakota	no	no	no	no	no	yes	yes	no	no
Tennessee	P	P	P	P	P	P	P	P	P
Texas	yes	yes	no	no	no	yes	yes	*	*
Utah	**	**	**	**	**	yes	yes	P	P
Vermont	yes	yes	yes	yes	yes	yes	yes	no	no
Virginia	*	*	*	*	*	*	*	*	no
Washington	*	*	no	no	*	*	*	*	no
West Virginia	*	*	*	*	*	no	*	*	no
Wisconsin	yes	yes	yes	yes	no	yes	yes	*	yes
Wyoming	yes	yes	no	no	yes	yes	yes	no	yes

P Coverage only for pregnant women
I Data not available
* Coverage varies by health plan
** Coverage provided only under certain conditions
+ Coverage for pregnant women includes post-partum period. Missouri = 12 months, New York = 6 months
# Required to cover treatments for pregnant women. As of November 5, 2010, in the process of implementing a benefit.

Appendix C:
Barriers to Medicaid Cessation Coverage in the States

	Limits on Duration	Lifetime Limits	Annual Limits	Prior Authorization Required	Co-payments Required	Stepped Care Therapy Required	Counseling Required for Medications
Alabama	yes	no	no	yes	no	n/a	n/a
Alaska	yes	no	yes	yes	yes	yes	yes
Arizona	yes	no	yes	no	no	no	no
Arkansas	yes	no	yes	yes	no	no	yes
California	*	*	*	*	*	*	*
Colorado	*	no	*	*	*	*	*
Connecticut	n/a	n/a	n/a	n/a	n/a	n/a	n/a
District of Columbia	yes	no	no	no	no	no	no
Delaware	no	no	yes	yes	yes	yes	yes
Florida	*	*	*	*	*	*	*
Georgia	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Hawaii	*	no	no	yes	*	*	*
Idaho	no	no	yes	yes	no	no	yes
Illinois	no	no	no	no	yes	no	no
Indiana	yes	no	yes	no	yes	yes	yes
Iowa	yes	no	yes	yes	yes	no	yes
Kansas	*	no	*	no	*	no	no
Kentucky	yes	no	yes	no	no	no	yes
Louisiana	no	no	no	no	yes	no	yes
Maine	yes	yes	yes	yes	yes	yes	no
Maryland	*	*	*	*	*	*	*
Massachusetts	no	no	no	yes	yes	no	no
Michigan	*	*	*	*	*	*	*
Minnesota	no	no	no	no	yes	no	no
Mississippi	no	no	no	no	yes	no	no
Missouri	yes	yes	no	yes	no	no	yes
Montana	yes	no	no	yes	yes	yes	no
Nebraska	yes	no	yes	yes	yes	no	yes
Nevada	yes	no	yes	yes	yes	no	no
New Hampshire	yes	no	yes	no	yes	no	no
New Jersey	*	*	*	*	*	*	*
New Mexico	*	no	*	*	*	no	*
New York	yes	no	yes	no	*	no	no
North Carolina	no	no	no	no	yes	no	no
North Dakota	yes	no	yes	yes	yes	no	yes
Ohio	no	no	no	no	yes	no	no
Oklahoma	yes	no	yes	yes	yes	no	yes
Oregon	no	no	no	no	yes	no	no
Pennsylvania	yes	no	yes	no	yes	no	no
Rhode Island	yes	no	yes	yes	no	yes	yes
South Carolina	yes	no	*	*	*	*	*
South Dakota	no	no	no	no	yes	no	no
Tennessee	no	no	no	yes	no	no	no
Texas	no	no	no	no	yes	no	no
Utah	no	no	no	yes	yes	no	no
Vermont	yes	no	no	yes	yes	no	no
Virginia	*	*	*	*	*	*	*
Washington	*	*	*	*	no	no	*
West Virginia	*	*	*	*	*	*	*
Wisconsin	no	no	no	no	yes	no	no
Wyoming	yes	no	yes	no	yes	no	no

* Barrier varies by managed care organization

I Data not available

For more information and a detailed listing of this coverage, please visit www.lungusa.org/cessationcoverage

Appendix D:
State Employee Health Plan Coverage of Cessation Treatments

	NRT Gum	NRT Patch	NRT Nasal Spray	NRT Lozenge	NRT Inhaler	Bupropion (Zyban)	Varenicline (Chantix)	Group Counseling	Individual Counseling	Phone Counseling
Alabama	yes	yes	yes	yes	yes	no	no	yes	yes	yes
Alaska	no	no	yes	no	no	yes	yes	no	no	no
Arizona	yes	yes	yes	yes	yes	yes	yes	no	no	yes
Arkansas	no	yes	no	no	no	yes	yes	yes	yes	yes
California	D	yes	yes	D	yes	yes	yes	*	*	*
Colorado	*	*	no	no	no	*	no	*	no	no
Connecticut	no	yes	yes	no	yes	yes	yes	no	no	*
DC	*	*	*	*	*	*	*	*	yes	*
Delaware	no	no	yes	no	no	yes	yes	P	no	no
Florida	no	*	*	no	*	*	*	no	no	no
Georgia	no	no	no	no	no	no	no	no	no	*
Hawaii	*	*	no	no	*	yes	*	*	*	yes
Idaho	no	no	no	no	no	yes	yes	no	no	yes
Illinois	yes	yes	yes	yes	yes	yes	yes	yes	yes	*
Indiana	*	*	*	no	*	yes	yes	*	no	*
Iowa	yes	yes	no	yes	no	no	no	no	no	no
Kansas	yes	yes	yes	yes	yes	yes	yes	no	no	yes
Kentucky	yes	yes	no	yes	no	yes	yes	yes	no	yes
Louisiana	no	no	no	no	no	no	no	no	no	no
Maine	yes	yes	yes	yes	yes	yes	yes	yes	yes	no
Maryland	D	D	D	D	D	D	D	D	D	D
Massachusetts	*	*	no	*	*	*	*	no	*	*
Michigan	*	*	*	*	*	*	*	*	*	*
Minnesota	yes	yes	yes	no	yes	yes	yes	no	no	yes
Mississippi	no	no	yes	no	yes	yes	yes	no	no	no
Missouri	no	no	*	no	no	*	*	no	no	no
Montana	yes	yes	no	yes	no	yes	yes	no	yes	yes
Nebraska	D	*	*	D	*	*	*	no	*	no
Nevada	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
New Hampshire	D	D	D	D	D	D	D	yes	no	no
New Jersey	no	no	no	no	no	no	no	no	no	*
New Mexico	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
New York	*	*	*	*	*	*	*	*	*	*
North Carolina	no	yes	yes	no	yes	yes	yes	no	yes	yes
North Dakota	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
Ohio	yes	yes	yes	yes	no	yes	yes	no	no	yes
Oklahoma	*	*	*	*	*	*	*	no	yes	yes
Oregon	yes	yes	no	no	no	yes	yes	no	no	yes
Pennsylvania	yes	yes	no	no	no	no	no	no	no	yes
Rhode Island	yes	yes	no	yes	no	yes	yes	no	no	yes
South Carolina	yes	yes	no	*	no	yes	yes	no	no	yes
South Dakota	no	no	no	no	no	no	no	no	no	no
Tennessee	yes	yes	yes	yes	yes	yes	yes	yes	no	no
Texas	no	no	*	no	*	*	*	no	no	*
Utah	no	no	yes	no	yes	yes	yes	no	no	no
Vermont	yes	yes	yes	yes	yes	yes	yes	no	yes	yes
Virginia	yes	yes	no	no	yes	yes	yes	no	no	yes
Washington	yes	yes	*	*	*	*	yes	*	no	*
West Virginia	yes	yes	yes	yes	yes	yes	yes	no	yes	no
Wisconsin	no	yes	yes	no	yes	yes	yes	no	yes	no
Wyoming	no	yes	no	no	no	yes	yes	no	no	no

P Coverage only for pregnant women
D Not covered, but discounts are available
* Coverage varies by health plan
For more information and a detailed listing of this coverage, please visit www.lungusa.org/cessationcoverage

Appendix E:
State Laws Requiring Coverage of Cessation Treatments

Colorado	Requires health plans to cover tobacco use screenings and tobacco cessation interventions by primary care providers. This coverage must be offered with no deductibles or coinsurance, though reasonable co-pays may apply. The legislation is unclear as to whether the interventions required include prescription drugs. This law went into effect January 1, 2010.
Maryland	Requires health plans that cover prescription drugs in the state to cover two 90-day courses of prescription NRTs per year. Over-the-counter NRTs are excluded, so the law only requires plans to cover the NRT nasal spray and inhaler. Copayments must be the same as other medications in the plan.
New Jersey	All health plans in the state must cover an annual "wellness" appointment with the members' physician to discuss (among other things) smoking cessation. Applies to members age 20 and older. If the physician determines that it is medically appropriate for the patient to enter smoking cessation treatment, the treatment must be covered up to a certain dollar amount: $125 for ages 20-39 $145 for men over age 40 $235 for women over age 40
New Mexico	Law requiring that all health insurance plans offering maternity benefits in the state cover smoking cessation treatment. The superintendent of insurance determines what this coverage is. Regulation specifies coverage of: 1. Diagnostic services 2. Two 90-day courses of prescription medications per year 3. Individual or group counseling These benefits can be subject to normal deductibles and coinsurance. This does not require coverage of over-the-counter medications.
North Dakota	Standard North Dakota insurance plan includes a $150 lifetime smoking cessation benefit (specifics of benefit not included). This only applies to small employers and the employers have several plans to choose from besides the standard plan when purchasing insurance.
Oregon	Requires insurance plans to provide payment, coverage or reimbursement of at least $500 for a tobacco use cessation program for a person enrolled in the plan who is 15 years of age or older. Program is to include "educational and medical treatment" components.
Rhode Island	Requires all health plans to cover all medications recommended by the U.S. Public Health Service Guideline (all seven cessation medications) in combination with four hours of cessation counseling. Normal deductibles and coinsurance can apply.
Vermont	Requires all health plans in Vermont to cover all seven medications FDA-approved for tobacco cessation. Medications must be covered for at least one three-month supply per year per member. Co-payments may apply to these medications.

Appendix F: State Quitlines

	Spending per Smoker FY2010	CDC-Recommended Spending per Smoker	Percentage of Smokers Treated FY2009*	CDC-Recommended Goal	Free Medications Provided to Callers in 2010?**
Alabama	$0.45	$10.53	0.27%	6.00%	yes
Alaska	+	$10.53	2.16%	6.00%	yes
Arizona	$2.89	$10.53	0.62%	6.00%	yes
Arkansas	$8.59	$10.53	3.21%	6.00%	yes
California	$0.87	$10.53	0.59%	6.00%	no
Colorado	$4.43	$10.53	5.17%	6.00%	yes
Connecticut	$3.23	$10.53	0.36%	6.00%	yes
Delaware	$7.33	$10.53	+	6.00%	no
District of Columbia	$6.14	$10.53	+	6.00%	yes
Florida	$3.48	$10.53	0.46%	6.00%	yes
Georgia	$0.69	$10.53	0.39%	6.00%	yes
Hawaii	$4.35	$10.53	1.36%	6.00%	yes
Idaho	$2.80	$10.53	1.91%	6.00%	no
Illinois	$0.32	$10.53	0.44%	6.00%	no
Indiana	$1.80	$10.53	1.11%	6.00%	yes
Iowa	$3.70	$10.53	+	6.00%	yes
Kansas	$0.22	$10.53	0.14%	6.00%	no
Kentucky	$0.42	$10.53	0.09%	6.00%	no
Louisiana	$0.44	$10.53	0.65%	6.00%	no
Maine	$10.34	$10.53	3.18%	6.00%	yes
Maryland	$1.30	$10.53	1.03%	6.00%	yes
Massachusetts	$1.31	$10.53	+	6.00%	yes
Michigan	$0.52	$10.53	0.18%	6.00%	yes
Minnesota	$2.08	$10.53	0.69%	6.00%	yes
Mississippi	$2.45	$10.53	0.56%	6.00%	yes
Missouri	$1.04	$10.53	0.57%	6.00%	yes
Montana	$9.79	$10.53	6.43%	6.00%	yes
Nebraska	$1.85	$10.53	0.48%	6.00%	no
Nevada	$1.42	$10.53	0.30%	6.00%	no
New Hampshire	$1.23	$10.53	0.05%	6.00%	yes
New Jersey	$0.20	$10.53	+	6.00%	no
New Mexico	$6.26	$10.53	3.31%	6.00%	yes
New York	$3.32	$10.53	6.30%	6.00%	yes
North Carolina	$1.15	$10.53	0.33%	6.00%	yes
North Dakota	$12.75	$10.53	1.45%	6.00%	yes
Ohio	$1.11	$10.53	0.71%	6.00%	yes
Oklahoma	$7.30	$10.53	3.98%	6.00%	yes
Oregon	$1.63	$10.53	0.73%	6.00%	yes
Pennsylvania	$0.54	$10.53	0.11%	6.00%	no
Rhode Island	$1.12	$10.53	0.77%	6.00%	no
South Carolina	$0.61	$10.53	0.19%	6.00%	yes
South Dakota	$23.33	$10.53	7.25%	6.00%	yes
Tennessee	$0.28	$10.53	0.27%	6.00%	no
Texas	$0.17	$10.53	0.16%	6.00%	yes
Utah	$8.64	$10.53	2.64%	6.00%	yes
Vermont	$2.72	$10.53	1.50%	6.00%	yes
Virginia	$0.18	$10.53	0.16%	6.00%	no
Washington	$2.01	$10.53	1.55%	6.00%	yes
West Virginia	$2.88	$10.53	4.47%	6.00%	yes
Wisconsin	$0.94	$10.53	1.60%	6.00%	yes
Wyoming	$10.31	$10.53	+	6.00%	yes

+ Data not reported

* FY2010 treatment reach data is not available at present time

** Data current as of November 1, 2010, as provided by http://map.naquitline.org/. Data are subject to change throughout the fiscal year.

Data provided by the North American Quitline Consortium. For more details, please visit www.naquitline.org

We will breathe easier when the air over every American city is clean and pure.
We will breathe easier when the air in our public spaces, workplaces and children's homes is free of secondhand smoke. We will breathe easier when Americans are free from the addictive grip of tobacco and the debilitating effects of lung disease. We will breathe easier when our nation's children no longer battle airborne poisons or the fear of an asthma attack.
Until then, we are fighting for air.

November 2010