AMERICAN LUNG ASSOCIATION®
Fighting for Air

Helping Smokers Quit

Tobacco Cessation Coverage 2011

Executive Summary

Many smokers know that quitting is the single most important step to improve their health,[1] and that quitting reduces their risk for serious diseases like lung cancer, heart disease and chronic obstructive pulmonary disease (COPD). Some smokers also know that they will save money when they no longer buy cigarettes, and that their employer will benefit from fewer sick days and smoke breaks.

Knowing this, however, does not make it any easier to quit. The addiction to nicotine is a powerful one, and it takes most smokers multiple quit attempts before they are successful. Quitting 'cold turkey' generally is not effective. The majority of smokers need help quitting. Fortunately there are several treatments, including medications and counseling, which are proven to help smokers quit for good.

Five Most Quit-Friendly States:

- Maine
- North Dakota
- Delaware
- Oklahoma
- Wyoming

The American Lung Association believes that every smoker should have easy access to the help they need to quit smoking, and that states and the federal government have a responsibility to enact public policies that reach this goal. In 2011, the federal government took important steps in this direction, as did some state policymakers. However, significant progress at the federal and state levels is still needed to ensure that all smokers have access to the *right* treatments to quit.

This report looks at recent and upcoming actions at the federal and state levels that will make it easier for smokers to quit. It includes state-by-state information on what tobacco cessation treatments are covered by Medicaid programs and state employee health plans, as well as which states require tobacco cessation coverage in private insurance plans, and resources provided to services that offer tobacco cessation counseling by phone, also known as quitlines.

Five Least Quit-Friendly States:

- Georgia
- Louisiana
- Alabama
- Maryland
- New Jersey

Additional Highlights

- Six states cover a comprehensive tobacco cessation benefit for all Medicaid enrollees: Indiana, Massachusetts, Minnesota, Nevada, North Carolina and Pennsylvania
- Two states do not cover any tobacco cessation treatments for all Medicaid enrollees: Alabama and Georgia
- Five states cover a comprehensive tobacco cessation benefit for all state employees: Illinois, Indiana, Maine, New Mexico and North Dakota
- Two states do not cover any tobacco cessation treatments for state employees: Louisiana and Maryland
- Nine states require private insurance plans to cover tobacco cessation treatments: Colorado, Illinois, Maryland, New Jersey, New Mexico, North Dakota, Oregon, Rhode Island and Vermont
- Four states invest in quitlines at or above the recommended amount: Maine, North Dakota, South Dakota and Wyoming

Quit-Friendly States

States can help smokers quit in several different ways. State Medicaid programs can cover a comprehensive tobacco cessation benefit for low-income enrollees. State governments can provide a similar benefit to state employees. State policymakers can require private insurance companies in the state to cover tobacco cessation treatments. State policymakers can also adequately fund tobacco cessation and prevention programs at levels recommended by the Centers for Disease Control and Prevention (CDC) to provide vital services, like quitlines, for tobacco users in their state.[2]

States should implement all of these strategies for a comprehensive approach to tobacco cessation. The following five states had the highest scores for their overall efforts to help smokers quit.

Five Most Quit-Friendly States

1. Maine
2. North Dakota
3. Delaware
4. Oklahoma
4. Wyoming

Other states have not put policies in place or made the investments necessary to help smokers quit. These states do not provide adequate coverage to help smokers on Medicaid, state employee health plans and private insurance; and provide little to no funding for quitlines. Policymakers in these states are tragically missing the opportunity to improve their citizens' health and lives, as well as save their state money. These five states had the lowest scores for their overall approach to helping smokers quit.

Five Least Quit-Friendly States

1. Georgia
2. Louisiana
3. Alabama
3. Maryland
5. New Jersey

* Note that several states tied within these rankings. States were ranked based on the methodology used in the American Lung Association's *State of Tobacco Control Report*. This methodology evaluates a state's (1) coverage of tobacco cessation treatments for Medicaid enrollees, (2) coverage of tobacco cessation treatments for state employees and dependents, (3) requirements for tobacco cessation treatment coverage in private insurance, and (4) funding of state quitline. More information about this methodology can be found at http://www.lung.org/stop-smoking/tobacco-control-advocacy/reports-resources/helping-smokers-quit-state.html.

Helping Smokers Quit Saves Lives and Money

Quitting smoking improves a smoker's health immediately—his or her heart rate and the amount of carbon monoxide in the bloodstream will return to normal levels within the first day. Within weeks, a former smoker's lung function begins to improve and risk of having a heart attack drops. He or she may experience fewer colds and respiratory infections, and avert immediate serious health issues like heart attacks and asthma attacks. In the long term, a smoker who quits considerably reduces his or her risk of diseases like chronic obstructive pulmonary disease (which includes emphysema and chronic bronchitis), heart disease, lung cancer and many other cancers.[3] Studies show that smokers' lives are more than 13 years shorter than nonsmokers.[4] Some benefits of quitting cannot be measured—like the benefit of living long enough to see a grandchild born or enjoying a long and healthy retirement.

Helping smokers quit not only saves lives—it also saves everyone money. These savings come from lower health care costs, increased workplace productivity and averted premature deaths. Studies indicate that helping smokers quit saves thousands of dollars in health care expenditures per smoker.[5,6]

These savings benefit the former smokers, insurance companies, employers, state budgets and taxpayers. A study released in 2010 by the American Lung Association and Penn State University shows for every dollar a state spends on smoking cessation treatments, it saves an average of $1.26. That represents a 26 percent return on investment.[7] The example below shows the potential for real world savings.

Massachusetts: A Closer Look

In 2006, MassHealth introduced a comprehensive cessation benefit for Medicaid enrollees, which included medications, counseling, low co-pays and no other treatment barriers.

A 2010 study analyzed the success of the MassHealth cessation benefit, as well as its health impact. Within the first two years of the benefit being offered,

- ✔ 40 percent of smokers (75,000 people) enrolled in MassHealth used the benefit
- ✔ 26 percent of smokers enrolled in treatment quit smoking

After only one year, among MassHealth enrollees who used the benefit:

- ✔ the risk of heart attack hospitalizations dropped 46 percent
- ✔ the risk of hospitalization for other acute coronary heart disease diagnoses dropped 49 percent

Source: www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000375

What Works to Help Smokers Quit?

While most smokers want to quit and many of them try every year, only a relatively small percentage are successful.[8] A study recently released by the CDC showed that in 2010, 69 percent of adult smokers wanted to stop smoking, 52 percent tried to in the past year, and only 6 percent had recently quit.[9] Many tobacco users require several quit attempts to quit for good, and many need help during the quitting process.[10] Quitting 'cold turkey' generally is not effective for the vast majority of smokers.[11] Fortunately, a number of treatments exist that are proven to increase a smoker's chances of quitting.

The U.S. Public Health Service's 2008 Clinical Practice Guideline *Treating Tobacco Use and Dependence*[12] recommends seven medications and three types of counseling that have been proven to be effective in helping smokers quit. The Guideline is a review of decades of research on tobacco cessation and is widely regarded as the definitive report on effectively treating tobacco users.

The list of recommended medications includes both over-the-counter as well as prescription medications, generic and brand name, in several different forms. The nicotine gum, nicotine patch, nicotine lozenge, nicotine nasal spray and nicotine inhaler are nicotine replacement therapies, while bupropion and varenicline do not contain nicotine and work in different ways.[13]

Cessation Benefits Should Include ALL of These Treatments:

MEDICATIONS	COUNSELING
✔ Nicotine Gum	✔ Individual
✔ Nicotine Patch	✔ Group
✔ Nicotine Lozenge	✔ Phone
✔ Nicotine Nasal Spray	
✔ Nicotine Inhaler	
✔ Bupropion	
✔ Varenicline	

Research has shown that smokers are more successful when they use medication and counseling in combination. Tobacco cessation counseling can be provided in many settings (including physician offices, hospitals, community centers, religious institutions and workplaces) and by many different people (physicians, dentists, nurses, other clinicians, tobacco treatment specialists, respiratory therapists or others specifically trained to help smokers quit). Phone counseling is available in every state by calling 1-800-QUIT-NOW, as well as from organizations including the American Lung Association 1-800-LUNG-USA (1-800-586-4872).

Designing a Comprehensive and Easy-to-Use Tobacco Cessation Benefit

While there are many ways in which policymakers and benefit designers can customize a benefit to fit their own plan and constituencies, below are some hallmarks of a model benefit that will give smokers the best chance to quit for good.

- Cover all treatments recommended in the Public Health Service Guideline, include all seven medications on plan formularies and preferred drug lists, and cover all three forms of counseling
- Cover each medication for its FDA-approved duration of use. Cover at least four counseling sessions per quit attempt, and at least two quit attempts per year—more is even better
- Eliminate or reduce copays and other cost-sharing on medications and counseling
- Do not require prior authorization of treatments, which slows down treatment and can decrease a smoker's motivation and momentum to quit
- Do not limit the amount of times a person can try to quit in their lifetime. Quitting is a process that usually takes many attempts
- Do not require stepped-care therapy, which can force a patient to use a treatment they have already tried or that is not right
- Do not require patients to attend counseling to obtain medications. Counseling should be encouraged, but requiring it may discourage some people from seeking any assistance with quitting

The Federal Government Steps Up

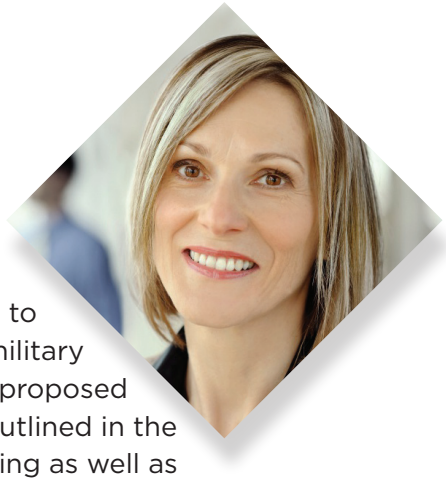
The federal government has taken many important steps in the last couple of years that will help smokers who want to quit. Some of these actions were outlined in the first-ever strategic plan on tobacco control released by the U.S. Department of Health & Human Services (HHS) in November 2010, *Ending the Tobacco Epidemic: A Tobacco Control Strategic Action Plan for the U.S. Department of Health and Human Services*.[14]

Leading By Example:
Federal Employees Health Benefits Program

Beginning January 1, 2011, the Office of Personnel Management offered a model comprehensive tobacco cessation benefit to the federal government's millions of employees and their families. The benefit consists of:

- ✔ Four tobacco cessation counseling sessions of at least 30 minutes each. This must include proactive telephone counseling, group counseling and individual counseling
- ✔ All seven FDA-approved tobacco cessation medications
- ✔ Coverage provided for two quit attempts per year
- ✔ These benefits must be provided with no copayments or coinsurance and may not be subject to deductibles, annual or lifetime dollar limits

The May 2010 Federal Employee Health Benefit (FEHB) Program Carrier Letter specifically outlined how insurance plans must approach comprehensive tobacco cessation treatments for federal employees.[15] An American Lung Association analysis of FEHB plans found that in addition to adding the coverage as required, some plans provided clear information about the new benefit in their plan brochures, and links to tobacco cessation information from their website's homepage.



New Tobacco Cessation Coverage Announced for Military Families

In a 2009 authorizations bill, Congress required the Department of Defense to provide a comprehensive smoking cessation benefit to members of the military and their families through the TRICARE military healthcare program. After much delay, the department released a proposed rule to implement this coverage in September 2011. The benefits outlined in the proposed rule include individual, group, phone and online counseling as well as prescription and over-the-counter medications. While the proposal includes some limitations on access to this coverage, it is a helpful, positive step for members of the military—many of whom begin smoking after they enlist.[16] The American Lung Association urges the Department of Defense to finalize the rule and begin implementation of a comprehensive benefit that all military members and their families may easily access.

New, Private Insurance Plans Required to Cover Tobacco Cessation

As of September 23, 2010, the Patient Protection and Affordable Care Act (ACA) required all new private insurance plans to cover any preventive service that receives an 'A' or 'B' rating from the United States Preventive Services Task Force (USPSTF) at no cost to plan members. Tobacco cessation services received an 'A' rating from the USPSTF but unfortunately this does not mean that all health insurance plans will automatically provide a comprehensive tobacco treatment benefit. In implementing this policy, HHS again failed to detail which treatments were required, leaving interpretation up to the insurance companies. The American Lung Association is concerned that this will result in less-than-comprehensive coverage under most plans and initial surveys confirm this concern.[17]

New Funding for Prevention Activities

The Prevention and Public Health Fund was established under ACA to provide vital funds for public health and wellness programs. Funding for this initiative started at $500 million in 2010, and is set to incrementally increase to $2 billion in 2015. In September 2011, HHS announced a $107 million initiative from this fund called the Community Transformation Grants. Community, state and national grantees will use these funds to fight chronic disease, much of which is linked to tobacco use, in communities nationwide. The American Lung Association is the recipient of a national grant. Additionally, $25 million from the Prevention Fund is intended to go toward increasing the ability of state quitlines to help smokers quit. Unfortunately, the money in this fund is in constant danger of being reallocated in Congress. Lawmakers must not divert these funds as they are crucial to preventing chronic diseases and making future generations healthier.

New Graphic Warning Labels for Cigarette Packs*

Under the authority given to the FDA in the Family Smoking Prevention and Tobacco Control Act of 2009, the agency released new, graphic warning labels that are scheduled to appear on cigarette packs and advertisements in the fall of 2012. Each label will include the national quitline number, 1-800-QUIT-NOW. Based on research from other countries, these labels will be an important tool in preventing kids from starting to smoke and will also encourage smokers to try to quit. Included here are a few of the new warning labels that have been chosen by the FDA to appear on cigarette packs and advertisements.

*At the time this report went to print, a federal court had issued a preliminary injunction blocking implementation of these warning labels. On November 29, 2011, the Obama administration appealed the lower court's decision.

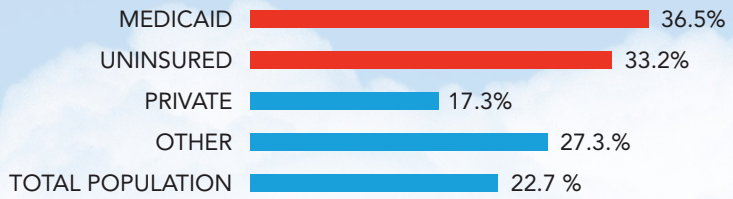
State Medicaid Programs Required to Help Pregnant Women Quit Smoking

The ACA requires all Medicaid programs to provide a comprehensive tobacco cessation benefit to pregnant women on Medicaid. This benefit is supposed to follow the recommendations of the Public Health Service Guideline on treating tobacco use and was to be in effect October 1, 2010. In June 2011, the Centers for Medicare and Medicaid (CMS) issued a letter to state Medicaid directors detailing this requirement. Unfortunately, the letter was not explicit in which treatments states are required to cover and left the specifics to be determined by the states. It remains to be seen how this requirement will affect coverage policies.

Medicaid Dollars Can Now Be Used to Reimburse Phone Counseling

Many people who call state quitlines are Medicaid enrollees. State-run quitlines provide a valuable and free service to these low-income smokers. Most state quitlines are also severely underfunded. Fortunately CMS announced in June 2011 that state Medicaid programs can now reimburse quitlines for callers who are Medicaid enrollees. This is an important new potential funding source to improve the reach of quitlines, especially because every dollar a state spends on Medicaid is matched by the federal government. However, it does not excuse state elected officials from adequately funding services to help tobacco users quit. State Medicaid programs must take advantage of this important opportunity and create partnerships with state quitlines.

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.

More Opportunities to Help Smokers Quit

Despite the many positive steps taken by federal policymakers in the last few years, there is still much more to be done to reduce the number of smokers in America. The American Lung Association strongly urges the federal government to take action on the following opportunities to help people quit.

Include a Comprehensive Cessation Benefit in the Essential Health Benefits Package

One of the major hallmarks of the ACA is a new system of state exchanges, which will operate in every state beginning in 2014. People who are unemployed, self-employed or not provided with employer-sponsored insurance can purchase insurance on these exchanges. Many of these people are currently uninsured because they cannot afford coverage.

Every insurance plan in state exchanges will be required to include the Essential Health Benefits package. This is a set of benefits to be defined by HHS. These benefits must also be covered for newly eligible Medicaid enrollees in 2014. These two groups of people—the currently uninsured and Medicaid enrollees—both smoke at much higher rates than their counterparts.[18] It is vital for HHS to require a specific, comprehensive tobacco cessation benefit in the Essential Health Benefits package. HHS should look at the Federal Employees Health Benefits program as the model for this coverage.

Promote and Encourage Quit Attempts

The national focus on tobacco cessation created by the debut of new cigarette warning labels in the fall of 2012 is an opportunity that must not be wasted. A media campaign around quitting and increased quitline funding is crucial to support smokers who are encouraged to quit by the warning labels.

Protect the Prevention and Public Health Fund

Congress must protect this crucial source of funding to prevent chronic disease, and the federal government must continue to use it to supplement and enhance public health programs, like community tobacco cessation clinics.

Implement a Comprehensive and Easy-to-Access Tobacco Cessation Benefit for Military Families

Tobacco use among soldiers and their families costs taxpayers money and jeopardizes the readiness of our troops. Our military men and women and their families need assistance quitting smoking that is comprehensive, simple to obtain, and effective.

Extend the Requirement for a Comprehensive Cessation Benefit to all Medicaid Enrollees

Pregnant women are not the only people on Medicaid who smoke—nor are they the only group that would generate savings for taxpayers if they quit. All Medicaid enrollees should have access to comprehensive tobacco cessation benefits.

Specify Tobacco Cessation Requirements for New Private Plans

This lifesaving and disease preventing benefit is too important to let insurance companies get away with providing the bare minimum. New health insurance plans should be specifically required to cover all tobacco cessation treatments recommended by the U.S. Public Health Service Guideline.

Ensure Quitlines are Adequately Funded

The federal government and state governments must ensure that quitlines have enough funding to ensure enough capacity to counsel all smokers who want help quitting.

Upcoming Actions

January 2012: HHS Releases Essential Health Benefit

HHS is expected to release its proposed rule regarding the Essential Health Benefit. This is the minimum federal standard that all plans offered in state health insurance exchanges will be required to cover.

September 2012: Warning Labels Appear on Cigarette Packs*

Consumers will begin seeing new graphic warning labels on cigarette packs and advertisements. These labels will include the 1-800-QUIT-NOW number and encourage smoking cessation.

January 1, 2013: Medicaid Preventive Services Incentive Begins

Medicaid programs that cover preventive services will receive an increase in matching funds from the federal government. Programs must cover all services given an 'A' or 'B' rating by the USPSTF, which includes tobacco cessation.

January 1, 2014: Medicaid Eligibility Expands

Eligibility for Medicaid will expand nationwide, bringing many currently uninsured individuals into the Medicaid system. Data show that people on Medicaid and those who are currently uninsured are about twice as likely to smoke as other people ages 18-65.[19]

January 1, 2014: State Health Exchanges Implemented

In accordance with the ACA, a health insurance exchange will operate in every state and territory.

January 1, 2014: Tobacco Cessation Medications Cannot Be Excludable

State Medicaid programs will no longer be able to exclude tobacco cessation medications from coverage. While a positive step, this provision of the ACA still does not guarantee states will cover a comprehensive cessation benefit.

* As previously noted, at the time this report went to print, a federal court had issued a preliminary injunction blocking implementation of these warning labels. On November 29, 2011, the Obama administration appealed the lower court's decision.

States Take Positive Steps

States also have a responsibility to smokers and taxpayers to help smokers quit. States can help smokers quit in the following areas: Medicaid, state employee health plans, private insurance and quitlines. Some states made improvements to tobacco cessation policies in 2011. Changes in coverage are detailed below.

State Medicaid Programs:

Several states that previously had not covered any treatments for tobacco cessation added this coverage for pregnant women because of requirements in the ACA in 2010. In 2011, some of these states expanded this important benefit to all people on Medicaid. **Missouri** now covers all seven recommended medications and individual counseling for everyone on Medicaid. **Connecticut** and **Tennessee** also announced new benefits for everyone on Medicaid—however, the details have not yet been released. The American Lung Association encourages each state's Medicaid program to make these benefits comprehensive and easy to use.

The **New York** and **Delaware** Medicaid programs already covered tobacco cessation medications for all people on Medicaid, but before 2011, counseling was only covered for pregnant women. This year these states expanded counseling to everyone on Medicaid. New York's program also added coverage for group counseling, making its covered benefit close to comprehensive. Delaware's program also now allows three quit attempts per year instead of just one.

Several other states made positive changes to the tobacco cessation benefits provided through Medicaid. **California**, **Iowa** and **North Dakota** all added coverage of one or more FDA-approved medications. California also lengthened the duration of allowed quit attempts and no longer requires counseling to be paired with medications in its fee-for-service plan. Lastly, **Montana** lifted its lifetime limit on quit attempts.

State Employee Coverage:

States also made positive changes for state employees in 2011. **South Dakota** and **Texas** previously did not cover any tobacco cessation treatments. This year both states added coverage of bupropion and varenicline, as well as a few counseling options for state employees and their families.

Mississippi, **Minnesota** and **New Jersey** also added coverage of one or more medications for state employees and dependents. **Arizona**, **Mississippi**, **Missouri** and **Ohio** all took important steps to make their tobacco cessation coverage easier to access for state employees and dependents.

Private Insurance Legislation:

In the area of private insurance, only one state passed a law requiring private plans to cover tobacco cessation in 2011. All insurance plans in **Illinois** are now required to offer employers and insurance purchasers coverage for tobacco cessation treatments.

All of the above states have made positive changes to help smokers quit in these areas. The American Lung Association encourages other states to follow these examples.

Medicaid Coverage of Cessation Treatments

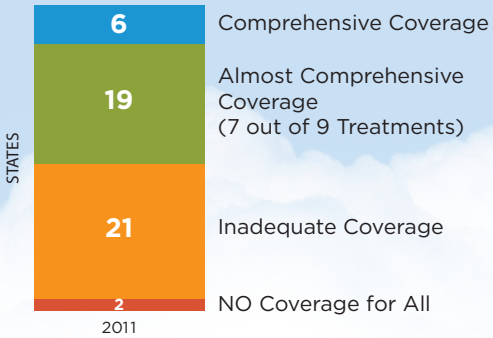
There is tremendous need for tobacco cessation coverage in the Medicaid population. People enrolled in Medicaid smoke at higher rates than the general population (36.5 percent versus 22.7 percent for ages 18-65).[20] These Medicaid enrollees also, by definition, have low incomes and are less able to pay out-of-pocket for tobacco cessation treatments. These are reasons enough to help people on Medicaid quit smoking. In addition, providing this help has fiscal advantages, as smoking-related disease costs Medicaid programs millions of dollars every year—an average of $761 million per state in 2010.[21]

Despite these compelling reasons, most states do not do enough to help people on Medicaid quit. American Lung Association data for 2011 show:

- Six states provide comprehensive coverage for tobacco cessation treatments to all Medicaid enrollees[22]
- Nineteen states came close to providing comprehensive coverage—covering all but one or two recommended cessation treatments.[23] Nine of these states cover all seven medications but no counseling[24]
- Two states provide NO coverage for cessation treatments to their entire Medicaid population[25]
- Twenty-five states charge copays for low-income Medicaid enrollees' tobacco cessation medications or counseling[26]
- Only two states have lifetime limits on quit attempts for Medicaid enrollees[27]

Since the American Lung Association began collecting these data four years ago, cessation coverage for the Medicaid population has improved—but not enough. Many Medicaid programs are in transition right now, as state budgets are extremely tight, health care costs are rising and federal health care reform is being implemented. Now is a great time for states to implement better coverage for tobacco cessation treatments—a change that will save states money and lives.

Medicaid Coverage of Smoking Cessation Treatments



Data for CT, KY and TN not included.
Source: American Lung Association. State Tobacco Cessation Coverage Database. 2011.
Available at: www.lung.org/cessationcoverage

Many Medicaid programs are currently moving more enrollees into managed care plans, operated by private or nonprofit insurance companies. State Medicaid programs pay these managed care plans a flat fee for each Medicaid enrollee, rather than paying a fee for each medical service/treatment. In states that use managed care in this way, it is crucial that the Medicaid program ensure each managed care plan provides all recommended tobacco cessation treatments. Moving to managed care does not absolve the Medicaid program from its responsibility to help smokers quit. Medicaid programs can do this by requiring this coverage in their contracts with the managed care plans, or by "carving out" those services and providing them through a wellness plan or separately for all enrollees regardless of which plan they belong to. As discussed earlier, detailing the specific medications and counseling to be covered is critical.

State Employee Health Plans

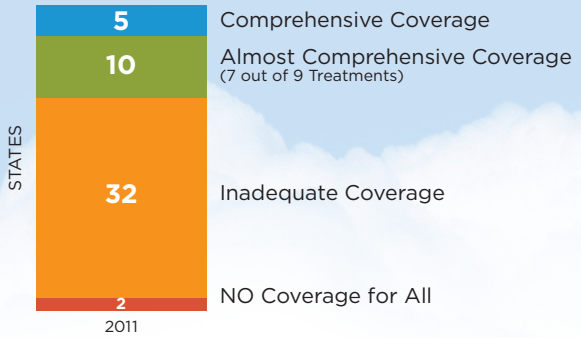
Every state provides health insurance to its employees.[28] As state governments are often one of the largest employers in states, this coverage reaches a large number of people. Many state employee health plans also serve as examples for other health insurance plans in the state. Therefore it is important these health plans lead by example and cover cessation treatment for tobacco users—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.[29]

Tobacco cessation coverage for state employees and their dependents varies widely from state to state. American Lung Association data for 2011 show:

- Five states provide comprehensive coverage for tobacco cessation treatments to all state employees and their dependents[30]
- Ten states provide nearly comprehensive coverage—covering all but one or two recommended cessation treatments[31]
- Two states provide NO coverage for cessation treatments to all state employees and dependents[32]
- Twenty-six states charge copays for tobacco cessation medications or counseling[33]
- Seven states have lifetime limits on quit attempts for state employees and their dependents[34]

Several state governments have instituted tobacco use surcharges over the last few years. These programs involve charging tobacco users higher health insurance premiums than non-tobacco users. 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.[35] If a state government is instituting a tobacco surcharge, at the very least it should provide full coverage of a comprehensive tobacco cessation benefit. If state government employees are to be charged more for their health insurance plan because they smoke, that insurance plan should provide them the means to quit.

State Employee Health Plan Coverage of Smoking Cessation Treatments



Data for CO and DC not included.
Source: American Lung Association. State Tobacco Cessation Coverage Database. 2011.
Available at: www.lung.org/cessationcoverage

Private Insurance

Currently, the majority of Americans who have health insurance receive coverage through their non-government employer or buy it on the individual market. The ACA makes major changes to this segment of the health insurance market, many which will be unfolding for years to come.

In 2014, some Americans will have the option of buying health insurance through a state health insurance exchange. The individual insurance exchange is intended for people who do not receive employer-sponsored insurance, or who are unemployed. A system of subsidies is designed to make these plans affordable for everyone. There will also be an exchange in every state for small businesses to purchase plans for their employees.

As discussed on page 10 of this report, plans offered through state exchanges must include coverage for an Essential Health Benefit, which has yet to be determined. Also, as discussed on page 8, the ACA requires all new private insurance plans to cover preventive services, including tobacco cessation—but this requirement is not specific and does not guarantee comprehensive coverage.

Beyond federal law, a few states have stepped in to ensure some level of cessation treatment coverage for privately-insured tobacco users in their states. Setting a standard that applies to the whole state is important: first and foremost, standard coverage helps the largest number of smokers quit. This leads to healthy and more productive people in each state. It is also easier to promote quitting tobacco use in a state where everyone is provided the same tobacco cessation benefit, regardless of insurer. The current varied coverage creates confusion for smokers about which treatments are available to them, and complicates messages and access points for these treatments. A statewide standard also makes it easier for doctors in the state to treat their patients.

American Lung Association data show that nine states currently have legislative or regulatory standards for tobacco cessation coverage: **Colorado, Illinois, Maryland, New Jersey, New Mexico, North Dakota, Oregon, Rhode Island** and **Vermont**. Each law is different and required coverage varies.

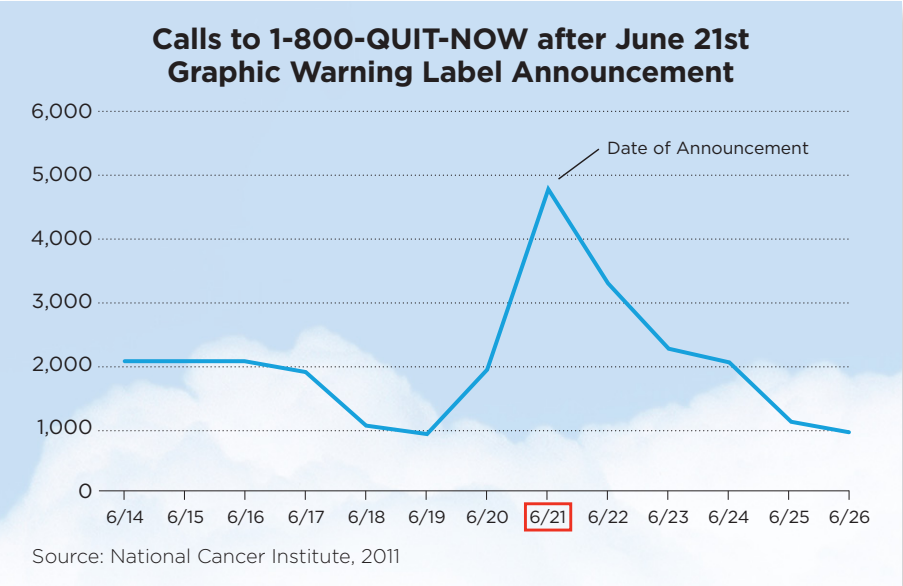
More information on each of the nine state laws/regulations can be found in Appendix E.

The American Lung Association recommends state tobacco cessation laws include:

- A requirement that plans specifically cover ALL treatments recommended in the current edition of the U.S. Public Health Service Guideline *Treating Tobacco Use and Dependence*
- Prohibitions on policies that make it harder for smokers to access treatment, like cost-sharing, prior authorization and yearly and lifetime limits
- A reporting and enforcement mechanism to ensure plans follow the law

Quitlines

Helping smokers quit by phone is an essential part of any state's tobacco cessation efforts. Since 2004, every state in the U.S., the District of Columbia, and Puerto Rico has operated a tobacco cessation quitline. Quitlines provide telephone counseling, which is one of the three types of counseling recommended by the Public Health Service Guideline. Quitlines can also provide information about other tobacco cessation services, and many provide medications to callers who want it. All state quitlines can be reached by calling 1-800-QUIT-NOW, which is a national number that will route the caller to the appropriate state.



Ease of access to quitlines is one reason why they are a crucial element of a comprehensive tobacco cessation approach. Quitlines are especially important for smokers who live too far away from their doctor or clinic, are uninsured, or cannot afford paying for treatment. Quitlines can and often do serve as the first and sometimes the only line of help for smokers who want to quit.

The demand for quitlines will most likely increase as the new graphic warning labels are placed on cigarette packs. As the graph above shows, calls to quitlines increased dramatically when the new warning labels, including the 1-800-QUIT-NOW number, were announced in June 2011. This is likely only a preview of the increase in demand once smokers are faced with the graphic warning labels, every day on their cigarette packs.

Despite the importance of and demand for quitlines, they are chronically underfunded in this country. According to the CDC and the North American Quitline Consortium, a quitline must be funded at a rate of $10.53 per tobacco user in the state to provide best practice-level services.[36]

However, data provided by the North American Quitline Consortium show that these services are not being given near this level of funding.

In Fiscal Year 2012:

- The average amount of funding for state quitlines per smoker was $3.57 (This average is down 27 cents from Fiscal Year 2011's average of $3.84)
- The median amount of funding for state quitlines per smoker was $1.76
- Only nine state quitlines received even half the CDC-recommended level of funding[37]
- Only four state quitlines receive funding at or above the recommended level[38]

Conclusion

There are proven treatments available to help smokers quit—including medications and counseling—and many different ways to get these treatments to smokers—through public healthcare programs, private insurance, state insurance exchanges, quitlines, and tobacco control and prevention programs. While the federal government and some state governments have taken important steps this year to provide cessation treatments through these avenues, there is still more work to be done. Federal, state and local governments all must play a role in helping smokers quit, as well as employers, insurance companies, healthcare professionals and smokers themselves.

The data in this report show that the amount and kinds of help available to smokers is inconsistent state-to-state, insurance plan-to-insurance plan, and smoker-to-smoker. By not providing all smokers help to quit, the U.S. is missing out on longer, happier, more productive lives and on economic gains. This country cannot afford the economic and health consequences of failing to make it a priority to help smokers quit.

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26. DE, IL, IN, IA, LA, ME, MA, MN, MS, MT, NE, NV, NH, NC, ND, OH, OK, PA, SD, TX, UT, VT, WV, WI and WY.
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Appendix A: Methodology

Data reported in this report are original, collected by staff of the American Lung Association (unless otherwise noted). These data were collected from June–November, 2011, and are intended to reflect coverage in effect as of November 1, 2011. 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, unless otherwise noted. For detailed information on coverage in each state and a specific state-by-state list of sources, please visit www.lung.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	*	yes
Colorado	yes	yes	*	*	*	yes	yes	*	*
Connecticut	#	#	#	#	#	#	#	#	#
District of Columbia	*	*	no	no	*	*	*	*	*
Delaware	yes	yes	yes	yes	yes	yes	yes	no	yes
Florida	*	*	*	*	*	*	*	*	yes
Georgia	P	P	P	P	P	P	P	no	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	yes	yes	yes	yes	yes	no	yes
Kansas	*	yes	no	no	*	*	*	*	no
Kentucky	+	+	+	+	+	+	+	+	+
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	yes	yes	yes	yes	yes	yes	yes	no	yes
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	*	yes	*	*	*	*	yes	no	no
New Mexico	*	*	*	*	*	*	*	*	no
New York	yes	yes	yes	yes	no	yes	yes	yes	yes
North Carolina	yes	yes	yes	yes	yes	yes	yes	yes	yes
North Dakota	yes	yes	yes	yes	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
Pennsylvania	yes	yes	yes	yes	yes	yes	yes	yes	yes
Rhode Island	yes	yes	yes	yes	yes	yes	yes	*	*
South Carolina	*	yes	*	*	*	*	*	no	no
South Dakota	no	no	no	no	no	yes	yes	no	no
Tennessee	#	#	#	#	#	#	#	#	#
Texas	yes	yes	no	no	no	yes	yes	*	*
Utah	**	**	**	**	**	yes	yes	P	P
Vermont	yes	yes	yes	yes	yes	yes	yes	P	P
Virginia	*	*	*	*	*	*	*	*	*
Washington	*	*	*	*	*	*	*	*	*
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
* Coverage varies by health plan
** Coverage provided only under certain conditions
# Coverage is currently for pregnant women only, and will expand to all enrollees in 2012. Plan details not yet available.
+ Data not reported

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	no	yes
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	#	#	#	#	#	#	#
District of Columbia	yes	no	no	no	no	no	no
Delaware	no	no	yes	yes	yes	yes	yes
Florida	*	*	*	*	*	*	*
Georgia	yes	no	yes	yes	no	yes	yes
Hawaii	*	no	yes	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	yes	yes
Kansas	*	no	*	no	*	no	no
Kentucky	*	no	*	*	no	no	yes
Louisiana	no	no	no	no	yes	no	yes
Maine	yes	yes	yes	yes	yes	yes	no
Maryland	*	*	*	*	*	*	*
Massachusetts	no	no	yes	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	no
Montana	yes	no	yes	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	*
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	#	#	#	#	#	#	#
Texas	no	no	no	no	yes	no	no
Utah	no	no	no	yes	yes	no	no
Vermont	yes	no	yes	yes	yes	no	no
Virginia	*	*	*	*	*	*	*
Washington	*	*	*	*	no	no	*
West Virginia	yes	no	yes	yes	yes	yes	yes
Wisconsin	no	no	no	no	yes	no	no
Wyoming	yes	no	yes	no	yes	no	no

* Barrier varies by health plan

State has announced a new benefit, but not yet details on coverage

Appendix D:
State Employee Health Plan Coverage of Cessation Treatments

	NRT Gum	NRT Patch	NRT Nasal Spray	NRT Lozenge	NRT Inhaler	Varenicline (Chantix)	Bupropion (Zyban)	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	no	yes	yes	no	yes	yes	yes	*	*	*
Colorado	+	+	+	+	+	+	+	+	+	+
Connecticut	no	no	no	no	no	yes	yes	no	no	*
District of Columbia	+	+	+	+	+	+	+	+	+	+
Delaware	yes	yes	no	yes	no	no	no	*	*	no
Florida	no	*	*	no	*	*	*	no	no	no
Georgia	#	#	#	#	#	#	#	#	#	#
Hawaii	*	yes	no	no	*	*	yes	*	*	yes
Idaho	yes	yes	yes	yes	yes	no	yes	no	no	yes
Illinois	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
Indiana	yes	yes	yes	yes	yes	yes	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	no	no	no	no	no	no	no	no	no	no
Massachusetts	*	*	*	*	*	*	*	*	*	*
Michigan	*	*	*	*	*	*	*	*	*	*
Minnesota	yes	yes	yes	yes	yes	yes	yes	no	no	yes
Mississippi	yes	yes	yes	yes	yes	yes	yes	no	no	no
Missouri	yes	yes	no	yes	no	yes	yes	no	yes	yes
Montana	yes	yes	no	yes	no	yes	yes	no	yes	yes
Nebraska	no	yes	no	no	no	yes	yes	no	yes	no
Nevada	yes	yes	*	yes	*	yes	yes	*	*	*
New Hampshire	yes	yes	yes	yes	yes	yes	yes	yes	no	no
New Jersey	no	no	yes	no	yes	yes	yes	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	no	yes	no	yes	yes	no	no	yes
Oklahoma	*	*	*	*	*	*	yes	*	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	yes	yes	yes	yes	yes	no	no	yes
South Carolina	yes	yes	no	*	no	*	*	no	no	yes
South Dakota	no	no	no	no	no	yes	yes	no	no	yes
Tennessee	yes	yes	yes	yes	yes	yes	yes	no	yes	no
Texas	no	no	no	no	no	yes	yes	*	no	*
Utah	no	yes	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	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

+ Data not reported

* Coverage varies by health plan

** Coverage provided only under certain conditions

State has announced a new benefit, but not yet details on coverage

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 goes into effect January 1, 2010.
Illinois	Requires insurance companies to offer a tobacco cessation benefit as a rider to any group health insurance policy offered to employers or group policyholders in the state. The rider must include reimbursement or coverage for up to $500 spent on a tobacco cessation program, which must include counseling and all FDA-approved tobacco cessation medications. Insurance companies can charge additional premiums for coverage of this rider, and employers do not have to purchase this coverage.
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 3-month supply per year per member. Co-payments may apply to these medications.

Appendix F: State Quitlines

	Spending per Smoker FY2012*	CDC-Recommended Spending per Smoker	Percentage of Smokers Treated FY2010**	Free Medications Provided to Callers in 2010?**
Alabama	$1.14	$10.53	0.20%	yes
Alaska	+	$10.53	2.34%	yes
Arizona	$2.21	$10.53	1.20%	yes
Arkansas	$4.69	$10.53	2.91%	yes
California	$1.18	$10.53	0.66%	no
Colorado	$3.04	$10.53	3.49%	yes
Connecticut	$0.34	$10.53	0.90%	yes
Delaware	$8.73	$10.53	+	yes
District of Columbia	+	$10.53	+	no
Florida	$4.16	$10.53	+	yes
Georgia	$0.79	$10.53	0.18%	yes
Hawaii	$7.10	$10.53	1.03%	yes
Idaho	$3.08	$10.53	1.68%	yes
Illinois	$0.68	$10.53	0.43%	no
Indiana	$1.06	$10.53	1.31%	yes
Iowa	$2.23	$10.53	3.59%	yes
Kansas	$1.10	$10.53	+	no
Kentucky	$0.33	$10.53	0.05%	yes
Louisiana	$0.39	$10.53	+	no
Maine	$13.56	$10.53	3.20%	yes
Maryland	$1.20	$10.53	0.70%	yes
Massachusetts	$1.26@	$10.53	0.33%	yes
Michigan	$0.53	$10.53	+	yes
Minnesota	$1.73	$10.53	0.59%	+
Mississippi	$1.98	$10.53	0.36%	yes
Missouri	$0.53	$10.53	0.82%	yes
Montana	$6.37	$10.53	4.20%	yes
Nebraska	$1.29	$10.53	+	no
Nevada	$1.19	$10.53	+	no
New Hampshire	$1.85	$10.53	0.07%	no
New Jersey	$0.35	$10.53	+	no
New Mexico	$5.25@	$10.53	3.35%	yes
New York	$1.75	$10.53	4.49%	yes
North Carolina	$3.34	$10.53	0.42%	yes
North Dakota	$11.86	$10.53	2.57%	yes
Ohio	$0.25	$10.53	0.38%	yes
Oklahoma	$7.48	$10.53	4.48%	yes
Oregon	$5.49	$10.53	0.62%	yes
Pennsylvania	$1.13	$10.53	+	yes
Rhode Island	$1.77	$10.53	0.14%	+
South Carolina	$4.93	$10.53	0.21%	yes
South Dakota	$23.07	$10.53	6.66%	yes
Tennessee	+	$10.53	+	+
Texas	$0.29	$10.53	+	yes
Utah	+	$10.53	+	yes
Vermont	$4.90	$10.53	+	yes
Virginia	$0.39	$10.53	0.14%	no
Washington	+	$10.53	1.17%	yes
West Virginia	$2.93	$10.53	1.98%	yes
Wisconsin	$0.73	$10.53	1.49%	yes
Wyoming	$14.59	$10.53	3.01%	yes

* Data current as of November 11, 2011. Budget data are subject to change throughout the fiscal year.
** FY2010 data are most current available.
@ Data obtained by American Lung Association
+ Data not reported
Unless otherwise noted, data in this chart were provided by the North American Quitline Consortium. For more details, please visit www.naquitline.org

We will breathe easier when the air in every
American community is clean and healthy.

We will breathe easier when people are free from the addictive
grip of tobacco and the debilitating effects of lung disease.

We will breathe easier when the air in our public spaces and
workplaces is clear of secondhand smoke.

We will breathe easier when children no longer
battle airborne poisons or fear an asthma attack.

Until then, we are fighting for air.

About the American Lung Association

Now in its second century, the American Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease. With your generous support, the American Lung Association is "Fighting for Air" through research, education and advocacy. For more information about the American Lung Association, a Charity Navigator Four Star Charity and holder of the Better Business Bureau Wise Giving Guide Seal, or to support the work it does, call 1-800-LUNG-USA (1-800-586-4872) or visit www.lung.org.

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