AMERICAN LUNG ASSOCIATION®
Fighting for Air

Tobacco Cessation Coverage 2012

Helping Smokers Quit

Helping Smokers Quit

Executive Summary

Quitting smoking is hard, but it can be achieved with the right motivation and support. The American Lung Association knows that if smokers have easy access to the help they need, they are more likely to succeed. "Help" can include medications and counseling, both of which have been proven effective in helping smokers quit. Smokers who quit for good reap the health rewards—and so does everyone else. Smoking not only ends lives prematurely, but it also puts a tremendous strain on both federal and state budgets. For all of these reasons, the American Lung Association believes federal and state governments have a responsibility to enact public policies and fund programs that will encourage and help smokers to quit.

When it comes to policies that help smokers quit, the United States now finds itself at a tipping point. As federal and state governments work to implement the Patient Protection and Affordable Care Act (ACA), there is huge potential to provide millions more smokers with the help they need to quit. The ACA makes major changes to the health insurance market and also puts more focus on prevention in healthcare, which includes tobacco cessation. The law has major implications for states, which are tasked with implementing many of the ACA's most transformative initiatives, including health insurance exchanges and a significant expansion of Medicaid. As major changes are being made to how healthcare is delivered and paid for in this country, there is a great opportunity to incorporate tobacco cessation treatment as a key to preventing deadly disease and rapidly rising healthcare costs. Several provisions in the ACA, discussed in the coming pages, specifically address prevention and tobacco cessation. The opportunities in the ACA for smokers who want to quit are very exciting.

In the Report:

Federal Government Actions 4
State Trends 6
Policymaker To-Do Lists 13
ACA Implementation Timeline 14
Appendices with State-by-State Data 17–21

However, with great opportunity to do the right thing also comes the opportunity to make misguided decisions that will have lasting effects. The federal government has missed several opportunities since the enactment of the ACA to grant smokers access to more cessation treatments. Now, as states are beginning implementation of state exchanges and Medicaid expansions, state policymakers have the opportunity to stand up for smokers in their states who want to quit. Unfortunately, a number of states are choosing otherwise. One troubling example is Maine, whose governor shortsightedly cut Medicaid coverage of tobacco cessation medications as part of larger efforts to change the Medicaid program and cut costs.

In the coming years, policymakers at all levels have the potential to encourage and help many smokers to quit. The American Lung Association urges policymakers to take advantage of the opportunities detailed in the following pages—to save both lives and money.

State Highlights

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

Helping Smokers Quit Saves Lives and Money

Quitting smoking improves a smoker's health immediately, but the most important health benefits are long term. A smoker who quits considerably reduces his or her risk for diseases like chronic obstructive pulmonary disease (COPD, which includes emphysema and chronic bronchitis), heart disease, lung cancer and many other cancers.[1] Studies show that smokers' lives on average are more than 13 years shorter than nonsmokers.[2] Some benefits of quitting cannot be measured—like the benefit of living long enough to see a grandchild born or enjoying a long and healthy retirement.

Helping smokers quit not only saves lives—it also saves money. These savings come from lower health-care costs, increased workplace productivity and averted premature deaths. Studies indicate that helping smokers quit saves thousands of dollars in healthcare expenditures per smoker.[3,4] Recent studies have also demonstrated that helping smokers quit is a smart, money-saving investment.[5] A 2012 study by George Washington University showed that when the Massachusetts Medicaid program covered a comprehensive tobacco cessation benefit, the state saw a 3-to-1 return on investment in only a year-and-a-half's time.[6]

What Works to Help Smokers Quit?

While most smokers want to quit and many of them try every year, only a relatively small percentage are successful.[7] In 2010, a Centers for Disease Control and Prevention (CDC) study showed that 69 percent of adult smokers wanted to stop smoking, 52 percent tried to in the past year and only 6 percent had recently quit.[8] Many tobacco users require several quit attempts to quit for good, and many need help during the quitting process.[9] Quitting "cold turkey" is not effective for the vast majority of smokers.[10] Fortunately, a number of treatments exist that are proven to increase a smoker's chances of quitting.

The U.S. Public Health Service's 2008 Clinical Practice Guideline *Treating Tobacco Use and Dependence*[11] recommends seven FDA-approved prescription and over-the-counter medications and three types of counseling that have proven to be effective in helping smokers quit. The guideline is a review of decades of research on tobacco cessation and is widely regarded as the definitive report on effectively treating tobacco users.

Cessation Benefits Should Include ALL of These Treatments:

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

Treatments available through cessation benefits must also be easy for patients to access. Policies such as prior authorization requirements, stepped care therapy and limits on how long a patient can be treated or how many times a year he or she can try to quit are all barriers for smokers trying to quit. Additionally, reducing or eliminating copayments—something done for many through ACA—is a crucial way to make treatment easy to access.

For more information, please see the American Lung Association cessation policy factsheets, at www.lung.org/cessationcoverage

Tobacco Cessation Treatment: What Is Covered?

The U.S. healthcare system is complex, and therefore so is coverage available to help smokers quit. Below is information on what the biggest health insurance programs cover for tobacco cessation, and how the Affordable Care Act (ACA) changes coverage.

Medicare

- Covers people over the age of 65
- Covers nicotine nasal spray, nicotine inhaler, bupropion and varenicline, as well as individual counseling, for 2 quit attempts per year
- The ACA adds
  - Prevention and wellness visit with member's doctor
  - Is closing the Medicare Part D "donut hole," making medications more affordable

Medicaid

- Covers low-income children and parents (eligibility varies by state)
- Covers comprehensive tobacco cessation treatment for pregnant women. Coverage for all other adults varies by state
- The ACA adds
  - Requirement for coverage of pregnant women in 2010
  - Expands eligibility to all low-income adults in 2014
  - Requires coverage of tobacco cessation medications in all states in 2014

33.3 percent of Medicaid enrollees smoke—that is more than 50 percent higher than the total population!

State Health Insurance Exchanges

- Will cover the unemployed, self-employed and those not provided with employer-sponsored insurance in 2014
- Coverage of comprehensive tobacco cessation treatment has not yet been defined
- The ACA adds
  - Creates state health insurance exchanges
  - Requires all plans in exchanges to cover Essential Health Benefit (the current proposal includes an undefined tobacco cessation benefit)

31.5 percent of the currently uninsured smoke. Many of these smokers will be eligible for coverage through health insurance exchanges in 2014.

Employer-Sponsored Insurance

- Covers all individuals provided health insurance through their employer or union
- All new plans must cover tobacco cessation treatment, but coverage varies widely plan to plan
- The ACA adds
  - Requires coverage of all preventive services given an 'A' or 'B' rating by the U.S. Preventive Services Task Force, including tobacco cessation

Uninsured

- Includes all individuals who do not have health insurance
- Phone counseling is available through 1-800-QUIT-NOW
- The ACA adds
  - Designed to reduce the number of uninsured through new state exchanges and expansion of Medicaid

Affordable Care Act: Opportunities for the Federal Government to Help Smokers Quit

Essential Health Benefit

One of the major hallmarks of the Affordable Care Act (ACA) is a new system of state health insurance exchanges, which will operate in every state beginning in 2014. People who are unemployed, self-employed or not provided with employer-sponsored insurance (and do not qualify for Medicaid) will be required to purchase health insurance through these exchanges. Many of these people are currently uninsured because they cannot afford individual insurance policies.

According to the ACA, every plan that is offered in a state exchange must cover an Essential Health Benefit (EHB). The legislation lists ten categories of coverage that must be included in the benefit, and tasks the Secretary of Health and Human Services (HHS) with further defining the EHB.[12] One of the ten categories is preventive services—which includes tobacco cessation. For private insurers, ACA requires new plans to cover clinical preventive services that receive an 'A' or 'B' for efficacy from the U.S. Preventive Services Taskforce (USPSTF). While tobacco cessation receives an 'A', HHS has not specifically required insurance plans to cover a comprehensive benefit. Defining the EHB for plans in state exchanges was an opportunity for the federal government to establish a comprehensive tobacco cessation benefit as the standard of coverage—a standard that would have far-reaching effects. The American Lung Association and other partners urged HHS to include a defined comprehensive tobacco cessation benefit in the EHB for insurance plans, which would have helped many smokers quit who previously did not have access to cessation treatment.[13,14]

Unfortunately, HHS has yet to seize this opportunity. In a proposed rule released in November 2012, HHS indicated it would allow each state to pick its own benchmark plan, which will then serve as the EHB standard for plans in that state's exchange. While preventive services earning an 'A' or 'B' from the USPSTF, including tobacco cessation, must be covered in every state benchmark plan, this proposed rule does not guarantee that states will offer a comprehensive cessation benefit. Not only does this create 51 standards of cessation coverage instead of a single standard, but it also gives health plans a lot of flexibility in meeting these standards.

Until HHS officially defines a comprehensive tobacco cessation benefit, it misses a crucial opportunity to provide many smokers with new access to help quitting, and to establish tobacco cessation as a truly essential health benefit for all health insurance coverage.

Medicaid

Another major change in the ACA is the upcoming expansion of Medicaid eligibility, also occurring in 2014. In June 2012, the U.S. Supreme Court ruled that the expansion of Medicaid is constitutional, but that HHS cannot enforce the expansion by threatening to take away all of a state's Medicaid funding. Since the ruling, some governors have indicated their states will not go through with the Medicaid expansion—even though the expansion is almost completely paid for by the federal government. This expansion of Medicaid is one of the major ways the ACA decreases the number of uninsured in this country. If states refuse to implement this provision, they are failing to help some of their most vulnerable citizens.

The ACA also includes two important changes to Medicaid specific to tobacco cessation coverage. One has already taken place: in 2010, all state Medicaid programs were required to begin covering a comprehensive tobacco cessation benefit for pregnant women. The other policy change is set to happen in 2014. Section 2502 of the ACA specifies that as of January 1, 2014, tobacco cessation medications will be removed from the list of "optional" medications and required for inclusion in states' prescription drug benefit. This small provision could have a major impact on smokers, if HHS implements it comprehensively. HHS must make it clear to states that this requirement includes all seven FDA-approved tobacco cessation medications, and that these medications need to be incorporated into Medicaid formularies. Also, this requirement must extend to all Medicaid plans, including managed care plans.

State Trends: Medicaid

There is a tremendous need to help smokers on Medicaid quit. People enrolled in Medicaid smoke at much higher rates than the general population (33.3 percent versus 21.3 percent for ages 18–65).[15] These Medicaid enrollees also, by definition, have low incomes and are less able to pay out of pocket for tobacco cessation treatments. These are reasons enough to help people on Medicaid quit smoking, but there are more: smoking-related disease costs Medicaid programs millions of dollars ever year—an average of $761 million per state in 2010.[16]

Two States Cover a *Comprehensive* Tobacco Cessation Benefit for all Medicaid Enrollees:

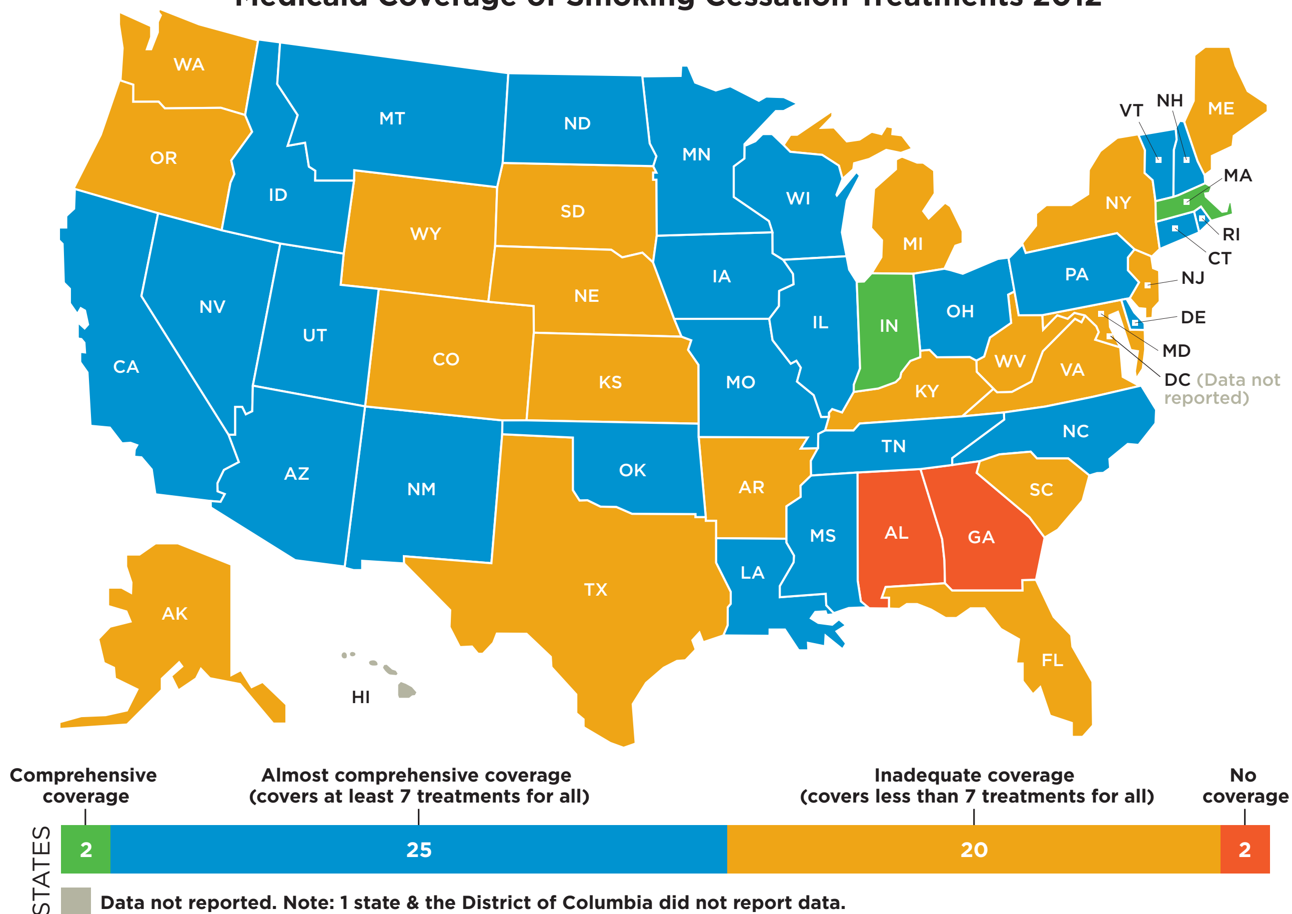
- Indiana
- Massachusetts

Two States Do Not Cover *Any* Tobacco Cessation Benefits for all Medicaid Enrollees:

- Alabama
- Georgia

Despite these compelling reasons, most states do not do enough to help people on Medicaid quit. The information below represents American Lung Association data for 2012.

Medicaid Coverage of Smoking Cessation Treatments 2012



Source: American Lung Association, State Tobacco Cessation Coverage Database. 2012. Available at: www.lung.org/cessationcoverage

Please note: the Lung Association's definition of "comprehensive" for the purposes of these charts has changed. Previously, a Centers for Medicare and Medicaid Services (CMS) rule prohibited Medicaid programs from paying for quitline counseling for Medicaid members. In June 2011, CMS lifted this prohibition. The Lung Association now includes phone counseling in its definition of comprehensive coverage for Medicaid.

State Trends: Medicaid

New Counseling Benefits for Pregnant Women

The ACA requires that state Medicaid programs cover medications and counseling for pregnant women. Four states added tobacco cessation counseling for pregnant women in 2012, recognizing the health and financial rewards to the mother, the baby and to Medicaid when pregnant women quit smoking:

- **Colorado**
- **Kansas**
- **North Dakota**
- **South Dakota**

While covering counseling for pregnant women is an important first step, it is crucial that these states take the next step and extend this coverage to everyone on Medicaid.

Adding New Benefits

Two states added a new tobacco cessation benefit for all Medicaid enrollees in 2012. Both of these new benefits are particularly noteworthy as these states did not provide coverage for any treatments to their entire Medicaid population before this year.

- **Connecticut** added coverage of all seven tobacco cessation medications and individual counseling.
- **Tennessee** added coverage of all seven tobacco cessation medications. Counseling is still only covered for pregnant women.

Cutting Benefits

In 2011, the American Lung Association named **Maine** one of the most quit-friendly states in the nation. Unfortunately, Maine has regressed on this front just one year later. This year Governor Paul LePage made several major changes to MaineCare, Maine's Medicaid program, including attempting to reduce the Medicaid population by changing eligibility requirements. These actions are being challenged in court. Unfortunately, the change relevant to this report is not in legal question: the governor cut coverage of all tobacco cessation medications (except for pregnant women, which is federally required). This move, ostensibly to save money, is tragic and incredibly short-sighted. MaineCare will be paying the financial and health consequences for years if this coverage is not restored.

Losing Benefits: Transitioning to Managed Care

State Medicaid policymakers are looking more and more to managed care plans to cut costs. When expanding Medicaid managed care systems, it is very important that states be aware of what tobacco cessation treatments are covered by the plans, and whether Medicaid members will lose benefits in the transition. The best way to guarantee this coverage for all and eliminate confusion is to require all managed care plans to cover the same comprehensive tobacco cessation benefit. Two states serve as cautionary examples:

- **Kentucky** had just scored a major victory by adding a robust Medicaid tobacco cessation benefit. However, in 2011 the state moved almost all Medicaid enrollees to managed care plans. Not only do Medicaid members now have access to fewer treatments, but information on coverage is very confusing for patients and healthcare providers.
- **New York** previously covered almost all tobacco cessation medications through its prescription drug plan. When the state moved prescription drug coverage to managed care, Medicaid members lost this guaranteed coverage. Now coverage varies widely from plan to plan, and bupropion is the only medication that is covered by every plan.

State Trends: State Employee Health Plans

Every state provides health insurance to its employees.[17] As state governments are often one of the largest employers in states, this coverage reaches a large number of people. Many state employee plans also serve as examples or benchmarks for other health insurance plans in the state. Therefore, it is important that these health plans lead by example and cover cessation treatment for tobacco users—not only to create a healthier state workforce, but also to benefit others in the state. Furthermore, helping state employees quit will directly save state taxpayers money.[18]

Most states do not do enough to help state employees and their families quit. The information below represents American Lung Association data for 2012.

Four States Cover a Comprehensive Tobacco Cessation Benefit for All State Employees:

- Illinois
- New Mexico
- North Dakota
- Rhode Island

State Employee Health Plan Coverage of Smoking Cessation Treatments 2012

DC (Data not reported)

	Comprehensive coverage	Almost comprehensive coverage (covers at least 7 treatments for all)	Inadequate coverage (covers less than 7 treatments for all)	No coverage (0)
STATES	4	21	22	

Data not reported. Note: 3 states & the District of Columbia did not report data.

Source: American Lung Association, State Tobacco Cessation Coverage Database. 2012. Available at: www.lung.org/cessationcoverage

Please note: the definition of comprehensive tobacco cessation benefits now includes coverage of phone counseling.

State Trends: State Employee Health Plans

Adding New Benefits

Several states added help for smokers to quit in 2012:

- **Florida** "carved out" its prescription drug plan for state employees, which means all beneficiaries now receive the same prescription drug benefit. Wisely, the plan chosen covers all tobacco cessation medications, therefore standardizing a benefit that previously varied widely by health plan.
- **Georgia** instituted a new tobacco cessation medications benefit on January 1, 2012. This is particularly noteworthy as Georgia previously did not cover any tobacco cessation treatment for state employees.
- **Nebraska** switched health insurance providers, and wisely chose a plan that provides almost comprehensive tobacco cessation benefits. Consequently, Nebraska employees gained access to nicotine gum, nasal spray, lozenge and inhaler, as well as phone and online counseling.
- **New Jersey's** state employee plan stopped excluding over-the-counter tobacco cessation medications, and therefore added nicotine patch, gum and lozenge to its medications benefit.

Essential Health Benefits

State employee health plans received special focus from policymakers and advocates this year because of the ACA. As states are choosing their EHB benchmark plans—which all other plans in the exchanges must be modeled after—one of the categories of plans to choose from is the state employee health plan. States are able to choose any of the three largest employee plans as the EHB benchmark. As of November 21, 2012, three states had chosen a state employee plan for their benchmark: **Arizona, Maryland** and **Utah**.[19]

Tobacco Surcharges

One troubling trend in state employee health plans is the increase in use of tobacco surcharges. Sometimes called tobacco premiums, or premium incentives, these policies charge tobacco users higher health insurance premiums than non-tobacco users. While these surcharges recognize the very real healthcare costs smokers incur, the American Lung Association does not support these policies. Tobacco surcharges are punitive measures, and such measures have not been recommended as effective in treating tobacco use or encouraging cessation.[20] Additionally, these surcharges could make health insurance so expensive for smokers that they will choose to not purchase it—therefore leaving them without general healthcare, and specifically without coverage for any tobacco cessation treatments.

If a state chooses to enact a tobacco surcharge for state employees, it should ensure that a comprehensive tobacco cessation benefit is available for employees who want to quit. American Lung Association data show that 12 states have tobacco surcharges, premiums or incentives for state employees and dependents. While each of these states provides some level of tobacco cessation treatment for employees, none of them cover a comprehensive benefit. In particular, **South Carolina**, **South Dakota** and **Texas** have a tobacco surcharge while providing an inadequate tobacco cessation benefit.

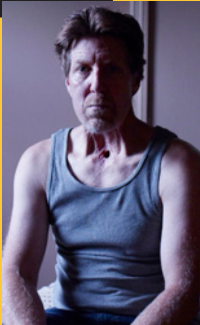
Twelve State Employee Health Plans Charge a Tobacco Surcharge:

- Alabama
- Georgia
- Indiana
- Kansas
- Kentucky
- Missouri
- North Carolina
- South Carolina
- South Dakota
- Tennessee
- Texas
- West Virginia

Promoting Use of Tobacco Cessation Treatments

While the first step to helping smokers quit is putting policies in place that give them access to treatment, there is a crucial next step: promoting these treatments and encouraging smokers to use them. Below are examples of this from the federal and state governments.

TIPS FROM
FORMER
SMOKERS



Centers for Disease Control and Prevention

On March 9, 2012, the CDC launched ***Tips from Former Smokers***, the first federally funded national mass media campaign designed to educate the public about the harmful effects of smoking and to encourage quitting. Running for twelve weeks, the ad campaign featured stories of people currently living with smoking-related diseases, detailing their struggles with their health and with everyday tasks such as eating and getting dressed. The ads also served as a way to let smokers know that quitting assistance is available over the phone (1-800-QUIT-NOW) and through the Web (www.smokefree.gov).

Many smokers tried to quit as a result of the campaign:

- Calls to 1-800-QUIT-NOW increased 132 percent
- Visits to www.smokefree.gov increased 428 percent

Wisconsin

In 2006, the Wisconsin Medicaid Program, Department of Health Services and University of Wisconsin Center for Tobacco Research and Intervention launched a media campaign to increase use of Medicaid's tobacco cessation benefit. The *You Can Afford to Quit: Medicaid Covers It* campaign included:[21]

- Brochures
- Factsheets
- Posters
- Reminder sheets for healthcare providers
- PowerPoint trainings

The campaign increased utilization of the tobacco cessation benefit:[22]

- The use of tobacco cessation medications among Medicaid enrollees increased by 190 percent during and after the campaign
- Average monthly enrollment in quitline services for Medicaid enrollees increased by 57 percent during the time period of the campaign

Quitlines

Quitlines are an essential part of any state's tobacco cessation efforts. Quitlines provide phone counseling through a toll-free number to callers, as well as help to doctors, friends and family of smokers who want information. All state quitlines can be reached by calling 1-800-QUIT-NOW, which is a national number that will route the caller to the appropriate state. Quitlines are especially important for smokers who live too far away from their doctor or clinic, are uninsured or cannot afford paying for treatment. Quitlines can and often do serve as the first and sometimes the only line of help for smokers who want to quit.

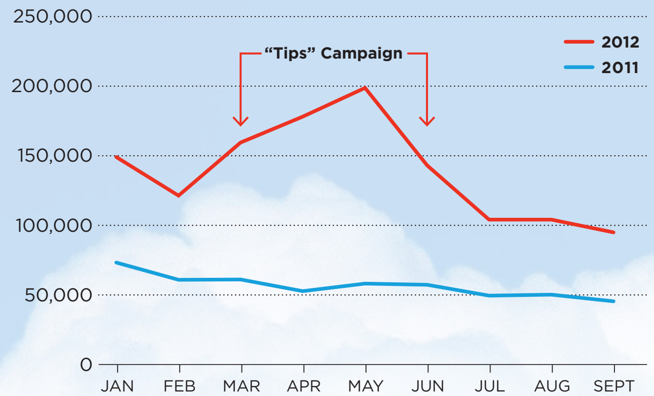
The value of quitlines was never more apparent than during the *Tips from Former Smokers* media campaign. Calls to quitlines increased 132 percent during the advertising campaign, which included 1-800-QUIT-NOW.

Quitline Funding

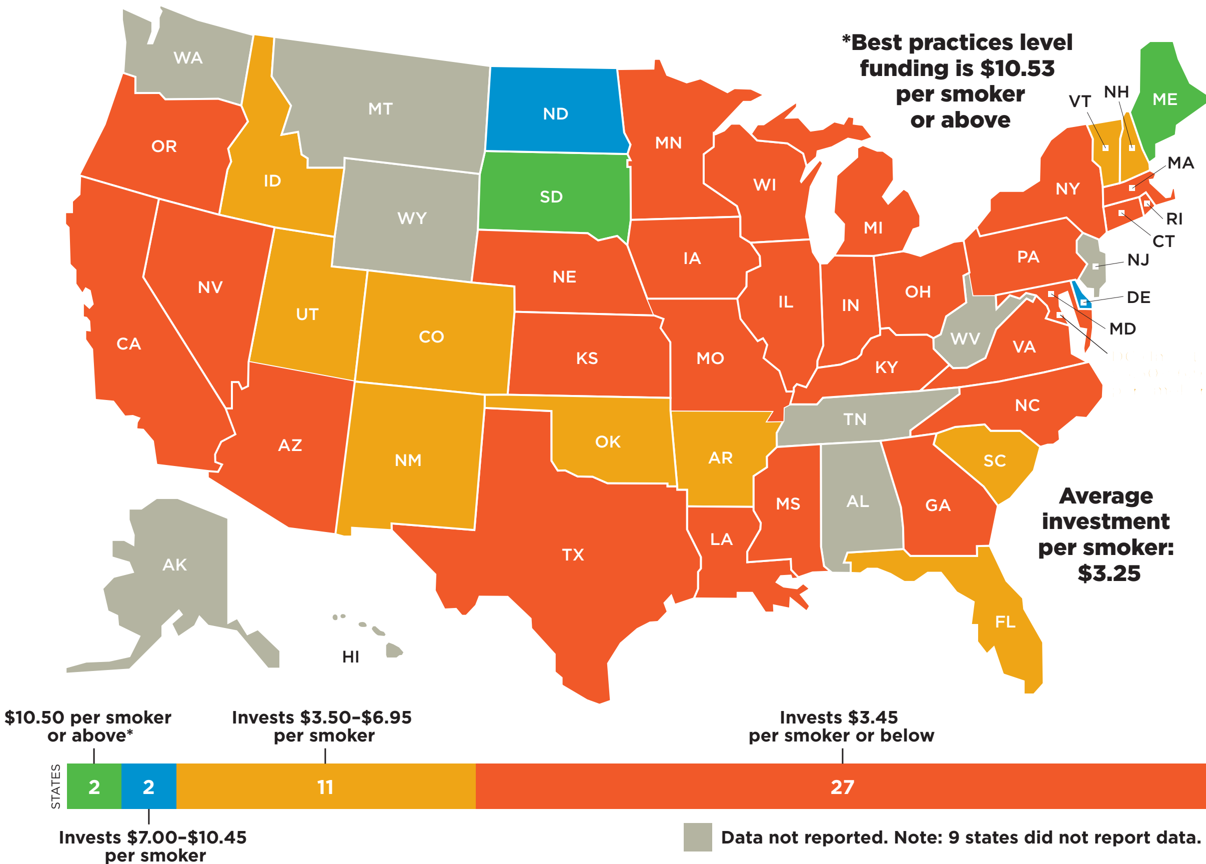
For these reasons states must adequately fund their quitlines. Unfortunately, quitlines in this country are chronically underfunded.

According to the CDC and the North American Quitline Consortium, a quitline must be funded at a rate of $10.53 per tobacco user in the state to provide best-practice services.[23] However, American Lung Association data show that only two states fund their quitline at or above this level: **Maine** and **South Dakota**.

Calls to Quitlines Increased Dramatically in Response to the "Tips" Campaign



Source: National Cancer Institute, 2012



Source: American Lung Association, State Tobacco Cessation Coverage Database. 2012. Available at: www.lung.org/cessationcoverage

Employer-Sponsored Insurance

Currently, the majority of Americans who have health insurance receive coverage through their non-government employer, sometimes called "employer-sponsored" or "private" insurance. The ACA does make changes to this segment of the health insurance market, though they are not as wide sweeping as the changes it makes to public insurance.

For tobacco cessation, HHS policymakers missed another great opportunity through the ACA to help more smokers with private insurance quit smoking. According to the law, as of September 23, 2010, all new private insurance plans[24] were required to cover any preventive service that receives an 'A' or 'B' rating from the U.S. Preventive Services Task Force (USPSTF) at no cost to plan members. Tobacco cessation services received an 'A' rating from the USPSTF, but unfortunately this does not mean that all health insurance plans will automatically provide a comprehensive tobacco treatment benefit. In implementing this policy, HHS again failed to detail which treatments were required, leaving interpretation up to the insurance companies. The Lung Association is concerned that this has resulted in less-than-comprehensive coverage under most plans, and initial surveys confirm this concern.[25] One recent study found that only four of 39 private plans analyzed covered even close to a comprehensive benefit. Also troubling, some of the plans analyzed included cost sharing for tobacco cessation treatments—something prohibited by the ACA.[26]

Nine States Have Legislative or Regulatory Standards for Tobacco Cessation Coverage:

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

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

Oregon

In 2009, the Oregon legislature passed SB 734, which requires all fully insured, private health insurance plans in the state to provide payment, coverage or reimbursement of at least $500 for a tobacco use cessation program for all plan enrollees at least 15 years old.

helping benefit Oregon smokers

In conjunction with implementation of the law, the Helping Benefit Oregon Smokers collaborative was formed with representatives from health plans, employers, health agencies and advocates. The goal was to use the opportunity of the new legislation to improve the quality of tobacco cessation benefits offered by the health plans. Initial results are very promising:

- Five health plans added or moved their tobacco cessation coverage to a core benefit
- Two health plans increased the selection of tobacco cessation medications on their formularies

For more information, please visit www.smokefreeoregon.com/policy/helping-benefit-oregon-smokers.

Conclusion

Tobacco use remains the leading cause of preventable death in the United States. There are proven treatments available to help smokers quit and reduce the burden caused by tobacco use, and many different ways to get these treatments to smokers—through public healthcare programs, private insurance, state insurance exchanges, quitlines and tobacco control and prevention programs. While the federal government and some state governments have taken important steps recently to provide cessation treatments through these avenues, there is still much more work to be done:

Federal Government To Do List

- Department of Health and Human Services—clarify that the tobacco cessation coverage required under ACA includes all FDA-approved cessation medications and group, individual and phone counseling. This definition must apply to:
    - Private plans
    - State health insurance exchange plans
    - Medicaid expansion plans

- Department of Health and Human Services—publish a rule implementing the Essential Health Benefit in state exchanges that includes a defined comprehensive tobacco cessation benefit as a required preventive service.
- Department of Health and Human Services—publish a rule implementing the Essential Health Benefit in the Medicaid expansion population that includes a comprehensive tobacco cessation benefit as a required preventive service.
- Department of Health and Human Services—give clear guidance to state Medicaid programs regarding the 2014 tobacco cessation medications requirement. Require programs cover each of the (seven) FDA-approved tobacco cessation medications.
- Department of Health and Human Services—continue to promote and encourage tobacco cessation through media campaigns like the *Tips from Former Smokers* campaign.
- Congress—protect the Prevention and Public Health Fund (an ACA initiative) and ensure it is only used for its original purpose.

State Policymaker To Do List

- Choose an EHB benchmark plan that includes a comprehensive tobacco cessation benefit, and require other plans in the exchange to cover this benefit.

- Expand Medicaid in 2014 to the federal minimum eligibility requirement. Ensure that the benchmark coverage available to these new Medicaid enrollees includes a comprehensive tobacco cessation benefit.
- Cover a comprehensive tobacco cessation benefit for all Medicaid enrollees, and make this benefit as easy to access as possible.
- Ensure quitlines are adequately funded (at least $10.53 per smoker in the state) so they are able to provide quality services to all callers.

Affordable Care Act and Tobacco Control: A Timeline

2010 · 2011 · 2012 · 2013 · 2014 · 2015 · 2016

March 23, 2010:
President Obama signs the Patient Protection and Affordable Care Act into law

September 23, 2010:
New private plans required to cover preventive services, including tobacco cessation

October 1, 2010:
All Medicaid programs required to cover tobacco cessation for pregnant women

January 1, 2011:
Medicare enrollees eligible for a new prevention and wellness visit, which can include tobacco cessation treatment

January 1, 2011:
Medicare prescription drug "donut hole" begins to close, making tobacco cessation medications more affordable for seniors who want to quit

December 16, 2011:
HHS releases bulletin outlining its implementation approach to the Essential Health Benefit

February 2, 2012:
Prevention and Public Health Fund raided. Cut by $6.25 billion in the Middle Class Tax Relief and Job Creation Act

March 15, 2012:
CDC launches the *Tips from Former Smokers* campaign, funded by the Prevention and Public Health Fund

November 26, 2012:
HHS releases proposed rules implementing Essential Health Benefit, rules on tobacco surcharges and wellness programs

January 1, 2013:
Medicaid programs that cover preventive services, including tobacco cessation, will receive an increase in matching funds

January 1, 2014:
Medicaid eligibility expands to 138 percent of the federal poverty level

January 1, 2014:
State health insurance exchanges implemented

January 1, 2014:
Tobacco cessation medications can no longer be excluded from state Medicaid coverage

2016:
HHS will re-evaluate the process for determining the Essential Health Benefit

References

1. U.S. Department of Health and Human Services. The Health Consequences of Smoking: A Report of the Surgeon General. Atlanta, GA: U.S. 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, 2004.
2. 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.
3. Lightwood JM & Glantz SA. Short-Term Economic and Health Benefits of Smoking Cessation—Myocardial Infarction and Stroke. Circulation. August 19, 1997, 96(4).
4. 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.
5. Penn State University. American Lung Association. "Tobacco Cessation: the Economic Benefits." 2010. Available at: www.lung.org/cessationbenefits.
6. Richard, P, West, K, and Ku, L. The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts. PLoS One. January 6, 2012, 7(1).
7. 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.ahrq.gov/clinic/tobacco/treating_tobacco_use08.pdf
8. Centers for Disease Control and Prevention. Quitting Smoking Among Adults - United States, 2001-2010. *MMWR* 2011;60(44):1513-1519.
9. 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.ahrq.gov/clinic/tobacco/treating_tobacco_use08.pdf
10. 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.ahrq.gov/clinic/tobacco/treating_tobacco_use08.pdf
11. Fiore, MC, Jaen, CR, Baker, TB, 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.ahrq.gov/clinic/tobacco/treating_tobacco_use08.pdf
12. The ten essential health benefits are: 1) Ambulatory patient services, 2) Emergency services, 3) Hospitalization, 4) Maternity and newborn care, 5) Mental health and substance use disorder services, including behavioral health treatment, 6) Prescription drugs, 7) Rehabilitative and habilitative services and devices, 8) Laboratory services, 9) Preventive and wellness services and chronic disease management, and 10) Pediatric services, including oral and vision care. Available at: http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf
13. American Lung Association. Letter to Kathleen Sebelius. June 15, 2012. Available at http://www.lung.org/get-involved/advocate/advocacy-documents/health-benefits-and-medicaid.pdf.
14. American Cancer Society, American Lung Association and Partnership for Prevention. Letter to Kathleen Sebelius. August 26, 2011. Available at http://www.lung.org/get-involved/advocate/advocacy-documents/letter-to-sec-sebelius-tobacco.pdf.
15. Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey, 2011. Analysis by the American Lung Association, Research and Program Services Division.
16. Centers for Disease Control and Prevention. "Tobacco Control State Highlights 2002: Impact and Opportunity." Smoking-attributable Medicaid costs are updated from 1998 to 2011 dollars, using the Medical Consumer Price Index.
17. National Conference of State Legislatures. State Employee Health Benefits. New Material Added September 20, 2012. Available at: http://www.ncsl.org/IssuesResearch/Health/StateEmployeeHealthBenefits2009EditionNCSL/tabid/14345/Default.aspx.
18. Lightwood JM & Glantz SA, Ibid.; Solberg LI, Maciosek MV, Edwards NM., Ibid.
19. State Refor(u)m. State Progress on Essential Health Benefits. Updated October 10, 2012. Available at: http://www.statereforum.org/state-progress-on-essential-health-benefits.
20. 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.ahrq.gov/clinic/tobacco/treating_tobacco_use08.pdf
21. Redmond, L & Adsit, R. You Can Afford to Quit: Medicaid Covers It. August 4, 2009. Available at: http://www.tcln.org/schedule/docs/080409/RedmondPresentation.pdf
22. Keller, PA, Christiansen, B, Kim, S-Y, et al. Increasing Consumer Demand among Medicaid Enrollees for Tobacco Dependence Treatment: The Wisconsin *Medicaid Covers It* campaign. American Journal of Health Promotion. July 2011, 25(6): 392-395. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3132115/
23. See page 41 of Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs. October 2007. Available at: http://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm.
24. This requirement does not apply to plans that are grandfathered under the ACA.
25. Centers for Disease Control and Prevention. Health Plan Implementation of U.S. Preventive Services Task Force A and B Recommendations—Colorado, 2010. MMWR 2011;60(39):1348-1350. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6039a3.htm?s_cid=mm6039a3_e&source=govdelivery
26. Georgetown University Health Policy Institute. Implementation of tobacco cessation coverage under the Affordable Care Act: Understanding how private health insurance policies cover tobacco cessation treatments. November 26, 2012. Available at: http://tfk.org/coveragereport/.

Appendix A: American Lung Association Smoking Cessation Programs

The American Lung Association helps tens of thousands of smokers quit every year. More information about these programs can be found at www.lung.org/stop-smoking.

Freedom from Smoking®

Considered "America's gold standard in smoking cessation programs," Freedom from Smoking® has been helping smokers quit for over three decades. The program is offered three ways: 1) a self-help manual, 2) an eight-session group clinic and 3) an online program available at www.FFSonline.org. Participants in the program develop a personalized step-by-step plan to quit smoking. Freedom from Smoking® uses a positive behavior change approach and encourages participants to work through the problems and process of quitting individually as well as with group support.

Not-On-Tobacco®

This program for teens aged 14–19 is the most widely available teen tobacco cessation program in the country. The N-O-T program includes ten sessions conducted in small groups. It 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. Learn more at www.NotOnTobacco.com.

Lung HelpLine (1-800-548-8252)

The Lung HelpLine is a valuable resource to anyone interested in and affected by lung health. The HelpLine is staffed by registered nurses, respiratory therapists and smoking cessation counselors. 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.

Appendix B: Methodology

Data reported in this report are original, collected by staff of the American Lung Association (unless otherwise noted). These data were collected from July–November, 2012, and are intended to reflect coverage in effect as of November 21, 2012. Data were collected through extensive Internet and document searches, as well as through contact with relevant Medicaid, Department of Health and Quitline 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 Medicaid coverage of phone counseling include American Lung Association survey and the North American Quitline Consortium's case study to Support Gaining Federal Medicaid Match for State Tobacco Cessation Quitlines. 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. Data on state quitlines were collected via survey of Quitline and tobacco control program staff. For detailed information on coverage in each state and a specific state-by-state list of sources, please visit www.lung.org/cessationcoverage.

Appendix C: Medicaid 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	P	P	P	P	P	P	P	no	P	no
Alaska	yes	yes	no	no	yes	yes	yes	no	yes	no
Arizona	yes	yes	yes	yes	yes	yes	yes	no	no	no
Arkansas	yes	yes	no	no	no	yes	yes	no	yes	yes
California	yes	yes	yes	yes	yes	yes	yes	*	*	*
Colorado	*	*	*	*	*	yes	yes	P	P	yes
Connecticut	yes	yes	yes	yes	yes	yes	yes	no	yes	no
Delaware	yes	yes	yes	yes	yes	yes	yes	no	yes	no
District of Columbia	#	#	#	#	#	#	#	#	#	#
Florida	*	*	*	*	*	*	*	*	yes	*
Georgia	P	P	P	P	P	P	P	no	P	no
Hawaii	#	#	#	#	#	#	#	#	#	#
Idaho	yes	yes	yes	yes	yes	yes	yes	no	no	no
Illinois	yes	yes	yes	yes	yes	yes	yes	no	no	no
Indiana	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
Iowa	yes	yes	yes	yes	yes	yes	yes	no	yes	no
Kansas	*	yes	no	no	*	yes	yes	P	P	*
Kentucky	*	yes	*	*	*	*	*	*	*	*
Louisiana	yes	yes	yes	yes	no	yes	yes	no	no	yes
Maine	P	P	P	P	P	P	P	no	yes	no
Maryland	*	yes	*	*	*	*	yes	*	*	yes
Massachusetts	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
Michigan	yes	yes	*	*	*	yes	yes	*	yes	yes
Minnesota	yes	yes	yes	yes	yes	yes	yes	yes	yes	no
Mississippi	yes	yes	yes	yes	yes	yes	yes	P	P	no
Missouri	yes	yes	yes	yes	yes	yes	yes	no	yes	no
Montana	yes	yes	yes	yes	yes	yes	yes	no	yes	yes
Nebraska	yes	yes	no	no	no	yes	yes	no	yes	no
Nevada	yes	yes	yes	yes	yes	yes	yes	**	**	no
New Hampshire	yes	yes	yes	yes	yes	yes	yes	P	yes	no
New Jersey	*	yes	*	*	*	*	yes	no	no	no
New Mexico	yes	yes	yes	yes	yes	yes	yes	*	*	*
New York	*	*	*	*	*	*	yes	yes	yes	no
North Carolina	yes	yes	yes	yes	yes	yes	yes	#	yes	yes
North Dakota	yes	yes	yes	yes	yes	yes	yes	no	P	no
Ohio	yes	yes	yes	yes	yes	yes	yes	no	no	no
Oklahoma	yes	yes	yes	yes	yes	yes	yes	no	yes	yes
Oregon	*	yes	*	*	*	yes	yes	*	yes	*
Pennsylvania	yes	yes	yes	yes	yes	yes	yes	yes	yes	no
Rhode Island	yes	yes	yes	yes	yes	yes	yes	*	yes	no
South Carolina	*	yes	*	*	*	*	*	no	no	*
South Dakota	no	no	no	no	no	yes	yes	no	P	no
Tennessee	yes	yes	yes	yes	yes	yes	yes	P	P	no
Texas	yes	yes	no	no	no	yes	yes	*	*	*
Utah	**	**	**	**	**	yes	yes	P	P	no
Vermont	yes	yes	yes	yes	yes	yes	yes	P	P	no
Virginia	*	yes	*	*	*	*	yes	*	yes	*
Washington	*	*	*	*	*	yes	*	no	*	*
West Virginia	**	**	**	**	**	no	**	*	no	*
Wisconsin	yes	yes	yes	yes	no	yes	yes	*	yes	no
Wyoming	yes	yes	no	no	yes	yes	yes	no	yes	no

P Coverage only for pregnant women
* Coverage varies by health plan
** Coverage provided only under certain conditions
# Data not reported

Appendix D: Barriers to Medicaid Cessation Coverage in the States

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

Data not reported

* Barrier varies by health plan

Appendix E:
State Employee Health Plan Coverage of Cessation Treatments

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

* Coverage varies by health plan
** Coverage provided only under certain conditions
\# Data not reported

Appendix F:
State Laws Requiring Coverage of Cessation Treatments

Colorado	Requires health plans to cover tobacco use screenings and tobacco cessation interventions by primary care providers. This coverage must be offered with no deductibles or coinsurance, though reasonable copayments may apply. The legislation is unclear as to whether the interventions required include prescription drugs. This law went into effect January 1, 2010.
Illinois	Requires insurance companies to offer a tobacco cessation benefit as a rider to any group health insurance policy offered to employers or group policyholders in the state. The rider must include reimbursement or coverage for up to $500 spent on a tobacco cessation program, which must include counseling and all FDA-approved tobacco cessation medications. Insurance companies can charge additional premiums for coverage of this rider, and employers do not have to purchase this coverage.
Maryland	Requires health plans that cover prescription drugs in the state to cover two 90-day courses of prescription NRTs per year. Over-the-counter NRTs are excluded, so the law only requires plans to cover the NRT nasal spray and inhaler. Copayments must be the same as other medications in the plan.
New Jersey	All health plans in the state must cover an annual “wellness” appointment with the member’s 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	Requires that all health insurance plans offering maternity benefits in the state cover smoking cessation treatment. The superintendent of insurance determines what this coverage is. Regulation specifies coverage of: 1. Diagnostic services 2. Two 90-day courses of prescription medications per year 3. Individual or group counseling These benefits can be subject to normal deductibles and coinsurance. This does not require coverage of over-the-counter medications.
North Dakota	Standard North Dakota insurance plan includes a $150 lifetime smoking cessation benefit (specifics of benefit not included). This only applies to small employers and the employers have several plans to choose from besides the standard plan when purchasing insurance.
Oregon	Requires insurance plans to provide payment, coverage or reimbursement of at least $500 for a tobacco use cessation program for a person enrolled in the plan who is 15 years of age or older. Program is to include “educational and medical treatment” components.
Rhode Island	Requires all health plans to cover all medications recommended by the U.S. Public Health Service Guideline (all seven cessation medications) in combination with four hours of cessation counseling. Normal deductibles and coinsurance can apply.
Vermont	Requires all health plans in Vermont to cover all seven medications FDA-approved for tobacco cessation. Medications must be covered for at least one 3-month supply per year per member. Copayments may apply to these medications.

Appendix G: State Quitlines

	Spending per Smoker FY2013
Alabama	#
Alaska	#
Arizona	$2.50
Arkansas	$6.66
California	$2.40
Colorado	$4.18
Connecticut	$3.40
Delaware	$7.30
District of Columbia	$5.45
Florida	$4.46
Georgia	$0.89
Hawaii	#
Idaho	$3.80+
Illinois	$1.23
Indiana	$1.14
Iowa	$3.33
Kansas	$0.82
Kentucky	$0.50
Louisiana	$0.51
Maine	$11.56
Maryland	$0.65
Massachusetts	$1.84
Michigan	$0.73
Minnesota	$1.32@
Mississippi	$2.22
Missouri	$0.62
Montana	#
Nebraska	$1.35
Nevada	$1.00
New Hampshire	$6.51
New Jersey	#
New Mexico	$6.05
New York	$1.77
North Carolina	$1.20
North Dakota	$9.91
Ohio	$0.40
Oklahoma	$6.79
Oregon	$3.13
Pennsylvania	$0.82
Rhode Island	$0.92
South Carolina	$4.91+
South Dakota	$13.28+
Tennessee	#
Texas	$0.84
Utah	$4.36+
Vermont	$3.62
Virginia	$0.42
Washington	#
West Virginia	#
Wisconsin	$1.21
Wyoming	#

Best Practices

In its document *Best Practices for Comprehensive Tobacco Control Programs*, CDC sets goals for state quitlines, which are achievable through adequate funding. **Best practices-level funding is $10.53 per smoker or above.**

According to CDC, an adequately funded quitline is able to:

- Be available to all smokers wanting phone counseling
- Reach eight percent of tobacco users in the state every year (measured by number of calls received from tobacco users)
- Deliver services to six percent of tobacco users in the state every year (measured by number of tobacco users who receive treatment)
- Offer two weeks of free nicotine-replacement-therapy to all tobacco users. Four weeks should be offered to uninsured or under-insured callers

Data not reported

+ Current estimate.

@ Reflects spending on QUITPLAN services provided to uninsured and underinsured Minnesotans. Seven health plans in the state provide quitline services for their members.

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

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

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

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

Until then, we are fighting for air.

About the American Lung Association

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

December 2012