

State Cessation Coverage 2009

Helping Smokers Quit



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Introduction

The United States is at a critical point in its history, with a rare opportunity to provide clinically proven treatments to help smokers quit. Health care reform must include a national prevention and wellness strategy that targets priority areas where public health can be improved. Key among those strategies is the full coverage of smoking cessation treatment.

All health care plans should fully cover comprehensive smoking cessation programs for all of their members. This includes state Medicaid programs, state employee health plans and private employer-provided health insurance. Smokers must have access to ALL tobacco cessation treatments recommended by the U.S. Public Health Service¹, and not just one or some of them. The American Lung Association fully supports full coverage for smoking cessation therapies in any health care reform proposal that becomes law.

The Benefits of Smoking Cessation Coverage

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.² The reasons to quit 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 non-smokers'.³

Quitting smoking also has economic benefits. Former smokers save on medical expenses associated with the diseases and illnesses they prevent by quitting. Studies indicate that

helping smokers quit saves thousands of dollars in health care expenditures per smoker.^{4,5} These savings in medical expenses benefit smokers, insurance companies, employers, and governments. Also, the money that a smoker spends on buying cigarettes can be spent on other things when the smoker quits.

Chances are that any smoker who wants to quit will also tell you he or she has tried to quit before. In 2008, 45 percent of smokers reported trying to quit in the last year.⁶ Unfortunately only four to seven percent are successful.⁷ Smoking is extremely addictive for most people. The combination of complex chemical and social addictions to tobacco products makes them very

hard to quit. Many smokers 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.

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Policymakers at the federal and state levels have an important opportunity **right now** to help smokers quit.

Fortunately, several treatments have been proven effective in helping smokers quit. These treatments include over-the-counter and prescription medications, as well as group, individual and phone counseling. Medications and counseling have helped millions smokers quit for good. The bad news is that smokers often do not have easy access to these treatments.

Policymakers at the federal and state levels have an important opportunity right now to help smokers quit. Smokers should receive the tools to help them end their addiction through their health insurance coverage. With the national spotlight currently focused on health care reform, now is the time to ensure that all smokers in this country are given a chance to quit using evidence-based treatments.

How Health Care Reform Can Help Smokers

In the current debate over health care reform, focusing on prevention is often mentioned as a way to make our country healthier and reduce the rising costs of health care. Many preventive services save lives, improve health and are cost effective. But tobacco cessation treatments and tobacco use screenings are often

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cited as one of the best, already-proven ways of preventing illness and saving money.⁸ In fact, in 2006 a ranking of the effectiveness of 25 preventive services scored smoking cessation as one of the top three services for preventing health consequences and for cost effectiveness. Smoking cessation services, including screening, counseling and intervention, received the highest possible score on both sets of measures.⁹ All of this is reason for policymakers to ensure that comprehensive smoking cessation coverage be included in any health care reform package.

What Should Be Covered?

Good news for policymakers—we already know what works. In its Clinical Practice Guideline called Treating Tobacco Use and Dependence,¹⁰ the U.S. Public Health Service 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.

Five of the medications the Guideline recommends are nicotine-replacement-therapies (NRTs). These medications deliver medicinal nicotine to a smoker's body in a variety of doses and forms, easing a quitter's withdrawal symptoms. Nicotine gum (like Nicorette and Nicorelief) and lozenges (like Commit) are available over-the-counter. This means smokers may buy them without a prescription. The NRT inhaler (Nicotrol Inhaler) and Nasal Spray (Nicotrol NS) are available only by prescription.

The nicotine patch is available in both over-the-counter and prescription-only forms (such as Nicoderm CQ, NTS and Nicotrol).

Cessation Benefits Should Include ALL of These:

- ✓ NRT Gum
- ✓ NRT Patch
- ✓ NRT Lozenge
- ✓ NRT Inhaler
- ✓ NRT Nasal Spray
- ✓ Bupropion
- ✓ Varenicline
- ✓ Individual counseling
- ✓ Group counseling
- ✓ Phone counseling

The other two medications recommended by the Guideline do not contain nicotine. Bupropion was originally developed and marketed for the treatment of depression, but is now approved to treat tobacco dependence by easing nicotine withdrawal symptoms. It is available both in generic form, bupropion, and under the brand name Zyban®. Varenicline is the newest smoking cessation drug, sold under the brand name Chantix®. Both bupropion and varenicline are available through prescription only.

While these medications combat the physical aspect of the addiction, counseling targets the social and psychological aspects. Counseling is the only treatment option for some smokers who should not take cessation medications (like some pregnant women or people with medical contra-indications), and is also critical for smokers able to take medica-

tions. 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 any 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. These brief interventions are important, as more than 70 percent of tobacco users visit a physician and 50 percent visit a dentist each year.¹¹ 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 should 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 that will help their patients.

All smokers with all types of insurance should have access to these treatments. Public insurance programs like Medicare, Medicaid and state employee health plans should cover them. Not only do these programs provide insurance to some of the most physically and economically vulnerable populations, but lower health care costs for these programs benefit taxpayers. Smokers who have private insurance through their employer or individually should also be provided these treatments.

Insurance companies, program administrators and employers should ensure that they cover comprehensive tobacco cessation treatments. Comprehensive cessation treatments include all seven FDA-approved medications and both individual and group counseling. Treatment for smoking cessation is not one-size-fits-all. Just like any other medical condition, everyone responds to treatment differently. It is normal for patients to try more than one treatment option before finding the right one. 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 should have the full range of treatment options available to them when they want to quit.

Barriers to Avoid:

- ✗ Required Co-payments
- ✗ Prior Authorization Requirements
- ✗ Limits on Treatment Duration
- ✗ Yearly or Lifetime Limits
- ✗ Dollar Limits
- ✗ “Stepped Care” Therapy
- ✗ Counseling Required for Medications

Cessation treatments should 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 members, are especially vulnerable to these barriers, as they are less likely to be able to afford treatment that is not covered on their own.

The most common barriers found in insurance plans are listed on the left. All of these barriers should be avoided where possible to ease the process of quitting for smokers. For more information on these barriers, please see the American Lung Association factsheet “What Doesn’t Work to Help Smokers Quit: Barriers to Avoid.”¹²

Tobacco dependence is a medical condition just like any other addiction, and its treatment should be covered by insurance plans.

Cessation Coverage in a Reformed Health Care System

As health care reform is being debated in Washington and across the nation, policymakers have an important opportunity to give all smokers the help they need to quit. To take advantage of this opportunity, we must ensure that a reformed health care system provides comprehensive cessation treatments for all smokers.

The American Lung Association urges that health care reform adequately provide all smokers with access to treatments for smokers to quit. Such coverage must include these components:

■ **Coverage of all recommended cessation treatments.** In the current debate language, that will require action in both legislation and implementation.

1. First, language to require the coverage of tobacco cessation services needs to be in the final health care reform law. Proposals may require this by reference. For example, one common provision requires all private health insurance plans to cover preventive services given an 'A' or 'B' grade by the U.S. Preventive Services Task Force. The Task Force gives tobacco cessation services an 'A' grade,¹³ which applies only to treatments showing "high certainty" that the "net benefits" of incorporating this service would be "beneficial."
2. Second, implementation of these provisions needs to ensure that private health insurance plans and Medicaid programs are required to cover ALL proven cessation treatments, not just one or some. The coverage required should follow the recommendations in the Public Health Service Guideline on *Treating Tobacco Use and Dependence*.¹⁴

■ **Removal of barriers to quitting.** Some proposals have eliminated or limited cost-sharing for preventive services, which is an important step in removing barriers. But there are more barriers to remove to make these treatments truly easy to use. Insurance plans should not be allowed to limit the length or frequency of or amount spent on cessation treatments. Plans also should be required to provide cessation treatments without prior authorization.

■ **Coverage applies to all.** These requirements should apply to an insurance plan's coverage of all its members—not just pregnant women. Additionally, Medicaid programs should ensure that any managed care organization they contract with provides comprehensive coverage.



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Other Proposals

Some proposals take positive steps towards helping smokers quit, but fall short of ensuring access to all treatments for all smokers. For instance, removing cessation drugs from the Medicaid "optional" list is a necessary step in requiring Medicaid programs to cover comprehensive cessation treatments, but it does not go far enough. Removing cessation drugs from this list would only require states to cover at least one cessation medication—

not all of them, and would not guarantee placement on preferred drug lists. This measure also would not guarantee any coverage of counseling, as it only addresses medications.

Others propose to give financial incentives to insurance companies, employers, and/or Medicaid programs that offer comprehensive coverage for cessation treatments. Incentives will not guarantee coverage for all smokers—these vital treatments must be considered parts of a standard benefit plan, not as “extras”.

The American Lung Association also warns against proposals that allow insurance plans to charge tobacco users higher premiums or surcharges for health insurance. Most current smokers started smoking when they were teenagers,¹⁵ and have been smoking for years without access to treatments that would help them quit. Charging these smokers more for health insurance may make coverage too expensive to buy—leaving them uninsured and without access to any health care, let alone cessation treatments. Instead of punishing smokers for their addiction, insurance plans should incentivize quitting and provide comprehensive support for those who want to quit.



The health care reform process not only has the potential to provide

coverage of cessation treatments, but also to increase their use. Including tobacco use status and clinician interventions to treat tobacco dependence as standard questions on patients' electronic health records will remind and prompt clinicians to ask about tobacco use and advise patients to quit. It will also provide valuable data to researchers and health care systems on utilization, quitting success rates, and improved health and financial outcomes. Tracking these measures can also help health care systems identify ways to improve the ways they help smokers.

Some policymakers also propose to create new sources of funding for public health and prevention programs and initiatives. These provisions would give much needed funding to proven programs and to research that would determine how to make them work better. The American Lung Association urges policymakers to ensure that these new sources of funding have a strong focus on preventing tobacco use and helping people quit. These new funds would help ensure that any smoker who wants to quit has somewhere to turn in their community for help.

Helping smokers across the country quit must be an integral part of any reformed health care system. As the U.S. Preventive Services Task Force concluded, smoking cessation treatment prevents disease. The single most important thing a smoker can do to improve his or her health is to quit smoking. The American Lung Association urges that policymakers provide smokers with the treatment they need.

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®

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 eight-session program is also offered as a 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.^{16,17}



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.^{18,19}

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 and respiratory therapists. Callers can ask about a variety of lung-related topics—but around 70% 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.

Quitter in You

Quitter in You is a new smoking cessation campaign designed to help people quit smoking for good. It provides a fresh way to think about cessation by not viewing past quit attempts as failures or wasted efforts, but as necessary steps along the way toward quitting for good. Research shows the majority of smokers are not able to successfully quit on their first try, and require multiple attempts to quit for good.

This campaign offers support through a new Web site called QuitterInYou.org that features user-generated content where people can share stories of their quit attempts and tactics that did and didn't work for them. It also provides tools and support from the American Lung Association's "Freedom From Smoking" program to help smokers at each step in the journey toward quitting.

The Quitter in You campaign is made possible through funding from Pfizer Inc.



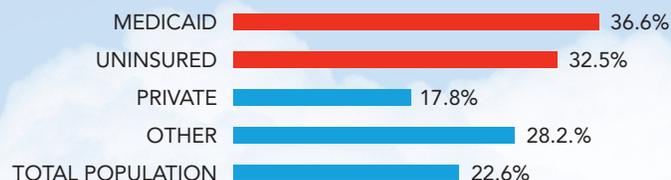
Medicaid Coverage of Smoking Cessation Treatments

Medicaid coverage of smoking cessation treatments targets essential help to people disproportionately affected by tobacco use. People who receive Medicaid benefits smoke at higher rates than the general population (36.6 percent versus 22.6 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 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 2004.²¹ A few states are leading the way in providing comprehensive coverage to help smokers on Medicaid quit, but most states are missing this opportunity.

According to American Lung Association data for 2009,²² six state Medicaid programs provide comprehensive coverage for smoking cessation treatments. These states give their Medicaid enrollees the best chances in quitting by providing *comprehensive* coverage; that is, they provide all seven FDA-approved cessation medications and group and individual counseling to all Medicaid recipients.¹

In 2009, 15 states came close to providing comprehensive coverage. These states covered all but 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. Six out of the fourteen states have this specific gap in their coverage.

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. 2008.

Five states provide NO coverage for cessation treatments to their entire Medicaid population in 2009. Most of these states specifically exclude cessation products or services from their Medicaid coverage policies. These exclusions are usually written in administrative regulations or Medicaid policy manuals, but occasionally are legislatively mandated. Alabama does cover some counseling for pregnant women, but that treatment is not available to the rest of the Medicaid population. While helping pregnant women quit smoking is important, limiting counseling in this way unfairly and unwisely leaves out many other smokers.

In many states, the Medicaid program contracts with one or more managed care organizations (MCOs) to provide health insurance to their members. If

6 States Offer Comprehensive Cessation Benefits to Medicaid Enrollees:

- Indiana
- Massachusetts
- Minnesota
- Nevada
- Oregon
- Pennsylvania

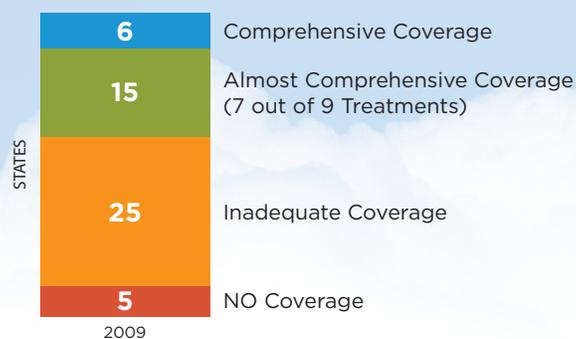
5 States Provide NO Cessation Coverage for Medicaid Enrollees:

- Alabama
- Connecticut
- Georgia
- Missouri
- Tennessee

¹ Some form of telephone counseling is provided to all state populations through state quitlines. Quitlines are discussed later in this report.

cessation treatments are not required in the state's contract with the MCO as a covered service, decisions about this coverage are left up to the MCO. This almost always results in coverage that is less than comprehensive and varies by MCO. 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 remedy this situation and ensure all smokers in Medicaid get the same level of quality cessation coverage, states should require comprehensive cessation coverage in their contracts with managed care organizations.

Not Enough States Provide Comprehensive Medicaid Coverage of Tobacco Cessation Treatments



Source: American Lung Association. State Tobacco Cessation Coverage Database. 2009.
Available at: www.lungusa.org/cessationcoverage

Unfortunately, potential quitters encounter barriers to getting the help they need even in the states where Medicaid covers 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. Copayments should not be charged or should be as low as possible.

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.

Since the American Lung Association began tracking these data in 2008, there have been a few changes to coverage policies. Four states took positive steps:

- In 2009, **New Hampshire** changed its policy to provide cessation medications to any patient who wants to quit, removing a formidable barrier to potential quitters. Their prior policy had limited those medications to patients whose doctors deemed it was “medically necessary” for them to quit smoking.²³
- In January 2009, **North Carolina’s** Medicaid program began reimbursing clinicians for providing individual cessation counseling to their patients.²⁴ Now group counseling is the only cessation treatment North Carolina does not cover for Medicaid enrollees.
- In September 2009, the **Colorado** Medicaid program announced that Medicaid patients are now allowed to receive smoking cessation treatment twice per year. Previously the benefit was available only once in a patient’s lifetime.²⁵

- In 2008, the **Nebraska** legislature passed a law establishing cessation coverage in Medicaid. This legislation was implemented in 2009. The Nebraska Medicaid program now covers NRT gum and patch, varenicline, bupropion, and individual counseling.²⁶ This is a positive step for smokers on Medicaid in Nebraska, but it is unfortunate that the Medicaid program did not opt to provide comprehensive coverage.

Unfortunately, one state decreased Medicaid cessation coverage in 2009:

- The **Texas** Medicaid program withdrew coverage of two proven treatments this year, when they dropped the NRT nasal spray and inhaler from the Texas Medicaid Drug Formulary.²⁷
- The **Texas** Medicaid program also changed their contracts for managed care organizations. Previous contracts required MCOs to cover cessation programs (like group or individual counseling) up to \$100 per year. In 2009 this requirement was removed, and now cessation services are considered a “value added” program at the option of the MCOs.²⁸

State Employee Health Plan Coverage of Smoking Cessation Treatments

Every state provides health insurance to its employees.²⁹ 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 (in fact some regulations for private insurance plans are based on the coverage available to state employees). 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

Helping state employees quit will save state taxpayers money.

benefit others in the state. Furthermore, helping state employees quit will save state taxpayers money.³⁰

Coverage of cessation treatments for state employees varies widely state-to-state, according to data collected by the American Lung Association for 2009.³¹ Five states lead the way in providing comprehensive coverage to all state employees and dependents. A few more states (Alabama, Arizona, Rhode Island, Tennessee, West Virginia and Vermont) come close, providing all but two treatments for cessation.

Unfortunately, 32 states provide inadequate coverage and eight states provide NO coverage for their employees and dependents who want to quit smoking.

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

5 States Provide Comprehensive Cessation Treatment Coverage for State Employees:

Illinois
Maine
Nevada
New Mexico
North Dakota

8 States Provide NO Cessation Treatment Coverage for State Employees:

Florida
Iowa
Louisiana
Montana
Nebraska
New Jersey
South Dakota
Texas

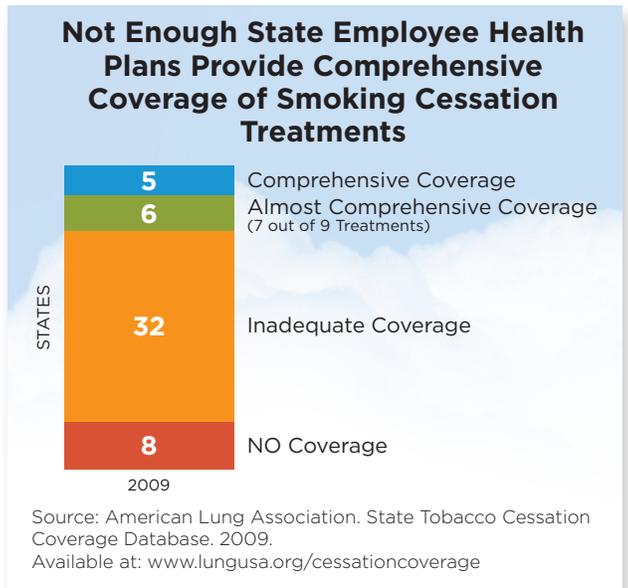
should specify in their contracts with MCOs that comprehensive cessation coverage is required. Another way to guarantee coverage for all employees and dependents is to provide it through a state employee wellness program.

Changes to these policies in 2009 were few, but almost all positive. Three states increased the number of medications available to employees who want to quit smoking this year:

- **Delaware's** state employee health plan, which previously did not cover any cessation treatments, changed prescription drug plan providers and gained coverage of three cessation medications.³²
- The **Kentucky** Employees Health Plan added varenicline and bupropion to its prescription drug plan.³³
- The **Mississippi** State and School Employees' Life and Health Plan, which previously did not cover any treatments, added coverage of prescription cessation medications in 2009.³⁴

Also, Tennessee began offering group counseling to state employees and their spouses (in addition to all seven cessation medications, which were already offered).³⁵

The only state that withdrew treatments for state employees in 2009 was **Nebraska**. In 2008, Nebraska's employee benefits program, known as Options, covered all cessation medications. As of January 1, 2009, however, Options' new prescription drug plan provider excludes all cessation medications from coverage.³⁶ Nebraska state government employees now are not able to receive any help to quit smoking.



Private Insurance Coverage of Smoking Cessation Treatments

Currently the majority of Americans that 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. In a few states, however, legislators and administrators have stepped in to ensure some level of cessation treatment coverage for privately-insured tobacco users in their states. Seven states currently have laws or insurance regulations that require cessation coverage in some or all private insurance plans in the state.³⁷

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 and Rhode Island have these more specific laws.

A few states created or changed these laws in 2009. Colorado and Oregon have new laws mandating tobacco cessation coverage that go into effect on January 1, 2010.^{38,39} Many details of the coverage mandated by these laws are yet to be determined, since the laws have not been implemented. Rhode Island provides a preview of how this can work. Recently, the Rhode Island Insurance Commission expanded its already existing tobacco cessation mandate to require all treatments recommended by the Public Health Service for cessation. If implemented as intended, this law would be the first in the country to require comprehensive coverage of cessation treatments for private insurance plans. This law went into effect August 14th, 2009, but it is to be implemented in insurance contracts signed after that date on a rolling basis.⁴⁰

**7 States have
Legislative or
Regulatory Standards
for Cessation
Treatment Coverage:**

Colorado
Maryland
New Jersey
New Mexico
North Dakota
Oregon
Rhode Island

Setting a standard for coverage helps the largest number of smokers quit and be healthier.

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.⁴¹

The Vital Role of Smoking Cessation Quitlines

Public and private insurance coverage of cessation treatments is not the only way states can reach smokers. One vital way is through a tobacco cessation quitline.

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 quitline numbers are available to anyone, regardless of insurance status. However, services available from the quitline (including phone counseling sessions and sometimes free or discounted medications) can vary depending on the insurance status of the caller (more sessions or medication available to uninsured, for instance), as well as the age of the smoker and other eligibility requirements.

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. Policymakers should ensure that quitlines are provided with enough resources to achieve this goal.

In its document, *Best Practices for Comprehensive Tobacco Control Programs*,⁴² the U.S. Centers for Disease Control and Prevention (CDC) set 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 eight percent of tobacco users in the state (measured by number of calls received from tobacco users);
3. Deliver services to six percent of tobacco users in the state (measured by number of tobacco users that receive treatment);
4. Offer two weeks of free NRT to all tobacco users. Four weeks should be offered to uninsured or under-insured callers.

As the quitline community develops uniform practices of measuring and recording data, researchers will discover what progress quitlines are making towards these goals. However, recent cuts to quitline budgets due to the poor economic situation in 2008-2009, are likely to substantially impede progress.

Quitlines have had a busy year in 2009. Calls to quitlines, just like general interest in quitting smoking, can be heavily affected by increases in cigarette taxes and the implementation of smokefree laws. Several states increased their tobacco taxes in 2009 to help plug

budget holes. Additionally, the federal cigarette tax increased by 62 cents in April 2009 to fund the Children's Health Insurance Program. These policy changes resulted in a large upswing in callers to state quitlines in February through April, as smokers anticipated the tax increase and the cost of tobacco products went up.

While the upswing in calls was prominent in most states, some saw more demand than others. In March, as smokers were preparing for the widely-publicized federal tobacco tax increase, the Michigan Tobacco Quit Line announced a give-away of two months of NRT gum, lozenges or patches for free

to tobacco users who enrolled in their phone counseling program. In five days the quitline received over 65,000 calls, causing it to quickly exceed its capacity. The quitline enrolled as many tobacco users as it could in its program before the funding for NRTs ran out, but

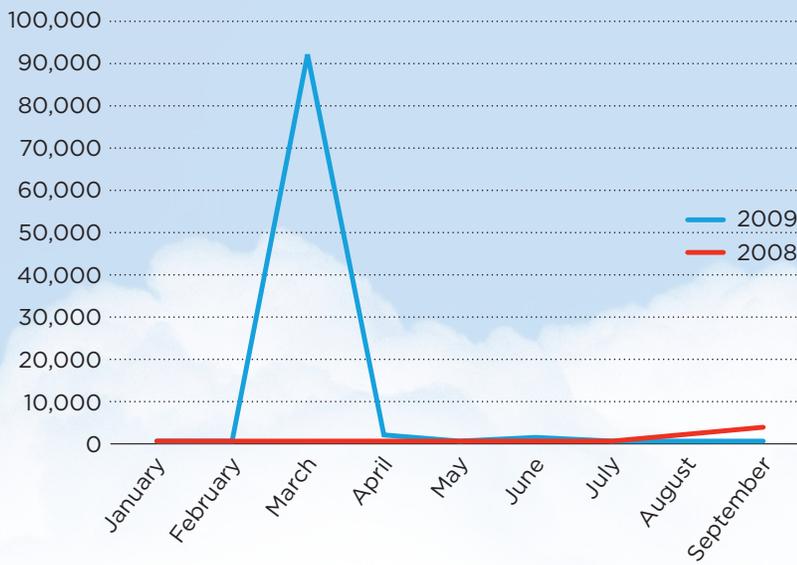
Calls to 1-800-QUIT-NOW* Increased Dramatically in 2009



*Calls recorded only include calls received to 1-800-QUIT-NOW, which are then routed to the appropriate state. Some states promote other quitline numbers, so this measure does not capture all calls to state quitlines.

Source: North American Quitline Consortium.
1-800-QUIT-NOW Stats. Available at:
<http://www.naquitline.org/?page=800QUITNOWstats>

Calls to Michigan's Quitline Increased Dramatically in 2009



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Source: North American Quitline Consortium.
1-800-QUIT-NOW Stats. Available at:
<http://www.naquitline.org/?page=800QUITNOWstats>

they then had to start turning away callers, hoping smokers would still try to quit on their own.⁴³

This was an opportunity to help tens of thousands of smokers quit, and it was missed for many smokers because of the quitline's lack of resources. Michigan's experience illustrates the high demand for free cessation treatments and the importance of adequately funding quitlines, especially when tobacco taxes are increased or smokefree policies are enacted.

As state budgets are not likely to rebound quickly, many states will continue to look to new tobacco taxes

for help in balancing budgets. States and communities are also continuing to pass smoke-free workplace laws, recognizing the health and economic benefits. This means that demand for quitlines and other cessation services will remain high. Quitlines can and often do serve as the first and sometimes the only line of help for smokers who want to quit. State and federal policymakers must adequately fund this vital service to help the increasing number of smokers who want to quit.

State and federal policymakers must adequately fund this vital service to help the increasing number of smokers who want to quit.

An Action Plan for State Cessation Coverage

The American Lung Association recommends the following for access to and coverage of smoking cessation treatments in every state:

- All health care plans should fully cover comprehensive smoking cessation programs for all of their members. This includes state Medicaid programs, state employee health plans and private employer-provided health insurance.^{II} Comprehensive coverage consists of all components recommended by the Public Health Service clinical guidelines and the CDC, including all first line medications and group and individual cessation counseling.
- Health care plans should provide smoking cessation coverage that is free of barriers. This includes eliminating co-pays, duration limits, prior authorization requirements, stepped care therapy, and other requirements for cessation medications and counseling. Eliminating these barriers to coverage is especially important for low-income populations, like Medicaid recipients, as barriers are more likely to discourage these smokers from getting help.
- Health care plans should widely publicize their smoking cessation coverage. Plan members need to know that the coverage exists in order to access it. Insurance companies should publicize the coverage directly to members and their clinical providers and should educate providers about smoking cessation treatment.
- Health care plans should package smoking cessation benefits in a way that is easy for plan members to find information about the coverage and understand how to use it.
- Public and private health care plans should track and report utilization rates for smoking cessation treatments as well as quit rates among their members.
- Medicaid, state employee health plans and private insurance companies should reimburse their participating clinicians for providing smoking cessation counseling and referring patients to other cessation treatments.
- State legislatures and/or insurance regulators should require all insurance companies operating in the state to cover defined, comprehensive smoking cessation treatments as a standard benefit and require that these companies publicly and annually report the number of covered lives with access to comprehensive treatment. Regulators should establish systems to ensure compliance with these provisions.
- Insurance purchasers, both public and private, should insert specific provisions into all contracts with insurance providers to provide coverage of comprehensive cessation treatments. Language in these provisions should be detailed and specific to ensure comprehensive coverage. Purchasers should be sure to enforce these contract provisions and ensure compliance.
- Statewide quitlines are a vital component of cessation coverage and should be adequately supported by the states. These quitlines can and should provide a vital link between all other cessation treatments offered in the state.
- More research should be done on the effectiveness of smoking cessation programs, including online treatments, as well as the prevalence of cessation coverage in private insurance plans.

^{II} The Lung Association also urges the federal government to expand coverage through the Medicare program in alignment with these recommendations.

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Appendix A: Methodology

Data reported on pages 9–13 of this report are original, collected by staff of the American Lung Association. These data were collected from June–September, 2009, and are intended to reflect coverage in effect as of November 1, 2009. 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. 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	no	no	no	no	no	no	no	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	yes	yes	yes	no	no
Connecticut	no	no	no	no	no	no	no	no	no
Delaware	yes	yes	yes	yes	yes	yes	no	no	no
DC	*	*	no	no	*	*	*	*	*
Florida	*	*	*	*	*	*	*	yes	yes
Georgia	no	no	no	no	no	no	no	no	no
Hawaii	*	*	*	*	*	*	*	*	no
Idaho	yes	yes	yes	yes	yes	yes	yes	yes	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	no	yes	no	no	no	yes	yes	no	no
Kentucky	no	*	no	no	no	*	*	no	P
Louisiana	yes	yes	yes	yes	no	yes	yes	no	no
Maine	yes	yes	yes	yes	yes	yes	yes	no	yes
Maryland	*	yes	no	no	*	*	*	*	*
Massachusetts	yes	yes	yes	yes	yes	yes	yes	yes	yes
Michigan	*	*	*	*	*	*	yes	no	no
Minnesota	yes	yes	yes	yes	yes	yes	yes	yes	yes
Mississippi	yes	yes	yes	yes	yes	yes	yes	P	P
Missouri	no	no	no	no	no	no	no	no	no
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	no	yes	yes	yes	P	yes
New Jersey	*	*	*	*	*	*	*	yes	no
New Mexico	*	*	*	*	*	*	yes	*	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	yes	yes
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
South Carolina	yes	yes	*	*	*	*	*	*	*
South Dakota	no	no	no	no	no	yes	yes	no	no
Tennessee	no	no	no	no	no	no	no	no	no
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

* Coverage varies by health plan

** Coverage provided only under certain conditions

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

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	yes	no	yes	yes	yes	no	yes
Connecticut	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Delaware	yes	no	yes	yes	yes	yes	yes
DC	yes	no	no	no	no	no	no
Florida	*	*	*	*	*	*	*
Georgia	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Hawaii	*	no	*	*	*	*	*
Idaho	no	no	yes	no	no	no	yes
Illinois	no	no	no	no	yes	no	no
Indiana	yes	no	yes	yes	yes	yes	yes
Iowa	yes	no	yes	yes	yes	no	yes
Kansas	yes	no	yes	no	yes	no	no
Kentucky	*	no	*	no	*	no	*
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	yes	no	no	*	*	no	no
Minnesota	no	no	no	no	yes	no	no
Mississippi	no	no	no	no	yes	no	n/a
Missouri	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Montana	yes	yes	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	yes	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	*	*	*	*	*	*	*
Oklahoma	yes	no	yes	yes	yes	no	yes
Oregon	yes	no	no	no	yes	no	no
Pennsylvania	yes	no	yes	*	yes	no	no
Rhode Island	*	no	no	*	*	no	yes
South Carolina	yes	no	*	*	*	*	*
South Dakota	no	no	no	no	yes	no	no
Tennessee	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Texas	no	no	no	no	yes	no	no
Utah	yes	yes	no	yes	yes	no	no
Vermont	yes	no	yes	yes	yes	no	yes
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

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

Appendix D: State Employee Health Plan Coverage of Cessation Treatments

	NRT Gum	NRT Patch	NRT Nasal Spray	NRT Inhaler	NRT Lozenge	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	D	yes	yes	yes	D	yes	yes	*	*	*
Colorado	*	*	no	no	no	no	*	*	*	*
Connecticut	no	yes	yes	yes	no	yes	yes	no	no	*
Delaware	no	no	yes	no	no	yes	yes	P	no	no
DC	*	*	*	*	*	*	*	*	yes	*
Florida	no	no	no	no	no	no	no	no	no	no
Georgia	no	no	no	no	no	no	no	yes	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	yes
Iowa	no	no	no	no	no	no	no	no	no	no
Kansas	no	no	yes	yes	no	yes	yes	no	no	yes
Kentucky	yes	yes	no	no	yes	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	*	*	*	*	D	*	no
Michigan	*	*	*	*	*	*	*	*	*	*
Minnesota	yes	yes	yes	yes	no	yes	yes	no	no	yes
Mississippi	no	no	yes	yes	no	yes	yes	no	no	no
Missouri	no	no	*	no	no	*	*	no	no	no
Montana	no	no	no	no	no	no	no	no	no	yes
Nebraska	D	D	no	no	D	no	no	no	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	yes	no	yes	yes	no	yes	yes
North Dakota	yes	yes	yes	yes	yes	yes	yes	yes	yes	no
Ohio	*	*	*	*	*	*	*	*	no	*
Oklahoma	no	no	*	*	no	*	*	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	yes	yes	yes	no	no	yes	yes	no
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	no	no	no	no	*
Utah	no	no	yes	yes	no	yes	yes	no	no	no
Vermont	yes	yes	yes	yes	yes	yes	yes	no	no	no
Virginia	yes	yes	no	yes	no	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	yes	no	yes	yes	no	yes	no
Wyoming	no	*	*	*	no	*	*	no	no	no

P Coverage only for pregnant women

D Not covered, but discounts may be available

* Coverage varies by health plan

Appendix E: State Laws Mandating 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.
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: <ul style="list-style-type: none"> \$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: <ul style="list-style-type: none"> 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. Legislation goes into effect January 1, 2010.
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.

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