

Update on the Role of Health Plans in Tobacco Cessation

Health plans play an increasingly important role in the deliver of tobacco cessation services. The PHS Clinical Practice Guideline devotes a chapter to recommendations for health systems and this section is likely to increase with the publication in 2008 of the updated Guideline. Health plans are responsible for managing the types and cost of healthcare that is available to most people. Including tobacco dependence treatment as a covered benefit is an important step towards insuring that tobacco users will receive the treatment they need to stop.

What are the current trends in health plan coverage?¹

- In four surveys over 6 years, conducted through the Addressing Tobacco in Managed Care program, coverage for any tobacco dependence treatment has increased from 25% of health plans in 1997 to 88% of health plans in 2003.
- There has been a decline in the number of health plans that require enrollment in counseling to receive medications from 25% to 19%.
- The most common types of counseling covered are phone counseling (42%) and individual counseling (36%). Coverage for group counseling has declined from 36% in 1997 to 21% in 2003.

What are the current trends in Medicaid coverage?^{2,3}

- In 2005, 72% of state Medicaid programs covered some form of tobacco dependence treatment.
- Medications are much more commonly covered than counseling. There were increases in coverage for all types of medications from 2000 to 2005.
- Individual, face-to-face counseling is most often covered (49%). Group counseling is covered by 35% of Medicaid programs and telephone counseling is covered by only 6% of programs.

What are the effects of co-payments or cost sharing with plan members?⁴

- In a recent Cochrane Review of the pooled effects of coverage:
 - Smokers were about 1 ½ times more likely to try to quit and to be abstinent if they had full coverage (i.e. no cost to smoker) than if they had no coverage at all.
 - Smokers were more than twice as likely to be quit if they had full coverage than if they had only partial coverage.

What is the utilization of health plan benefits by health plan members?

Many health plan members do not know that they have benefits and if they do, they are not well used. Data from Medicaid surveys illustrates this problem:

- Only about a third of Medicaid recipients who have comprehensive coverage for tobacco dependence treatment (counseling and medications) and were surveyed were aware of these benefits.⁵
- Less than two-thirds of Medicaid physicians knew that tobacco dependence treatments were covered.⁵

- In Wisconsin, less than 2% of Medicaid recipients who were enrolled in fee-for-service plans used their pharmacotherapy benefit for tobacco cessation medications.⁶

What are the trends at the clinical practice level?⁷

- In a 2001 survey of US physician groups (>20 MD's), 70% reported offering some support for smoking cessation.
- Medical groups, larger groups, and primary care groups are more likely to offer support for cessation.
- Among these groups, 17% require that MD's provide the services and 38% offer programs.
- Physician groups were more likely to offer services if there was recognition (income or public) for the quality of services offered; there were financial incentives; they were required to report deliver of services to meet HEDIS measures; they were aware of the PHS Clinical Practice Guideline.

What are the trends in state tobacco cessation programs for working with health plans to cover tobacco dependence treatment?

While the trends nationally are towards more coverage, the effort needed to increase access to cessation services through health plans is complex. Health plans compete for business in a market that is driven by consumer demand and industry trends. Health plans need a compelling reason to add these benefits and often need assistance in the development and implementation of the benefit itself. Because the health care setting is so important to the delivery of tobacco dependence treatment, state programs are developing outreach strategies to increase health plan involvement in the funding and delivery of cessation services.

One state example is New York State.⁸

- New York has partnerships with health plans through its state program infrastructure including cessation centers, a quitline, and chemical dependency programs.
- Cessation Centers
 - 19 across state
 - Goal is to reach primary care settings and hospitals to screen patients and provide services.
 - Outreach staff lay groundwork for coverage of tobacco dependence treatment; make the case for health plans.
 - Cessation centers also partner with health plans to increase utilization of benefits.
 - Pilot project was coordinated with three health plans to promote use of quitline.
 - Created a warm transfer to services covered by health plan when health plan members called the quitline.
 - Increased quitline calls and benefit utilization.
- Quitline
 - Quitline is fully integrated with cessation centers.
 - Cessation Center, outreach staff promotes referrals to quitline through health systems.
 - Created partnership in delivery of cessation services.

- Chemical dependency programs
 - New initiative in 2007-2008.
 - Will integrate tobacco dependence treatment into 1400 chemical dependency treatment programs to reach smokers treated in this system.
- Summary
 - States use multiple strategies for reaching smokers through systems.
 - Health systems and health plans are important partners in this outreach.
 - Health systems and health plans are increasing their involvement as they see opportunities for their members and in partnership with state programs.

What is the “model” benefit for health plans to cover tobacco dependence treatment?⁹

The Campaign for Tobacco-Free Kids has developed a model benefit through a consensus process with cessation and health plan experts across the US. The essential features of this benefit are:

1. Screening for tobacco use – Every patient at every clinic visit should be asked if they use tobacco and should have their tobacco use status documented (in outpatient and inpatient health care visits, including home care and case management) and should be advised and assisted to quit. Documentation of tobacco use should be recorded as part of a patient’s vital signs in the patient’s electronic or paper medical record.

2. Evidence-based counseling for tobacco use treatment –

(a) The term ‘evidence-based counseling for tobacco use treatment’, described and recommended by “Treating Tobacco Use and Dependence: A Clinical Practice Guideline”, published by the U.S. Public Health Service in June 2000, includes diagnostic and counseling services that combine problem solving and quitting skill training, direct social support, and training in garnering external social support for quitting. Effective counseling can be provided in individual, group and phone counseling formats. Such counseling can be delivered by a variety of clinicians, including:

- by or under the supervision of a physician; or
- by any other health care or counseling professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished.

(b) The term ‘evidence-based counseling for tobacco use treatment’ is limited to--

- services recommended in ‘Treating Tobacco Use and Dependence: A Clinical Practice Guideline’, published by the U.S. Public Health Service in June 2000, or any subsequent modification/update of such Guideline; and
- such other services that the State Secretary/Commissioner of Health recognizes to be effective.

3. Evidence-based pharmacotherapy – As described and recommended by “Treating Tobacco Use and Dependence: A Clinical Practice Guideline”, published by the U.S. Public Health Service in June 2000, the term ‘evidence-based pharmacotherapy’ includes all pharmacologic agents, prescription and over-the-counter products, approved by the U.S. Food and Drug Administration for tobacco use cessation (including nicotine transdermal patches, nicotine polacrilex gum, nicotine lozenges,

nicotine inhaler, nicotine nasal spray, bupropion SR, and varenicline, or any subsequent products approved by the FDA for the same purpose) along with required diagnostic and medication counseling services. These products shall be covered individually and in combinations recommended by 'Treating Tobacco Use and Dependence: A Clinical Practice Guideline' and published by the U.S. Public Health Service in June 2000 (or any subsequent updates of such Guideline).

4. Duration of treatment – Due to the chronic, relapsing nature of tobacco use dependence, a disease that often requires multiple quit attempts in order to achieve long-term abstinence from tobacco, counseling and pharmacotherapy shall be available for multiple episodes of treatment per benefit year with no lifetime limit.

5. Targeting benefits – If specific population groups have been identified (e.g., pregnant smokers) to receive medically appropriate tobacco use treatment services, the benefit design (counseling and pharmacotherapy) must be tailored, consistent with the scientific evidence-base for tobacco use treatment, to the unique needs of that population.

6. Unlinked vs. linked medication benefits – All providers are strongly encouraged to combine counseling with pharmacotherapy when clinically appropriate. The receipt of counseling or pharmacotherapy shall not be a precondition for the use of one form of treatment (e.g., counseling) in order to receive the other (e.g., pharmacotherapy).

7. Cost-sharing and deductibles – Patients' out-of-pocket treatment costs (e.g., deductibles, cost-sharing) for all forms of evidence-based counseling and pharmacotherapy for treatment of tobacco use shall be eliminated or minimized to remove financial barriers to treatment.

8. Adequacy of reimbursement – Provider, clinic, health plan and hospital reimbursement for services rendered under this benefit shall be sufficient to cover the reasonable and necessary costs for the delivery of tobacco use treatment services incurred by covered providers and health systems.

9. Promotion, education and awareness – Sustained efforts, including employer and community-based outreach activities, to educate and promote awareness of tobacco use treatment services shall be conducted in an effort to increase utilization and quit rates of all evidence-based tobacco use treatment services.

10. Data collection and evaluation - Data shall be collected at a minimum for the purposes of monitoring and reporting on the delivery of recommended tobacco use screening and treatments (consistent with the measures required by the National Committee for Quality Assurance and the Joint Commission on Accreditation of Healthcare Organizations) and optimally for the purpose of evaluating the clinical and economic impacts of the tobacco use treatment benefit (use of data from billing code ICD-9 305.1 is recommended for this purpose).

References

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