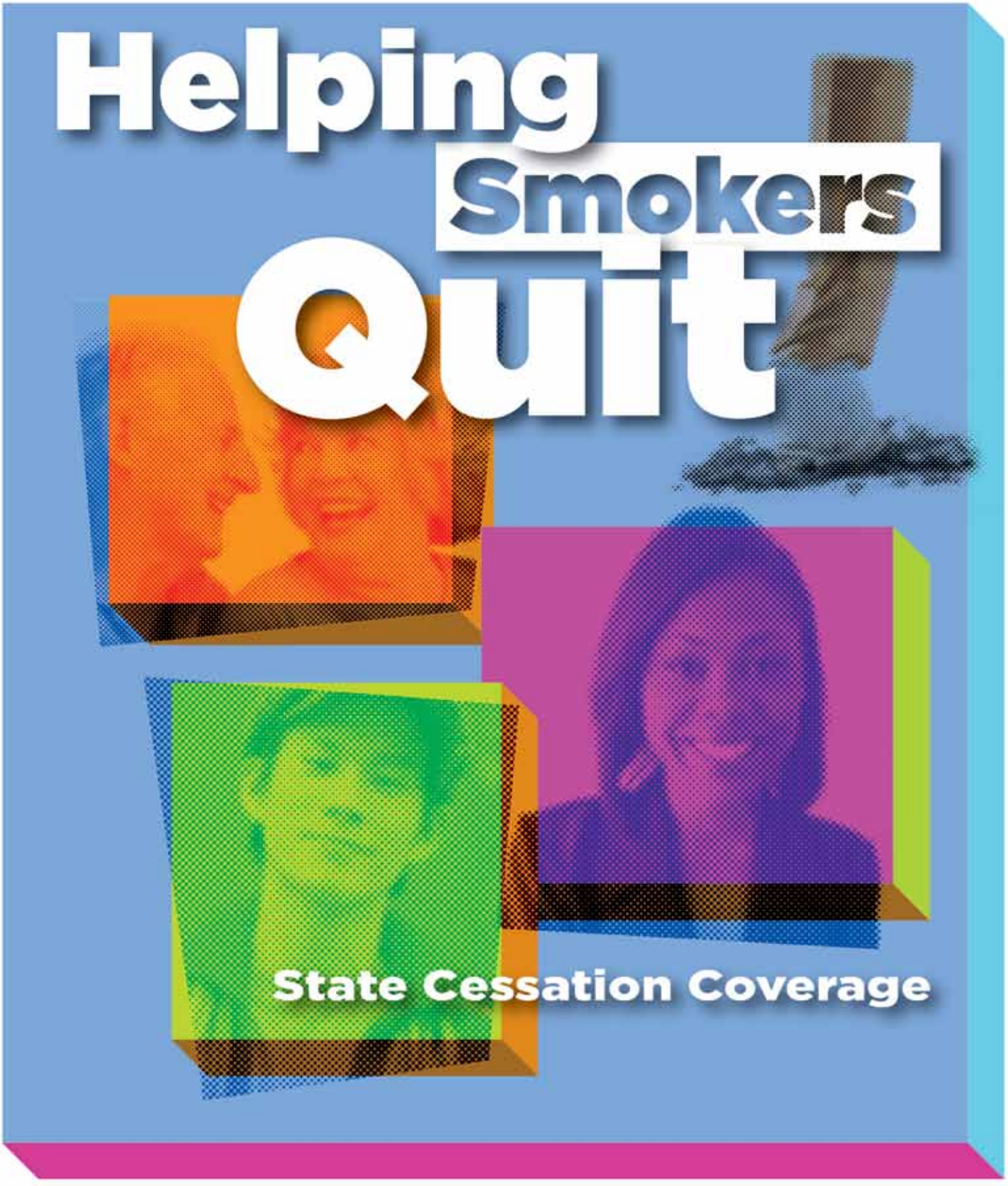
AMERICAN LUNG ASSOCIATION®

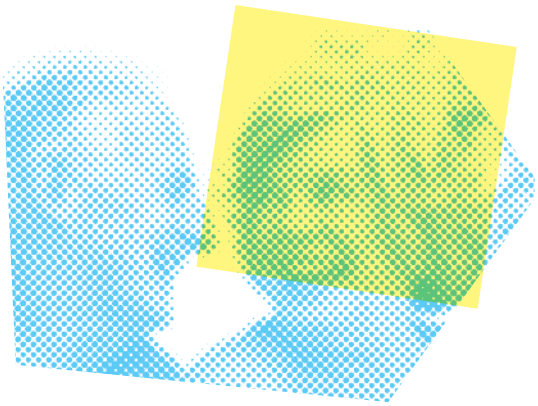
TOBACCO POLICY TREND REPORT

Helping Smokers Quit



State Cessation Coverage

Introduction



Over 70 percent of smokers want to quit,[1] and 44 percent of these smokers report trying to quit in the last year.[2] Unfortunately most of these quit attempts are unsuccessful—in 2005, of the 19 million adults who tried to quit, only four to seven percent succeeded.[3] Why? One important reason is that many smokers lack the tools to help them succeed. Having access to these tools increases the willingness of smokers to try quitting and improves their likelihood of success. States that cover cessation treatments through state Medicaid programs, state employee health plans, private insurance plans and quitlines save lives and money.

The addiction to tobacco is extremely deadly and costly. Smoking kills more than 392,000 people in this country each year.[4] About 20 percent of the American adult population smokes—a total of more than 43 million Americans.[5] The Centers for Disease Control and Prevention (CDC) estimates that this addiction costs $193 billion annually in health-related costs and lost productivity in the U.S.[6]

States that cover cessation treatments save lives and money.

Smokers who quit reduce their risks from the harms of prolonged tobacco use. On average, smokers' lives are cut short by 13-15 years.[7] Yet if a smoker quits by the age of 35, he or she will have a life expectancy similar to those who never smoked.[8] Helping these smokers quit not only adds years onto their lives, but improves their quality of life. Former smokers are less likely than current smokers to be afflicted with chronic diseases associated with smoking, such as COPD (Chronic Obstructive Pulmonary Disease, which includes chronic bronchitis and emphysema), heart disease and lung and other cancers.

Coverage of smoking cessation treatments has proven a wise financial investment for governments, insurance companies, and employers. A 2008 study in the state of Florida found that "the ratio of benefits to cost varies from $1.90 to $5.75 saved per dollar spent on smoking cessation programs, depending on the type of intervention."[9] In 1997, the average smoker incurred $1,041 in additional healthcare expenses over a period of five years compared to smokers who quit.[10] This cost would amount to $1,419 in 2008 dollars. In the Medicaid program alone, direct costs related to smoking in 2004 amounted to an average of $607 million per state.[11] In 2006, the National Commission on Prevention Priorities estimated that lifetime savings in tobacco-related health expenditures for every former smoker who does not relapse is $22,434. The study also found that when comparing the cost of a cessation program (medications and counseling) to the savings gained from smokers quitting, the net savings were $542 per smoker.[12]

Smoking cessation treatments have long been recognized for their medical- and cost-effectiveness. A July 2006 ranking of the effectiveness of 25 preventive health services recommended by the U.S. Preventive Services Task Force scored smoking cessation as one of the top three services for both 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.[13]

Smoking cessation treatments have long been recognized for their medical and cost-effectiveness.

Clearly there are many good reasons for states, insurers, and employers to provide cessation treatments to their citizens, members and employees. Unfortunately these treatments are not provided as widely as they should be. Based on original research

as well as a review of existing literature, this report details the cessation coverage provided by states through Medicaid programs, state employee health plans, standards for private insurance, and quitlines. It illuminates the wide gap between what states are currently doing to help smokers quit and what they should be doing, and recommends steps to improve state coverage of cessation treatments.

What Works to Help Smokers Quit: Cessation Treatments

Multiple therapies exist for smokers who want to quit. In its Clinical Practice Guideline on Treating Tobacco Use and Dependence, the Department of Health and Human Services' Public Health Service provides an evidence-based path to helping smokers quit.[14] Updated most recently in 2008, the Clinical Practice Guideline bases its recommendations on rigorously reviewed scientific evidence. Unless otherwise noted, all the information in this discussion comes from recommendations and conclusions of this Guideline (subsequently referred to as "Guideline" in this report).

The Guideline recommends seven first-line smoking cessation medications and three forms of smoking cessation counseling as effective in helping smokers quit.

FDA–Approved Medications

The Guideline recommends the use of seven medications to treat tobacco use. Five of these medications are nicotine-replacement-therapies (NRTs) that deliver medicinal nicotine to a smoker's body in a variety of doses and forms, easing a quitter's withdrawal symptoms. Some of these NRTs are available over-the-counter, and some by prescription only, as follows:

NICOTINE REPLACEMENT THERAPIES

COMMON NAME	U.S. BRAND NAMES	AVAILABILITY
Gum	Nicorette, Nicorelief, Nicotine Polacrilex	Over the counter
Patch	Nicoderm CQ, NTS, Nicotrol	Over the counter & prescription
Lozenge	Commit	Over the counter
Inhaler	Nicotrol Inhaler	Prescription
Nasal Spray	Nicotrol NS	Prescription

In addition to nicotine-replacement-therapy, the Guideline recommends two other medications as effective in treating tobacco use: bupropion and varenicline. Bupropion, which was originally developed and marketed for the treatment of depression, eases withdrawal symptoms (although the mechanism through which it does this is still unknown). Varenicline, the newest smoking cessation medication, alters the nicotine receptors in a smoker's brain. These medications are available by prescription, under the brand names shown below:

ADDITIONAL PRESCRIBED THERAPIES

MEDICATION	U.S. BRAND NAME	AVAILABILITY
Bupropion	Zyban	Prescription
Varenicline	Chantix	Prescription

The Guideline states that all seven of these first line medications "reliably increase long-term smoking abstinence rates." It also recommends that clinicians consider the use of some of

these medications in combination (NRT patch combined with another NRT), and encourages clinicians to consider this as a treatment option. Approved duration of these medications varies anywhere from 12 weeks (most NRTs) to 6 months (varenicline).

Cessation Counseling

The Guideline recommends brief and intensive counseling as effective in helping smokers quit. It strongly encourages doctors and other clinicians to ask patients if they smoke, and at least briefly counsel them to quit if they do. Brief interventions in the clinical setting (doctor's and dentist's offices, etc.) have the potential to reach and help large numbers of smokers. More than 70 percent of tobacco users visit a physician and 50 percent visit a dentist each year.[15] The widely accepted 5 A's method is recommended to health care providers as an effective interventions: **Ask** about tobacco use, **Advise** to quit, **Assess** willingness to make a quit attempt, **Assist** in quit attempt, **Arrange** follow up.

The Guideline recommends three types of intensive cessation counseling:

- Individual (defined as face-to-face) counseling
- Group counseling
- Telephone counseling

Each type of counseling can be provided by any suitably trained clinician and is often provided by tobacco cessation specialists. Effective cessation counseling addresses practical coping and problem-solving skills as well as social support. The Guideline says that counseling sessions should last longer than ten minutes (sessions in most counseling programs usually last at least 30 minutes), and patients should attend at least four sessions. The more time patients spend in counseling, the more likely they are to be successful in quitting. Some established programs, including the American Lung Association's Freedom from Smoking® program, provide as many as eight sessions.

While the Guideline states that either cessation medications or counseling therapies are effective on their own, treatments are even more effective when used in combination. The Guideline recommends that patients taking cessation medications should be encouraged to attend counseling (and vice versa). However this should not be a requirement, because the treatments are effective on their own and such a requirement may discourage some from seeking help.

Expanding Insurance Coverage for Cessation Treatments

The Guideline also strongly supports expanding insurance coverage within healthcare systems to help smokers quit. These healthcare systems can and should provide both clinical and financial support in smoker's attempts to quit. Clinicians, an important segment of any healthcare system, are crucial in helping smokers quit. Not only can clinicians identify smokers, deliver the 5 A's, and engage in more intensive counseling, but they also must write prescriptions for some cessation medications. For all these reasons and more, it is very important for clinicians do be integrated into smoking cessation efforts. The Guideline recommends that healthcare systems should provide adequate training, education and evaluation in smoking cessation for clinicians.

The responsibility for helping smokers lies not only with clinicians, however. Changes must also be made by health insurance providers and purchasers (such as governments,

Brief and intensive counseling are effective at helping smokers quit.

employers, etc.) to provide smokers with access to life-saving smoking cessation treatments. The Guideline recommends that insurers and purchasers ensure that the recommended treatments be provided as a comprehensive, covered benefit in all insurance plans. Providing this coverage is cost-effective, increases quit attempts and improves smokers' chances of staying tobacco-free.

What should Tobacco Cessation Coverage include?

MEDICATIONS

- ✔ NRT Gum
- ✔ NRT Patch
- ✔ NRT Lozenge
- ✔ NRT Inhaler
- ✔ NRT Nasal Spray
- ✔ Bupropion – Zyban
- ✔ Varenicline – Chantix

COUNSELING

- ✔ Individual Counseling
- ✔ Group Counseling
- ✔ Telephone Counseling

Lessons Learned in Covering Smoking Cessation Treatments as a Health Care Benefit

Healthcare coverage of cessation treatments should be *comprehensive*, to include all of the Guideline-recommended treatments. Providing comprehensive benefits recognizes that not all smokers are the same. Just like any other health condition, patients respond differently to various smoking cessation treatments. Every patient and his or her healthcare provider should be able to choose from among all the treatments that have been proven effective. Additionally, due to the relapsing nature of nicotine addiction, most smokers try to quit more than once, and many may need to try different treatments in subsequent attempts. Appropriate coverage requires that all evidence-based treatments for cessation be available to all smokers attempting to quit.

Not all smokers are the same. Just like any other health condition, smokers respond differently to various treatments.

Barriers to Accessing Treatment

Providing a comprehensive benefit is not the sole consideration in covering these treatments, however. A health plan can provide a medication or service to its members, but can put up so many barriers to receiving the treatment that patients and/or clinicians are dissuaded from using it. Most of these barriers to treatment were intended to save costs for the health plan. However, smoking cessation treatments actually save money in the long run, so states and providers could benefit from encouraging their use. Below is a list of common barriers to smoking cessation coverage:[16]

- **Required Co-payments:** Many plans require co-payments for services and medications, or the payment of a percentage of the cost as co-insurance. Requiring members to pay these co-payments every time they fill a prescription or receive a service discourages the member from seeking the treatment, especially if the payment is particularly large. This is especially true among Medicaid recipients.
- **Prior Authorization Requirements:** Plans may require that either the member or clinician contact the insurance provider for authorization of a medication or treatment. Prior authorization may be required before the prescription is written or the treatment dispensed. Plans often use this requirement to steer patients towards less expensive medications. Prior authorization can delay or discourage the delivery of treatment.
- **Limits on Duration of Treatment:** Health plans may limit the length of treatment for medications, or limit the number of counseling sessions that are covered. Commonly, cessation

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. 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-module program is also offered as a group clinic in many areas of the country. Additionally, in 1999 the American Lung Association launched Freedom From Smoking Online (www.ffsonline.org), which takes smokers through the modules online and provides interaction with other smokers from across the country.

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.[21 22]

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.[23,24]

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—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.

medications are limited to twelve weeks—which is shorter than the recommended treatment duration for the NRT inhaler, NRT nasal spray, bupropion, and varenicline. After the patient has reached the limit, he or she either has to pay for the remaining treatment out-of-pocket, or stop treatment early.

- **Annual Limits on Coverage:** Often insurance plans will only allow a certain number of quit attempts per year. Once the member has reached the limit, he or she must wait until the following year to try quitting again. Recognizing that most smokers make several attempts before quitting, they should be allowed unlimited attempts per year. The CDC recommends smokers should be allowed a minimum of two courses of treatment per year.[17]

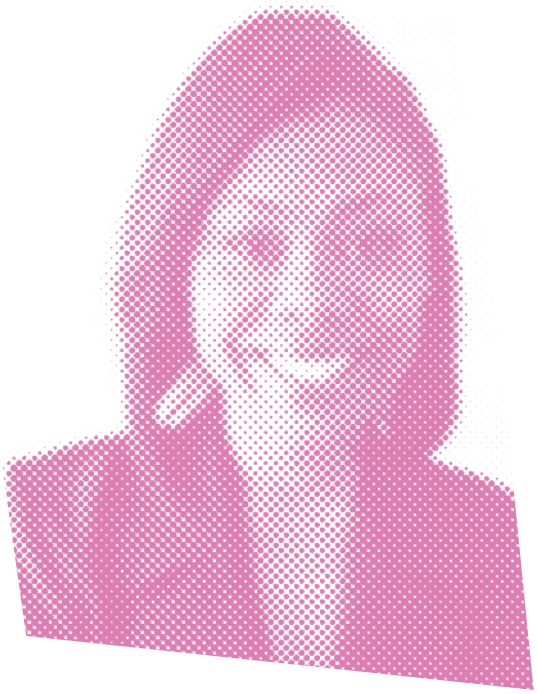
What DOESN'T Help Smokers Quit?

- ✖ Required Co-payments
- ✖ Prior Authorization Requirements
- ✖ Limits on Duration of Treatments
- ✖ Yearly or Lifetime Limits on Coverage
- ✖ Dollar Limits
- ✖ "Stepped Care" Therapy
- ✖ Counseling Required for Medications

- **Lifetime Limits on Coverage:** Some health plans only allow a certain number of quit attempts per lifetime for their members. These limits fail to recognize that tobacco use is an addiction that may be fought for years, and that relapses are likely for most users. Most smokers try several times before they can quit successfully.[18]

- **Dollar Limits:** Some insurance plans will only pay up to a certain amount for a member to quit smoking. These dollar limits can apply annually and to a lifetime.

- **"Stepped Care" Therapy:** Some health plans require members to try a certain medication before they are allowed to try others. Usually the first "step" in a system is the gum, patch, or bupropion (generally the cheapest options), and only if the member fails using those methods are they allowed to try other medications. This barrier usually discourages the use of more expensive medications and fails to recognize that some treatments may not appeal to or work for certain smokers. Members also may have tried certain treatments before under a different insurance plan and would only want to try treatments they had not tried before.



- **Counseling Required for Medications:** Some health plans require that members enroll in cessation counseling in order for them to get a prescription for cessation medications. The Guideline recommends that while health plans should encourage this combination, they should not require it. The requirement could discourage certain smokers (wary of or unable to attend counseling, or alternatively, not wanting to take or pay for medicine) from attempting to quit at all.

In addition to the Public Health Service, others recommend the coverage of comprehensive cessation benefits. One of the Healthy People 2010 objectives established by the U. S. Department of Health and Human Services is to "increase insurance coverage of evidence-based treatment for nicotine dependency to 100%".[19] The National Academy of Science's Institute of Medicine recommends that "all insurance, managed care and employee benefit plans, including Medicaid and Medicare, cover reimbursement for effective smoking cessation programs as a lifetime benefit."[20]

Medicaid Coverage of Smoking Cessation Treatments

The Medicaid population smokes at a rate almost 60 percent higher (32.6 percent for ages 18-65) than the general adult population (20.4 percent for ages 18-65),[25] so this population is especially in need of cessation coverage. Medicaid is a public healthcare program for low-income Americans jointly funded by the federal and state governments. Covering cessation treatments through Medicaid would provide help to a large number of smokers who are most in need and least likely to be able to find or pay for such treatments themselves. Despite this importance, coverage for these treatments in Medicaid varies widely from state-to-state.

The Medicaid population smokes at a rate almost 60 percent higher than the general adult population.

According to data that the American Lung Association collected for 2008, only seven states provide comprehensive cessation coverage for Medicaid recipients. Comprehensive coverage consists of all seven FDA-approved cessation medications and group and individual counseling.[i] To be considered comprehensive, this coverage must be provided to all Medicaid recipients.

Coverage of cessation medications is much more common than coverage of cessation counseling. Forty-five states provide coverage for at least one medication for smokers who want to quit. Twenty states cover all seven cessation medications for their Medicaid population. Twenty-nine states provide some form of cessation counseling to their entire Medicaid population, but only 14 states provide both individual and group counseling. An additional eight states provide some form of counseling only to pregnant women in their Medicaid programs.

Six states provide no coverage for any cessation treatments to their entire Medicaid populations. Most of these states specifically exclude cessation medications and counseling from coverage under the Medicaid program. These exclusions are usually written in administrative regulations or Medicaid policy manuals.

7 States Offer Comprehensive Cessation Benefits to Medicaid Beneficiaries:

- Indiana
- Massachusetts
- Minnesota
- Nebraska
- Nevada
- Oregon
- Pennsylvania*

*The Pennsylvania Department of Public Welfare requires all contracting MCOs to cover comprehensive cessation benefits. Some MCOs, however, do not presently comply with this directive, and provide moderate or inadequate coverage.

6 States Provide NO Cessation Coverage for Medicaid Recipients:

- Alabama*
- Connecticut
- Georgia
- Kentucky*
- Missouri
- Tennessee

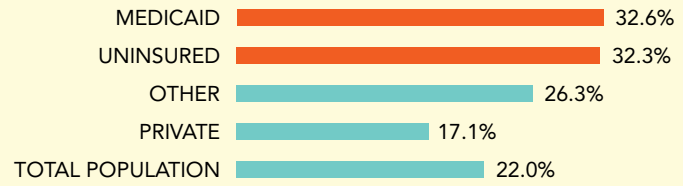
* Alabama and Kentucky cover cessation counseling only to pregnant women.

Every state that provides Medicaid coverage for smoking cessation treatments has at least one barrier to accessing this coverage. The most common barriers require co-pays and limit the duration of treatment, but all barriers listed previously are used to some degree. Some states with the fewest barriers include Minnesota, North Carolina, Ohio, Oregon and Wisconsin (all require a co-pay of $3 or less) and Washington (requires prior authorization). All other states have more than one barrier to coverage: most have numerous barriers. The low-income Medicaid clients are likely to be discouraged from seeking help or trying to quit because of these barriers.

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

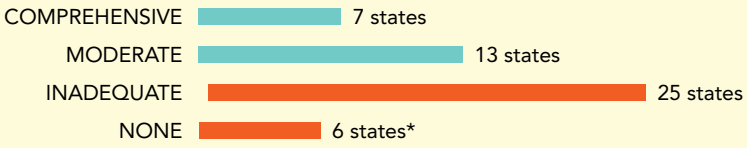
A Lot of Smokers But Not Enough Help

The Medicaid and Uninsured Populations (Age 18-65) Smoke at Higher Rates than Other Populations



Source: Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey, 2007.

Most States Provide Little or NO Coverage for Medicaid Recipients



Source: American Lung Association, 2008
*includes states providing coverage only to pregnant women

Categories of Coverage

Comprehensive: covers all 7 recommended medications + individual & group counseling

Moderate: covers at least 2 NRTs + bupropion + varenicline + one form of counseling

Inadequate: covers at least one treatment

None: covers no medications or counseling, or only covers treatment for pregnant women

Data missing: coverage impossible to determine

Some States Show Leadership

Covering Medicaid Recipients: Oregon

The Oregon Medicaid program has long been recognized as a leader in the provision of tobacco cessation benefits for its Medicaid recipients.

- The Oregon Medicaid program contractually requires its Managed Care Organizations to provide tobacco cessation treatments.
- The Oregon Department of Human Services spells out in detail what tobacco cessation coverage all Medicaid recipients are required to receive from their MCOs. Plans must provide all tobacco cessation medications to their members, as well as several options for cessation counseling.
- Tobacco cessation services are included on the Health Services Commission's Prioritized List of Health Services, which means that every Oregon Medicaid plan is required to cover these services.

Providing Information to Medicaid Recipients: Massachusetts

The Massachusetts Medicaid program, MassHealth, provides comprehensive tobacco cessation coverage to its recipients. The program also makes information about these provided treatments easily available to Medicaid recipients and physicians through its website.

- The link to information about tobacco cessation benefits can be found on the main MassHealth information page.
- The quit smoking page contains links to information about the health consequences of smoking, lists the medications and counseling provided, and explains which members are eligible for these treatments and how they can receive them.
- The page also links to community cessation resources, the Massachusetts Tobacco Control Program and the Massachusetts Department of Health; as well as consumer fact sheets in several languages.
- The information is clear and easy to understand.

State Employee Health Plan Coverage of Cessation Treatments

States governments are often among the largest employers in any state. As a result, state employee health plans may serve as examples for other health plans in the state. Many regulations for private health plans in a state are based on the standard set by the state's health plan for its employees. In this way, it is important for these state health plans to cover smoking cessation treatments—not only for the health of state employees, but also for the benefit of others in the state.

6 States Provide Comprehensive Cessation Coverage for State Employees:

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

Most states contract with multiple managed care, health maintenance, or preferred provider organizations to provide their employees with much of their healthcare. Usually each health plan determines its own smoking cessation coverage (or lack thereof). These plans vary in covered treatments. Some states that offer multiple health plans contractually require each health plan to cover a certain standard of cessation coverage. Often these standards are very vague, contributing to the variation in (and often lack of adequate) coverage. On the other hand, some states provide a separate, stand-alone cessation program for which all employees are eligible.

6 States Provide NO Cessation Coverage for State Employees

- Delaware*
- Louisiana
- Mississippi
- Montana
- South Dakota
- Wyoming

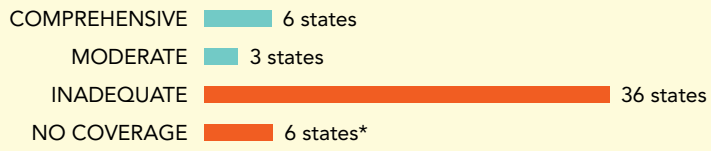
* Managed Care Organizations may cover counseling for pregnant women only.

Coverage of cessation treatments for state employee health plans varies widely, according to data collected by the American Lung Association for 2008. While 44 states and the District of Columbia provide some sort of cessation coverage for their employees, only six states provide comprehensive coverage (all seven Guideline-recommended medications, individual and group counseling).

Beyond that, 38 states and the District of Columbia cover at least one cessation medication, but only ten states cover all seven first line cessation medications. The situation is similar for cessation counseling: while 24 states and the District of Columbia provide for either group or individual counseling, only six states provide both. Finally, six states do not provide any cessation coverage for their employees.

Many state employee health plans provide telephone and/or online counseling as part of their cessation programs. Proactive telephone counseling is a Guideline-recommended counseling method, and is also available in every state through 1-800-QUIT NOW. Internet coaching or online counseling is not yet recommended by the Guideline

Most States Provide Little or No Coverage for State Employees



Source: American Lung Association, 2008
*includes states providing coverage only to pregnant women

Categories of Coverage

Comprehensive: covers 7 recommended medications + individual & group counseling

Moderate: covers at least 2 NRTs + bupropion + varenicline + one form of counseling

Inadequate: covers at least one treatment

None: covers no medications or counseling, or only covers treatment for pregnant women

Data missing: coverage impossible to determine

because of the lack of published evidence on its effectiveness. All together, over half the states (28) offer some form of telephone and/or online counseling through their state employee health coverage.

Providing Coverage for State Employees: Nevada

The state of Nevada provides a comprehensive benefit for treating tobacco use to its employees through its Wellness Benefit.

- The Wellness Benefit provides coverage up to $2500 per person per year for wellness and preventive treatments.
- All smoking cessation medications are eligible for this benefit.
- All smoking cessation counseling programs are eligible for this benefit.
- Co-pays and deductibles are waived for services provided under this benefit.
- No barriers (other than the $2500/year limit) exist to these treatments.

Private Insurance Coverage of Cessation Treatments

The majority of Americans receive their healthcare through their non-government employers. Many decisions about coverage and benefits for these private insurance plans are made by the insurance company and employers, rather than the state. This does not, however, make cessation coverage for the privately insured population any less important or cost-effective.

Coverage of smoking cessation treatments through private insurance benefits employers as well as employees. Helping workers quit smoking also improves their productivity, and saves employers and employees money on life insurance premiums. Employers and insurance plans could save up to $210 per year for every covered smoker who quits.[26] Unfortunately, because of the nature of employer-based health insurance in this country and the plethora of insurance companies, it is difficult to know what smoking cessation treatments are covered for this population. Currently, only a limited amount of survey data is available.

6 States have Legislative or Regulatory Standards for Cessation Coverage:

Colorado
Maryland
New Jersey
New Mexico
North Dakota
Rhode Island

One survey from 2003 showed that the majority of health maintenance organizations (HMOs) cover some form of cessation treatment. Eighty-eight percent of responding HMOs indicated that they provided coverage for at least one type of prescribed or over-the-counter cessation medication. Nearly three-quarters (72 percent) of these HMOs covered at least one form of "behavioral intervention," but this category includes self-help materials and online counseling, two methods not yet recommended by the Guideline. Comparisons to previous surveys revealed that the percentage of HMOs covering cessation medications increased from 25 percent in 1997 to 88 percent in 2003. Trends were not as easy to see for counseling. Coverage for counseling varied markedly year-to-year.[27] A different survey from the Society for Human Resource Management in 2004 said that as few as one-third of employers and insurers offer "comprehensive," though undefined, smoking cessation benefits.[28] Most recently, the annual survey of employer health benefits by the Kaiser Family Foundation found that in 2008, 19 percent of small

firms and 59 percent of large firms offered a smoking cessation program (also undefined) as a covered benefit to employees.[29]

Not surprisingly, coverage for cessation treatments among private insurance companies varies widely, as with all other forms of health care. Legislators and administrators in a few states have stepped in to ensure cessation coverage for private employees in their states. Eight states have created standards either legislatively or through regulation that require a certain level of cessation coverage for all insurance plans operating in that state.

While most of these laws are vague or do not require close to comprehensive coverage, New Jersey, New Mexico and Rhode Island require at least a majority of cessation treatments to be covered in all health plans. The federal Employee Retirement Income Stability Act (ERISA) creates an exception if the employer providing coverage is self-funded. Self-insured employers do not have to comply with state requirements for cessation coverage.[30] See Appendix D for more information about each state's requirement.

Four other states have laws relating to private insurance cessation coverage in less effective ways. Florida, Illinois, Indiana and North Carolina have laws on their books that allow insurance plans to offer wellness programs that include smoking cessation. These laws are much weaker than the laws discussed above, as they only allow the plans to have smoking cessation programs, rather than require. Mentions of smoking cessation in these laws are also brief and do not contain any details or definitions of smoking cessation programs.

Requiring Coverage for Private Insurance: Rhode Island

Rhode Island is one of the few states to require private insurance coverage of tobacco cessation treatments. This law, enacted in 2006, requires almost every insurance plan in the state to cover a defined tobacco cessation benefit.

- All health plans must cover all nicotine-replacement-therapies.
- NRT coverage must be combined with 8 half-hour sessions of cessation counseling.
- All members of the health plan must be eligible to receive this benefit every year.

While there are still barriers and limitations with this standard (coverage of bupropion and varenicline should also be required, and counseling should not be required for medication, for instance), it still goes a long way in providing smoking cessation coverage for most privately-insured people in the state.

What About the Uninsured? The Vital Role of Smoking Cessation Quitlines

The previous discussion explored the provision of cessation treatments through various public and private insurance plans. Unfortunately, coverage through these systems does not reach the entire U.S. population. About 45 million people in the United States do not have health insurance and, therefore, are not eligible for the benefits discussed above.[31] The uninsured population also smokes at rates similar to the Medicaid population and at much higher rates than the general population (32.3% compared to 20.4% for ages 18-65).[32]

> Only one source of help and information on quitting is available to all smokers: the national network of quitlines.

Fortunately, uninsured smokers can still get help quitting, though the assistance may be limited. Some organizations, including the American Lung Association, offer programs free or at low cost to the public. Many local departments of health have smoking cessation programs for anyone living in that community. Hospitals sometimes offer cessation classes to their patients and other community members. Some pharmaceutical companies have programs to help people pay for their medications. Currently, access to help from these sources may depend upon where smokers live and other circumstances. However, there is one source of help and information that is available to all smokers: the national network of smoking cessation quitlines.

Some smoking cessation quitlines have been in operation since the 1980s.[33] In the United States, the California quitline was the first publically funded, statewide cessation quitline, operating since 1992. Until 2004, however, access to quitlines was as varied as to any other cessation treatment. That year, the U.S. Department of Health and Human Services launched the National Network of Tobacco Cessation Quitlines Initiative, which provided funding to states to establish or enhance already existing quitlines. The initiative also created one toll-free number, 1-800-QUIT NOW, which anyone can call to be directed to their state's quitline.

As of 2008, a quitline operates in every state, the District of Columbia, and Puerto Rico. Most of these quitlines receive funding from multiple sources, including the federal government, state governments[ii] and private foundations. Five states, however, have quitlines that rely entirely on federal funding with no additional support from the state government: Connecticut, Idaho, Nebraska, New Hampshire and Virginia.

All of these quitlines provide some services to the entire adult population, regardless of income or insurance status (though services may vary depending on these factors). Each quitline differs in structure and content. Most quitlines are proactive, where a quitline counselor calls the smoker to initiate counseling. This type of phone counseling sometimes involves a fax-referral program, where clinicians, after seeking permission, refer patients who

[ii] State government funds may include dollars the state receives from the tobacco companies as part of the Master Settlement Agreement. This funding is a result of a legal agreement between the tobacco companies and 46 state Attorneys General in 1990s.

Most quitlines are proactive, where a quitline counselor calls the smoker.

are interested in quitting to the quitline (referred to Ask-Advise-Refer). The clinician faxes the quitline the patient's information and the quitline calls the patient for counseling.

Many quitlines also provide free or discounted cessation medications to callers. This provision of medications is often focused specifically on callers who are uninsured or unable to get medications through their insurance plan. Many quitlines also provide online and translation services and materials geared towards special populations (pregnant women, smokeless tobacco users, ethnic groups, etc.). Quitline counselors will also provide information to non-smokers who want to help friends or family members to quit. State quitlines can serve as a vital source of information, referring smokers to more resources in their communities. They can coordinate with public and private insurance programs to provide consistent and integrated service to smokers who want to quit.

Policy Recommendations

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

- All healthcare 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.[iii] 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.
- Healthcare 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.
- Healthcare 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.
- Healthcare 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 healthcare 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.

[iii] While this report addresses ***state*** coverage of tobacco cessation treatments, the Lung Association also urges the federal government to expand coverage through the Medicare program in alignment with these recommendations.

Sources

1. Gallup. Tobacco and Smoking. July 10-12 2008 results. Available at http://www.gallup.com/poll/1717/Tobacco-Smoking.aspx.
2. Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey, 2007. Analysis by the American Lung Association, Research and Program Services Division using SPSS and SUDAAN software.
3. Fiore MC, Bailey WC, Cohen SJ, et al. Treating Tobacco Use and Dependence. A Clinical Practice Guideline. US Department of Health and Human Services. Public Health Service, 2008. Available at: http://www.surgeongeneral.gov/tobacco/treating_tobacco_use.pdf.
4. CDC. Smoking-attributable mortality, morbidity, and economic costs (SAMMEC): adult and maternal and child health software. Atlanta, GA: US Department of Health and Human Services, CDC; 2008.
5. Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey, 2007. Analysis by the American Lung Association, Research and Program Services Division using SPSS and SUDAAN software.
6. CDC. Smoking-attributable mortality, morbidity, and economic costs (SAMMEC): adult and maternal and child health software. Atlanta, GA: US Department of Health and Human Services, CDC; 2008.
7. Centers for Disease Control and Prevention. Annual smoking-attributable mortality, years of potential life lost, and economic costs—United States, 1995–1999. MMWR 2002;51(14):300–303. Available at: http://www.cdc.gov/mmwr/PDF/wk/mm5114.pdf.
8. Doll R, Peto R, Boreham J, Sutherland I. Mortality in relation to smoking: 50 years' observations on male British doctors. *BMJ*. 2004;328:1519-27.
9. Washington Economics Group, Inc. The Net Benefits and Economic Impacts of Investing in Employee-Smoking Cessation Programs in the Public and Private Sectors of Florida. March 6, 2008.
10. Lightwood JM & Glantz SA. Short-Term Economic and Health Benefits of Smoking Cessation—Myocardial Infarction and Stroke. *Circulation*. August 19, 1997, 96(4).
11. Centers for Disease Control and Prevention. Sustaining State Programs for Tobacco Control: Data Highlights 2006. 2006. Available at: http://www.cdc.gov/tobacco/data_statistics/state_data/data_highlights/2006/00_pdfs/DataHighlights06rev.pdf
12. Solberg LI, Maciosek MV, Edwards NM. Tobacco Cessation Screening and Brief Counseling: Technical Report Prepared for the National Commission on Prevention Priorities,2006. July 2006, 325(7356):128.
13. Maciosek MV, Coffield AB, et al. Priorities Among Effective Clinical Preventive Services: Results Of A Systematic Review And Analysis. *American Journal of Preventive Medicine*. July 2006, 31(1). Available at: http://www.prevent.org/images/stories/clinical-prevention/article%201669p.pdf.
14. Fiore MC, Bailey WC, Cohen SJ, et al. Treating Tobacco Use and Dependence. A Clinical Practice Guideline. US Department of Health and Human Services. Public Health Service, 2008. Available at: http://www.surgeongeneral.gov/tobacco/treating_tobacco_use.pdf.
15. Tomar SL, Husten CG, Manley MW. Do dentists and physicians advise tobacco users to quit? J Am Dent Assoc 1996;127:259-65.
16. Original data collected by American Lung Association staff.
17. George Washington University Center for Health Services Research and Policy and Centers for Disease Control and Prevention. Sample Purchasing Specifications Related to Tobacco-Use Prevention and Cessation. October 2002. Available at: http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/newsps/tobacco/smokingspecs.pdf.
18. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. The Health Consequences of Smoking: a Report of the Surgeon General. Atlanta, GA, 2004.
19. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Healthy People 2010: Understanding and improving health. Available at: http://www.healthypeople.gov/Publications/.
20. Institute of Medicine. Ending the tobacco problem: a blueprint for the nation. Washington, DC, The National Academy Press, 2007.
21. Lando HA, McGovern PG, Barrios FX, Etringer BD. Comparative evaluation of American Cancer Society and American Lung Association smoking cessation clinics. *American Journal of Public Health* May 1990, 80(5): 554 9.
22. Thieleke J, McMahon J, Meyer G, AhYun K. An evaluation of the Freedom From Smoking® Online cessation program among Wisconsin residents. *Wisconsin Medical Journal* 2005, 104(4): 41-4.
23. Horn K, Dino G, Kalsekar I & Mody R. The impact of Not On Tobacco on teen smoking cessation: End-of-program evaluation results, 1998 to 2003. *Journal of Adolescent Research* 2005, 20(6): 640-61.
24. Horn K, Dino G, Kalsekar I & Fernandes A. Appalachian teen smokers: Not On Tobacco 15 months later. *American Journal of Public Health* 2004, 94(2): 181-4.
25. Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey, 2007. Analysis by the American Lung Association, Research and Program Services Division using SPSS and SUDAAN software.
26. American Legacy Foundation and McMilliman Consultants and Actuaries. Covering Smoking Cessation as a Health Benefit: A Case for Employers. December 2006. Available at: http://www.americanlegacy.org/PDFPublications/Milliman_report_ALF_-_3.15.07.pdf.
27. McPhillips-Tangum C, Rehm B, Carreon R, Erceg CM, Bocchino C. Addressing tobacco in managed care: results of the 2003 survey. *Prev Chronic Dis* [serial online] July 2006. Available at: http://www.cdc.gov/pcd/issues/2006/jul/05_0173.htm.
28. Levy DE. Employer-sponsored Insurance Coverage of Smoking Cessation Treatments. *Am J Manag Care* 2006 12:553-562.

29. Kaiser Family Foundation and Health Research & Educational Trust. Employer Health Benefits: 2008 Annual Survey. Available at: http://ehbs.kff.org/pdf/7790.pdf.

30. U.S. Code Title 29, Chapter 18, Section 1144. See at http://www4.law.cornell.edu/uscode/29/1144.html.

31. Kaiser Commission on Medicaid and the Uninsured. Five Basic Facts on the Uninsured. September 2008. Available at http://www.kff.org/uninsured/upload/7806.pdf.

32. Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey, 2006.

33. Unless otherwise noted, all information and data for this section was obtained from the North American Quitline Consortium: www.naquitline.org.

Appendix A: Methodology

The second, third and fourth sections of this report contain original data collected by staff of the American Lung Association. These data were collected from June-September, 2008, and are intended to reflect coverage in effect as of January 1, 2008. 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.

Appendix B: Medicaid Cessation Coverage in the States

	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+	no	yes	no	no	no	no	yes	no	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	no	no	no	yes	yes	yes	yes
Georgia	no	no	no	no	no	no	no	no	no
Hawaii	*	*	*	*	*	*	*	*	no
Idaho	yes	yes	yes	no	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	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	*	*	no	no	*	*	*	yes	yes
Massachusetts	yes	yes	yes	yes	yes	yes	yes	yes	yes
Michigan	*	yes	*	*	*	*	*	*	*
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	yes	yes	yes	yes	yes	yes	yes
Nevada	yes	yes	yes	yes	yes	yes	yes	**	**
New Hampshire	**	**	**	**	**	**	**	P	yes
New Jersey	*	yes	no	no	no	*	*	yes	yes
New Mexico	*	*	*	*	*	*	*	*	no
New York	yes	yes	yes	yes	no	yes	yes	P	P
North Carolina	yes	yes	yes	yes	yes	yes	yes	no	no
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	*	*	*	*	*	*	*	*	*
South Carolina	yes	yes	yes	yes	yes	yes	yes	no	no
South Dakota	no	no	no	no	no	yes	yes	no	no
Tennessee	no	no	no	no	no	no	no	no	no
Texas	yes	yes	yes	yes	no	yes	yes	*	*
Utah	**	**	**	**	**	yes	yes	P	P
Vermont	yes	yes	yes	yes	yes	yes	yes	no	no
Virginia	yes	yes	yes	yes	yes	yes	yes	P	no
Washington	yes	yes	no	no	no	yes	yes	no	yes
West Virginia	*	*	*	*	*	no	*	*	no
Wisconsin	yes	yes	yes	yes	no	yes	yes	**	yes
Wyoming	yes	yes	no	no	yes	yes	yes	no	yes

\+ Information only pertains to Fee-for-Service plan. No data available for managed care organizations.
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	yes	no	yes	no	yes	no	yes
Colorado	yes	yes	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	*	no	no	no	no	no	no
Florida	*	*	*	no	*	yes	no
Georgia	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Hawaii	*	no	*	*	*	*	*
Idaho	yes	no	yes	no	no	no	yes
Illinois	no	no	no	yes	yes	no	no
Indiana	yes	no	yes	no	yes	yes	yes
Iowa	yes	no	yes	yes	yes	no	yes
Kansas	yes	no	yes	no	yes	no	n/a
Kentucky	yes	no	no	no	no	no	n/a
Louisiana	no	no	no	no	yes	no	yes
Maine	yes	yes	yes	yes	yes	yes	no
Maryland	*	*	*	*	*	*	*
Massachusetts	no	no	no	yes	yes	no	no
Michigan	*	*	*	*	*	*	*
Minnesota	no	no	no	no	yes	no	no
Mississippi	no	no	no	no	yes	no	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	yes	no	no	no	*
New York	yes	no	yes	no	*	no	no
North Carolina	no	no	no	no	yes	no	no
North Dakota	yes	no	no	no	yes	no	no
Ohio	no	no	no	no	yes	no	no
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	yes	yes	yes	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	yes	no	yes	no	*	*	*
Utah	yes	yes	no	yes	yes	no	no
Vermont	yes	no	yes	no	yes	no	no
Virginia	no	no	no	no	yes	no	no
Washington	no	no	no	yes	no	no	no
West Virginia	yes	no	no	yes	no	no	yes
Wisconsin	no	no	no	no	yes	no	no
Wyoming	yes	no	yes	no	yes	no	no

* Barriers vary by health plan

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

Appendix D: State Employee Health Plan Coverage of Cessation

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

P Coverage only for pregnant women
D Not covered, but discounts may be available
* Coverage varies by health care plan
** Coverage provided only under certain conditions
For more information and a detailed, listing of this coverage, please visit www.lungusa.org

Appendix E: Required Standards for Private Insurance Coverage of Tobacco Cessation in the States

Colorado	Requires basic health plans in the state to cover cessation services, among other preventive health measures. Benefit must be under physician supervision, and does not exceed $150 per lifetime. Law does not specify which treatments are covered.
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 patch, 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: Diagnostic services Two 90-day courses of prescription medications per year 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.
Rhode Island	Requires all health plans to cover NRTs in combination with four hours of cessation counseling. Normal deductibles and coinsurance can apply.

State Requiring or Allowing Wellness Programs that Include Smoking Cessation

Florida	Individual health plans are ***allowed*** to offer rebates of premiums for beneficiaries who complete wellness programs, including smoking cessation. HMO's are ***required*** to offer such a rebate.
Illinois	Institutes a state grant program for small businesses who want to implement wellness programs for insurance beneficiaries, including smoking cessation
Indiana	Law requiring the standards for employee wellness programs to include smoking cessation programs
North Carolina	Authorizes the NC Health Insurance Risk Pool to use "cost containment measures" like wellness programs including smoking cessation treatments

This report is supported by a grant from
the Robert Wood Johnson Foundation
in Princeton, New Jersey.

Beginning our second century, the American Lung Association works to prevent lung disease and promote lung health. Asthma is the leading serious chronic childhood illness. Lung diseases and breathing problems are one of the leading causes of infant deaths in the United States today. Smoking remains the nation's number one preventable cause of chronic illness. Lung disease death rates are currently increasing while other major causes of death are declining.

The American Lung Association has long funded vital research to discover the causes and seek improved treatments for those suffering with lung disease. We are the foremost defender of the Clean Air Act and laws that protect citizens from secondhand smoke. The Lung Association teaches children the dangers of tobacco use and helps teenage and adult smokers overcome addiction. We help children and adults living with lung disease to improve their quality of life. With your generous support, the American Lung Association is "Improving life, one breath at a time."

For more information about the American Lung Association
or to support the work we do, call
1-800-LUNG-USA (1-800-586-4872)
or log on to ***www.lungusa.org****.*

AMERICAN LUNG ASSOCIATION®
Improving Life, One Breath at a Time™

Revised 1/09