Preventing 3 Million Premature Deaths

Helping 5 Million Smokers Quit

A National Action Plan for Tobacco Cessation

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Executive Summary

We face a national imperative to address tobacco use in America. A confluence of circumstances and events makes this an ideal time to take bold, effective steps to reduce tobacco use. At a time when healthcare dollars are scarce, we are spending billions of dollars to treat diseases caused by tobacco use. At a time when numerous effective tobacco dependence treatments exist, millions of tobacco users are unable to obtain or afford such treatments. At a time when sound scientific research reveals how to reduce tobacco use, funding sources such as the Master Settlement Agreement are being used to address budget shortfalls, not to implement effective tobacco control programs. Unless the prevalence of tobacco use is cut dramatically, about 24 million Americans, 1 out of 2 current smokers in America, will die prematurely of a disease directly caused by their dependence on tobacco.

This report outlines a series of feasible, science-based action steps to promote tobacco cessation. These steps involve both Federal initiatives as well as public-private partnerships that will, at a minimum:

- Prevent approximately three million premature deaths
- Help five million Americans cease tobacco use within one year.

These proposed action steps will accomplish these goals, in part, by reducing illness and death among those Americans most adversely affected by tobacco use: i.e., the poor, the least educated, and racial and ethnic minorities. Moreover, these action steps will reduce tobacco use and its devastating health consequences while simultaneously raising more than enough revenue to fund their implementation.

The proposed action steps, a series of Federal initiatives and public-private partnership opportunities, are listed below.

Federal Initiatives

- Establish a federally-funded National Tobacco Quitline network by FY 2005 that will provide universal access to evidence-based counseling and medications for tobacco cessation. This quitline would provide a national portal to available state or regionally managed quitlines.

- Launch an ongoing, extensive paid media campaign by FY 2005 to help Americans quit using tobacco.

- Include evidence-based counseling and medications for tobacco cessation in benefits provided to all Federal beneficiaries and in all federally-funded healthcare programs by FY 2005.

- Invest in a new, broad, and balanced research agenda (basic, clinical, public health, translational, dissemination) by FY 2005 to achieve future improvements in the reach, effectiveness and adoption of tobacco dependence interventions across both individuals and populations.

- Invest in training and education by FY 2005 to ensure that all clinicians in the United States have the knowledge, skills and support systems necessary to help their patients quit tobacco use.

- Establish a Smokers' Health Fund by FY 2005 by increasing the Federal Excise Tax on cigarettes by $2.00 per pack (from the current rate of $0.39 to $2.39) with a similar increase in the excise tax on other tobacco products. At least 50% of the new revenue generated by this tax increase (at least $14 billion of the estimated $28 billion generated) should be earmarked to pay for the components of this action plan.

Public-Private Partnerships

- The Secretary will challenge and engage all insurers, employers, and purchasers that pay for or provide health coverage to include barrier-free coverage for evidence-based tobacco dependence treatment (counseling and pharmacotherapy) as part of the basic benefits package offered to all individuals and groups seeking insurance coverage.

- The Secretary will advocate for systems-level changes and quality improvement strategies to expand the delivery of evidence-based tobacco dependence treatments and engage decision-makers in the public and private sectors to achieve those aims.

- The Secretary will work in partnership with national quality assurance and accreditation organizations and other healthcare stakeholders to ensure that provision of evidence-based tobacco dependence treatment is established as a standard of care and is measured uniformly in all healthcare delivery settings.

- The Secretary will initiate and support partnerships between DHHS and community organizations (e.g., schools, employers, voluntary health agencies, and faith-based organizations) to put in place programs and policies that foster tobacco users' motivation to quit, success in quitting, and use of evidence-based treatments, and that address disparities in treatment participation and success.

These action steps are based upon the best scientific evidence available and hold tremendous promise for producing dramatic decreases in tobacco use and its resulting human and economic costs. Moreover, the benefits of these action steps will be both immediate and sustained and will be felt by all segments of society including the poor, the elderly, and racial and ethnic minorities. Finally, these action steps provide a source of funding that will, for the first time, assure smokers that a portion of the tax revenue they generate will be dedicated to helping them quit through direct services, tobacco dependence treatment options, and cutting-edge research. By taking these action steps today, we will save millions of lives and help millions of Americans quit using tobacco.

Introduction

Today, we have an opportunity to dramatically reduce tobacco use in the United States by promoting smoking cessation. Such a reduction would prevent needless premature death and disease for millions of Americans. This report outlines a series of feasible, science-based action steps to promote tobacco use cessation, both Federal initiatives as well as public-private partnerships that will, at a minimum:

- Prevent approximately three million premature deaths
- Help five million Americans quit smoking within one year

The proposed action steps will accomplish the above goals population-wide, but especially by reducing illness and death among those Americans who are most adversely affected by tobacco use: i.e., the poor, the least educated, and certain racial and ethnic minorities.

Rationale

A confluence of events makes this a highly propitious time to adopt bold and effective measures to reduce the prevalence of tobacco use in the US.

- Rates of tobacco use have stabilized: Since 1990, the prevalence of smoking among adult Americans has remained relatively stable at 23 to 25 percent. Moreover, an additional 4 to 6 percent of adult males continue to use spit tobacco, and sales of these products continue to increase. The United States Healthy People 2010 goal of reducing smoking prevalence among adults to 12% will not be achieved unless we substantially increase smoking cessation rates.

- HealthierUS: This new Federal initiative emphasizes the importance of avoiding tobacco use as the single most preventable cause of death and disease in the United States. The National Action Plan for Tobacco Cessation provides clear steps to a HealthierUS by reducing tobacco use.

- Numerous effective treatments exist to treat tobacco dependence: Recent comprehensive analyses of hundreds of research reports have revealed that numerous, effective tobacco dependence treatments now exist. Not only do such treatments more than double a smoker's likelihood of achieving long-term abstinence, but research shows that such treatments are highly cost-effective. In terms of life-years saved per dollar spent, effective counseling and medications for smoking cessation have been found to be among the most cost-effective healthcare practices. In fact, tobacco dependence treatment is more cost-effective than the treatment of hypertension, diabetes and hyperlipidemia.

- Numerous effective community and policy interventions exist to promote smoking cessation: Recent comprehensive analyses have identified a number of evidence-based policy interventions that will dramatically reduce tobacco use by promoting smoking cessation. These include proactive tobacco quitlines, paid mass media campaigns, increasing the unit price of tobacco products, systems-level changes within healthcare delivery systems to enhance the identification of and intervention with tobacco users; and reducing patient out-of-pocket costs for effective treatments.

- Health effects of secondhand smoke: Over the past decade, research has led to a greater understanding of the health effects of secondhand smoke. There is now compelling

evidence that nonsmokers living and working in proximity to smokers face heightened risks of diseases such as asthma, respiratory infections, cardiovascular diseases and lung cancer. Thus, it is now clear that reductions in smoking prevalence benefit not only smokers, but also their families, friends, and co-workers. Children in particular are harmed by secondhand smoke, both in terms of increased rates of illness and a greater likelihood that they will become smokers themselves if their parents smoke. The effects of tobacco use on the unborn child during pregnancy are also substantial.

- Insufficient access to treatment: While numerous, effective smoking cessation treatments exist, many Americans do not have ready access to such treatments, and therefore the treatments remain underutilized, particularly by low income tobacco users and racial and ethnic minorities. For instance, a 1998 survey determined that only four states mandated any health insurance coverage of effective tobacco dependence treatment. A Year-2000 survey revealed that only 33 states provided any coverage for guideline-based counseling or pharmacotherapy for their Medicaid beneficiaries and only 21 states provided coverage for the counseling services recommended for pregnant smokers. About 60% of all Americans receive healthcare through Managed Care Organizations (MCO's), but a Year-2000 survey found that fewer than half of MCO's covered such effective tobacco dependence treatments as face-to-face counseling, nicotine replacement, or bupropion. Finally, Medicare does not cover tobacco dependence counseling and medications in either its managed care or fee-for-service plans.

- Public-Private Partnership opportunities: The private sector has increasingly committed to joining with the public sector to decrease tobacco-caused illness and death. Initiatives and coalitions such as the National Dialogue on Cancer, the Washington Business Group on Health, the Partnership for Prevention and others provide models and mechanisms to produce a public-private synergy to achieve this vital goal.

With every passing year there is greater recognition of the human and economic costs of tobacco use--costs that argue forcefully for bold, scientifically-grounded strategies to curb tobacco use.

Costs of Tobacco Use: The Need for Action

In the early 1900's, lung cancer was a rare condition in the United States. As cigarette smoking became more common over the course of the 20th century, lung cancer became epidemic with mortality rates increasing over 15 fold from 1930 to 1990. It is now estimated that approximately 90% of lung cancer is directly caused by smoking, resulting in more than 100,000 deaths in the U.S. each year.

Tobacco use also causes a host of other diseases including heart disease, peripheral vascular disease, strokes, laryngeal and esophageal cancers, chronic obstructive pulmonary disease, and low birth weight. This burden of premature death and disease exerts profound human costs since death due to tobacco-related disease shortens lives, on average, 13 – 14 years. Thus, children are deprived of parents, spouses are deprived of partners, and immense human capital is lost to businesses, families and society. If dramatic action is not taken to reduce tobacco use, it is estimated that approximately 5 million American children living today will die prematurely because of tobacco-related disease. The risk to current smokers is even greater. It is estimated that of the almost 50 million smokers alive in the U.S. today, approximately 15 to 25 million will die prematurely as a direct result of tobacco use. Moreover, the adverse health

impacts of tobacco use are inflicted disproportionately on individuals of lower socioeconomic status and on certain racial and ethnic minorities.

Beyond the enormous human and public health impact of tobacco use, the economic costs are profound. The excess healthcare costs of tobacco use are estimated at $75 billion dollars/year, with an even greater sum of nonmedical costs (e.g., lost productivity, fires, absenteeism from work): i.e., over $150 billion/year in economic costs incurred by governments, employers, insurers, and individuals.

Establishment of the Subcommittee on Cessation of the Interagency Committee on Smoking and Health

In August 2002, a Subcommittee on Cessation (Subcommittee) of the Interagency Committee on Smoking and Health (ICSH) was established and asked to develop a series of recommendations to increase substantially rates of tobacco cessation in the United States, and thereby decrease substantially tobacco use prevalence. The Subcommittee was asked to present these recommended action steps to the United States Secretary of Health and Human Services by February 2003. Sixteen individuals with expertise in tobacco control, representing the public and private sectors, agreed to work together to develop this National Action Plan for Tobacco Cessation. The United States Centers for Disease Control and Prevention's Office on Smoking and Health served as the Secretariat for the Subcommittee on Cessation. The Subcommittee on Cessation was asked to base their recommended action steps on the existing body of scientific evidence regarding effective tobacco dependence strategies and policies and upon the testimony and experience of individuals across America. The Subcommittee on Cessation met on five occasions starting on October 1, 2002 and ending on January 16, 2003, including three public hearings in Washington, D.C., Denver, and Chicago. Four evidentiary documents served as the primary science base for the recommended action steps: the U.S. Public Health Services' Clinical Practice Guideline: *Treating Tobacco Use and Dependence* (PHS Clinical Practice Guideline); the U.S. Task Force on Community Preventive Services' *Guide to Tobacco Use Prevention and Control* (Guide to Community Preventive Services); the *ICSH Action Plan on Tobacco Use Cessation* report from August 2001, and the *Draft National Blueprint for Disseminating and Implementing Evidence-Based Clinical and Community Strategies to Promote Tobacco Use Cessation*. In addition to these documents, the Subcommittee considered relevant scientific research, heard oral testimony from approximately 100 individuals and organizations at three regional meetings and received written testimony from over 85 individuals and organizations. A deadline of December 20, 2002 was established for submitting written testimony.

The recommendations presented in this report are based upon the scientific evidence base described above as well as on public input, and represent the Subcommittee's best effort to present the Secretary of Health and Human Services with proposals designed to prevent millions of premature deaths by helping millions of Americans stop using tobacco.

Targeted Features of a National Action Plan for Tobacco Cessation

The Subcommittee on Cessation determined that a new National Action Plan for Tobacco Cessation should be implemented by FY 2005 and have the following features:

- Meaningful reductions in both tobacco use and the resultant burden of illness, premature death, and economic costs: Because of the unacceptable costs of tobacco use, coupled with the ready availability of effective treatments, it is essential that the new plan achieve

meaningful reductions in tobacco use. The plan described in this report aims to reduce tobacco use by a *minimum* of 10% in its first year; i.e., 5 million smokers will quit in the first year. This reduction target was chosen because it will benefit public health significantly and yet is eminently feasible. As a consequence of this reduction in tobacco use, a conservative estimate is that approximately 3 million premature deaths will be prevented (due to smoking cessation and prevention of smoking initiation). This will also reduce the significant economic costs of tobacco use including healthcare costs and lost productivity.

- Science-based: The elements of the plan should be based upon strong scientific evidence. Because of the importance of reducing tobacco use, and the considerable resources to be applied to this purpose, plan elements should be based on the best available science. Elements of this plan are consistent with existing Department of Health and Human Services (DHHS) clinical and community guidelines and rigorous research.

- Address disparities**:** Substantial disparities exist across populations in rates of tobacco use, harmful impacts, and availability of treatment. Thus, the harmful effects of tobacco use occur disproportionately among blue-collar workers, the impoverished, racial and ethnic minorities, pregnant women, and the least educated. Any national plan for tobacco cessation should have the potential to benefit all American tobacco users and their families, from adolescents to the elderly, thus addressing these disparities.

- National in scope, regional in application: While tobacco use is a nationwide problem, great differences exist across states and communities with respect to availability of, and support for, evidence-based tobacco dependence treatments. Therefore, a new plan should make treatment resources available to Americans regardless of where they live. However, by permitting some local control over the delivery of services, state and local needs can be met.

- Public-private partnerships: Plan elements should enlist both governmental as well as private resources and mechanisms in order to leverage all available and appropriate resources in an efficient manner. Such partnerships can markedly enhance the impact that would be achieved by either group working alone.

- Impact should be both immediate *and* sustained: Plan elements should exert both significant immediate impacts and be sustained in terms of their effects. Moreover, the plan must sow the seeds for future improvements in the understanding and treatment of tobacco dependence. Given the enormous burden resulting from tobacco use in our society and the potential of cessation interventions to reduce that burden, plan elements are designed to be implemented by FY 2005.

- Comprehensive and integrated: To achieve maximum effectiveness, the plan needs to be comprehensive and its individual components integrated. While each of the proposed elements is effective by itself, the impact of the plan elements will be substantially increased when implemented as part of a comprehensive effort. In particular, the proposal is designed to complement, rather than replace, the comprehensive tobacco prevention and control programs in existence in some states.

- Evaluated: In order to ensure that the action plan has its intended impact, an evaluation plan is necessary. Existing surveillance systems can be utilized or supplemented to provide objective measures of the success of these initiatives.

- Securely funded: The best scientific recommendations have little likelihood of being implemented and sustained unless a secure and on-going funding source is established. Recent experience has shown that sustained tobacco control programs require a sustained funding source. Thus, these recommendations include a source of funding that will both drive down tobacco use by itself as well as provide sustained funding for other components of the National Action Plan for Tobacco Cessation. Alternatively, DHHS agencies are encouraged to include funds in their budget requests to support coordinated initiatives consistent with these recommendations.

Plan Elements

The National Action Plan for Tobacco Cessation includes both Federal initiatives and public-private partnership opportunities:

Federal Initiatives:
- A nationwide Tobacco Cessation Quitline providing counseling and medications for all Americans motivated to quit to be managed by the states;
- A multi-faceted, paid national media campaign to encourage cessation;
- Insurance coverage for tobacco dependence treatment for all federally-covered lives;
- A new tobacco research infrastructure to improve understanding of tobacco dependence and its treatment;
- A new tobacco training infrastructure to ensure that all clinicians have the knowledge, tools and support systems to intervene with their patients who use tobacco;
- A Smokers' Health Fund dedicated to reducing tobacco use by funding other action plan elements through a $2/pack increase in the Federal excise tax on cigarettes;

Public-Private Partnership Opportunities:
- Mobilize health insurers, employers and others to foster evidence-based tobacco dependence coverage for all covered lives;
- Mobilize health systems to implement system-level changes that result in effective utilization of tobacco dependence treatments;
- Mobilize national quality assurance and accreditation organizations, clinicians, health systems, and others to establish and measure the treatment of tobacco dependence as part of the standard of care;
- Mobilize communities to ensure that policies and programs are in place to increase demand for services and to ensure access to such services.

Each of these action plan components and the supporting evidence are discussed below.

Federal Initiatives

Recommendation: Establish a federally-funded National Tobacco Quitline network by FY 2005 that will provide universal access to evidence-based counseling and medications for tobacco cessation. This quitline would provide a national portal to available state or regionally managed quitlines.

Action Steps:

- In 2003, a group of experts will be convened to design the quitline treatment services to be offered and to establish a set of core performance standards. The tobacco dependence treatments offered through the quitline (counseling and medications) should be evidence-based.

- By FY 2005, the National Tobacco Quitline network will be established. Key features of the network will include:
  - A single, toll-free number that is accessible 24 hours a day, 7 days a week in every state, the District of Columbia, and U.S. Territories;
  - States would receive earmarked grants to fund existing quitlines or develop new quitlines with all state quitlines ultimately meeting national core performance and accountability standards;
  - All calls to the national toll-free number would be transferred to the appropriate state-managed quitline. Residents of states that do not offer quitline services would be able to access services through regional quitlines or via a national quitline service;
  - The National Tobacco Quitline will be linked to a national paid media campaign that would include, but not be limited to, television, radio and print advertising;
  - Legislation will be sought to require the prominent display of the national quitline number on every tobacco product sold in the United States and on all tobacco product advertising;
  - All tobacco users will be eligible to receive the quitline services (both counseling and medications) without any cost or insurance barriers;
  - Counseling services will include at least four person-to-person, proactive calls from the quitline;
  - All quitline counseling will be augmented with free FDA approved pharmacotherapy (either over-the-counter medications or vouchers for prescription medications that must be signed by a physician) for every caller for whom it is medically appropriate;
  - To the extent feasible, quitline services will be tailored to the language and culture of the user. When necessary and/or for economy of scale, regional or national service providers will be used for particular targeted populations;
  - Personnel and their families assigned to military bases in the United States will be eligible to participate in the National Tobacco Quitline. Additionally, those military members and their families assigned overseas will have access to the toll-free quitline; and,
  - Wherever possible, state (e.g., California) and national (e.g., the NCI's Cancer Information Service, the American Legacy's Foundation Great Start) quitline services will be integrated into public-private partnership components of this action plan (e.g., within healthcare systems, worksite initiatives).

Statement of Need:

While numerous effective treatments for tobacco dependence exist, research shows that only a minority of smokers use such treatments. Therefore, it is essential that effective treatments, including both counseling and medications, be provided through innovative delivery systems that will significantly increase the participation of smokers in such treatments. Moreover, research reveals significant disparities in access to treatment across different geographic locations, racial and ethnic groups, and socioeconomic strata. Therefore, treatments should be available nationwide to the whole population of tobacco users, and should pose minimal financial, language, or logistical barriers to participation.

While previous implementation of quitline strategies at the state, local, or corporate level has been successful, the Subcommittee envisions that the National Tobacco Cessation Quitline will build on existing successes and dramatically enhance the population-wide effectiveness of the services provided.

Supporting Evidence:

- A persuasive body of research shows that proactive smoking cessation quitlines are a highly effective means of helping large numbers of individuals quit smoking. Proactive quitlines are those that initiate counseling calls to tobacco users once the individual has taken the first step of contacting the quitline. Quitlines may also contact tobacco users with their permission, after a healthcare clinician has provided the quitline with their names and contact information. Quitlines have the following benefits: they are effective, provide cessation treatment at relatively low cost, and are highly acceptable and accessible to a wide range of smokers, including the elderly, racial and ethnic minorities, and the uninsured. These positive features were noted repeatedly during the public testimony and in written comments to the Subcommittee. Specifically, these comments emphasized the powerful population-wide impact of quitlines and the importance of making these quitlines, including both counseling and medications, universally available.

- A meta-analysis of some 26 uses of quitline interventions revealed that quitline counseling increased smokers' chances of long-term abstinence by approximately 30%. This resulted in the PHS Clinical Practice Guideline recommending this intervention with its highest level of evidence.

- The Task Force on Community Preventive Services thoroughly evaluated evidence on the effectiveness of 15 tobacco control strategies in creating the Guide to Community Preventive Services. Strategies were either not recommended, recommended, or strongly recommended based upon the strength of the supporting scientific evidence. Quitlines were endorsed as a strongly recommended cessation strategy.

- A study published in 2002 of approximately 3,200 smokers confirmed the effectiveness of a quitline program used in California versus the use of self-help materials alone. This research showed that the quitline encouraged new quit attempts and helped prevent relapse among those who had quit previously.

- Quitlines have tremendous potential to reach a wide range of tobacco users because there are essentially no barriers to their use and users find them very appealing. Moreover, their accessibility can be enhanced by making the service available many hours per day and requiring only an initial call to a toll-free number for participation. Because of these features, smokers are much more willing to seek quitline treatment than other forms of intervention. For instance, one study suggests that smokers are four times more likely to use a quitline than to seek face-to-face counseling.

- Because quitlines eliminate the need for transportation and other resources, they tend to be utilized more heavily by smokers who are elderly, live in rural areas, or are of lower socioeconomic status. For instance, the American Legacy Foundation's Great Start quitline for pregnant smokers received nearly 10,000 calls within 3 months, and most of these calls came from low socioeconomic status smokers. In the California quitline study about one-third of callers were racial and ethnic minorities. One feature of quitlines that promotes their widespread use is that they can be made available in multiple languages. Therefore, the Subcommittee believes that implementation of a national quitline network has great potential to reduce the health disparities experienced by the poor and racial and ethnic minorities.

Cost and Funding Source:
Testimony provided to the Subcommittee indicated that the estimated cost of an optimal state-managed, national quitline is about $3.2 billion/year. This includes approximately $1.1 billion for medications, and $2.1 billion for counseling and other quitline components. Testimony also indicated that an optimal quitline service providing both counseling and medication may reach up to 16% of smokers each year. Conservatively estimating a 10% use rate/year by smokers and a 20% long-term successful cessation rate, such a quitline service could result in approximately one million quitters each year. While the Subcommittee believes that this level of quitline funding would have an optimal public health impact, lower funding of a national quitline could also yield significant public health benefits if appropriate public-private partnerships could be established. Quitline monies would be allocated to states on a per capita basis, permitting states to design specific quitline services to meet special state needs. For states with existing quit lines, funds are designed to complement, rather than replace, existing funding. In sum, a national quitline managed by states presents a unique opportunity to make effective smoking cessation treatment available to virtually all smokers in the U.S., at relatively low cost. The Smokers' Health Fund mentioned below could serve as a source of funding for this initiative. Alternatively, DHHS could propose funding this initiative as a new program beginning in FY 2005.

Recommendation: Launch an ongoing, extensive paid media campaign by FY 2005 to help Americans quit using tobacco.

Action Steps:
- DHHS will convene a standing group of experts to design and monitor a multi-faceted paid national media campaign and to establish a set of core performance standards. The media campaign will have these goals:
  - To promote the use of the National Tobacco Quitline and other effective cessation interventions;
  - To motivate tobacco users to make a quit attempt and increase demand for effective cessation services;
  - To motivate parents to quit by informing them of the health risks that secondhand smoke poses to their families and informing them that their smoking increases the likelihood that their children will smoke; and
  - To reach all segments of the population, including the most underserved and hard-to-reach populations (e.g., lower socioeconomic status, racial and ethnic minorities, and those with limited English proficiency).

The campaign will have these characteristics:

- Offer powerful and effective messages that are guided by media and communications science;
- Be multifaceted and pervasive;
- Employ diverse messages and types of media (e.g., radio, television, print media, signage, internet) in order to reach multiple groups including women, youth, racial and ethnic minorities (including those with limited English proficiency), pregnant women, blue-collar workers, and tobacco users at all educational and socioeconomic status levels; and
- Be independent and employ the most effective strategies available.

Statement of Need:
This campaign is needed because many of the other National Action Plan for Tobacco Cessation components will not be optimally effective without increased public awareness and demand for effective treatment. This factor was repeatedly emphasized in public testimony and written comments. For instance, the Subcommittee heard that a national quitline will be of markedly reduced benefit if tobacco users do not know of its availability. Similarly, tobacco users are unlikely to use tobacco cessation services provided by their insurance plans if they do not know that effective treatment services are available. This knowledge is likely to be especially helpful to persons with limited English proficiency or low-income individuals who do not have access to a wide range of media resources. Finally, an effective media campaign is needed because it is a cessation intervention in its own right, directly motivating tobacco users to quit even without other formal interventions.

Supporting Evidence:
- Multifaceted media campaigns were strongly recommended in the Guide to Community Preventive Services. Moreover, the Guide noted that the strongest evidence of effectiveness of such campaigns comes from settings where they were implemented in the context of multicomponent programs. Further, the relevant research showed that such programs increased cessation across a variety of populations, indicating their widespread impact.

- Comprehensive, multicomponent tobacco control programs, including media campaigns, have been markedly effective wherever they have been introduced. For instance, in California such a program was introduced in 1988 and since that time cigarette consumption has declined by 57%. This is in contrast to a nationwide decline of 27%. Moreover, smoking prevalence in California has declined 25% (from 22.8% to 17.1% from 1988 – 2000). Similarly, in 1992, Massachusetts voters approved a tobacco excise tax increase that funded a comprehensive tobacco control program that included prominent paid media messages. From 1992 to 1999, cigarette consumption declined 32% compared to a national decrease of 8%. In addition, smoking prevalence declined 7.5% resulting in 80,000 fewer smokers, with the largest decreases occurring among youth. Similar findings have been obtained in other states such as Maine and Florida. In sum, there is a substantial and consistent body of evidence that media campaigns, especially when they are integrated with other tobacco control actions, reduce the consumption of tobacco and the prevalence of tobacco use.

- Research on statewide tobacco control programs has shown that aggressive media campaigns have been effective in targeted ways such as prompting individuals to use quitline services or discouraging children and adolescents from starting to smoke.

Cost and Funding Source:

Expert public testimony indicated that at least $1 billion be spent on this media campaign annually to counter the effects of tobacco company advertising and promotional activities (for which expenditures were approximately $9.5 billion in 2000). The Smokers' Health Fund mentioned below could serve as a source of funding for this initiative. Alternatively, DHHS could propose funding this campaign as a new program beginning in FY 2005.

Recommendation: Include evidence-based counseling and medications for tobacco cessation in benefits provided to all Federal beneficiaries and in all federally-funded healthcare programs by FY 2005.

Action Steps:

- Partner with the Office of Personnel Management to ensure that all Federal employees and their dependents covered by the Federal Employee Health Benefits Program have evidence-based counseling and FDA-approved medications to treat tobacco dependence as a fully covered benefit. Coverage should be consistent with the PHS Clinical Practice Guideline. Beneficiaries should be made aware of this benefit change.

- Partner with the Department of Defense to identify a methodology to provide Department of Defense beneficiaries with evidence-based tobacco cessation processes and programs to treat tobacco dependence consistent with the PHS Clinical Practice Guideline.

- Partner with the Department of Veterans Affairs to ensure those covered by the Department of Veterans Affairs have evidence-based counseling and FDA-approved medications to treat tobacco dependence as a fully covered benefit. Coverage should be consistent with the PHS Clinical Practice Guideline. Beneficiaries should be made aware of this benefit change.

- Work with the Centers for Medicare and Medicaid Services (CMS) and Congress to propose legislation to ensure that all Medicare beneficiaries have evidence-based counseling and FDA-approved medications to treat tobacco dependence as a fully covered benefit. Coverage should be consistent with the PHS Clinical Practice Guideline. Beneficiaries will be made aware of this benefit change.

- Work with CMS, Congress, and the states to ensure that all Medicaid beneficiaries have evidence-based counseling and FDA-approved medications to treat tobacco dependence as a fully covered benefit. Coverage should be consistent with the PHS Clinical Practice Guideline. State Medicaid programs will require that Medicaid providers offer these services, and Federal funds will pay for these services. The Smokers' Health Fund described below can serve as a potential funding source. Beneficiaries will be made aware of this benefit change.

- The Secretary will direct that all individuals accessing healthcare from federally- funded clinics such as community and migrant health centers and tribal clinics receive evidence-based counseling and FDA-approved medications to treat tobacco dependence consistent with the PHS Clinical Practice Guideline at no cost. This will be a federally-funded mandate for these healthcare facilities, and the Smokers' Health Fund described below can serve as a potential funding source.

Statement of Need:
Extending tobacco treatment insurance coverage to all federally-covered lives is recommended by the Subcommittee for several reasons:

- First, this action will ensure that a large proportion of the U.S. population (approximately 100 million individuals and their families) has effective and comprehensive insurance coverage for the treatment of tobacco dependence. Covered lives would include Medicaid and Medicare beneficiaries, Department of Defense beneficiaries, persons covered by the Department of Veterans Affairs, Federal employees (Federal Employee Health Benefits Program), and individuals receiving healthcare at federally-funded clinics.

- Second, the basic benefit components of these insurance plans frequently serve as a model for other insurers, thereby potentially expanding the number of individuals receiving insurance coverage for the treatment of tobacco dependence.

- Third, these actions will help DHHS address health disparities pertaining to tobacco use by serving populations that are socioeconomically disadvantaged or that suffer disproportionately from smoking related death and disability (e.g., Medicaid beneficiaries, veterans, those receiving healthcare from federally-funded clinics such as community and migrant health centers and tribal clinics). Therefore, this recommendation addresses health disparities resulting from tobacco use.

- Finally, the provision of tobacco use treatment through enhanced support for federally-supported health programs is not only justified from a clinical and public health perspective, but it makes economic sense as well. For instance, in the context of total spending for either Medicare or Medicaid, the costs of offering a tobacco cessation benefit are reasonable. The estimated costs for tobacco dependence counseling as a Medicare benefit represent about one-half of one percent of current program spending. Such costs could be substantially offset by non-program savings due to the prevention of acute illnesses such as infections and peptic ulcer disease and due to the prevention of chronic illnesses such as coronary heart disease, asthma, diabetes, stroke, COPD, and cancer.

One might ask why it would be advantageous to cover tobacco use interventions through health insurance programs if counseling and medications are made available through a national quitline. There are several reasons to support this recommendation. First, healthcare delivery constitutes a “teachable moment.” That is, for many tobacco users, tobacco use treatment will be more effective if it occurs in a healthcare context. This is because of the ability of physicians and other clinicians to influence health decisions and the fact that the patient’s tobacco use can be related directly to their health problems and concerns (e.g., asthma, diabetes, heart disease). Previous research shows consistently that tobacco dependence treatment that occurs in the context of healthcare delivery is highly effective. Additionally, there is a strong dose-response relationship between treatment intensity and treatment success. Since many intense treatments involve in-person treatment, availability through a health insurance plan will increase the likelihood that smokers will take advantage of these services. Finally, the success of a national action plan for cessation will be enhanced if it is comprehensive and provides tobacco users with evidence-based treatment at varied levels of intensity.

Supporting Evidence:

- There is a large and compelling body of evidence that:
  - tobacco use treatments (counseling and medications) exist that are highly effective in the clinical practice setting;

- their use is highly cost effective relative to other common preventive medical interventions; and
- lack of insurance coverage and lack of availability serve as barriers to the use of these treatments.

- The PHS Clinical Practice Guideline showed that system level changes that promote access to tobacco dependence treatments increase the use of such treatments.

- The PHS Clinical Practice Guideline recommended that all insurance plans include as a reimbursed benefit, effective counseling and medications in order to increase treatment utilization.

- The Guide to Community Preventive Services recommends reducing patient out-of-pocket costs as a way to increase cessation.

- The PHS Clinical Practice Guideline recommends that clinicians should be reimbursed for providing tobacco dependence treatment just as they are reimbursed for treating other chronic medical conditions.

- Estimates are that if effective tobacco cessation treatment benefits are provided to all Medicare and Medicaid beneficiaries, over half-a-million individuals will be saved from premature death due to tobacco use, and that ultimately Medicare, Medicaid and non-government savings would exceed $800 million. Savings in lives and costs should be even greater when other federally-covered lives are included (e.g., veterans).

- Many individuals who provided testimony to the Subcommittee recommended that the Department require coverage for effective tobacco dependence treatment by all federally-funded healthcare programs under its purview, and work in partnership with federally-funded programs that are not under its direct purview to ensure that such coverage is in place. Some of the key messages provided to the Subcommittee during the public hearing were: there is a pressing need for the Federal government to lead by example; barriers to treatment must be eliminated; and Federal action is needed to address health disparities related to tobacco use.

Cost and Funding Source:
The cost of such a benefit, based on the extant literature, could range from $0.47 to $0.73 per member per month (in 1998 dollars), or from $0.22 to $0.34 per enrollee per month (in 1993-1994 dollars). The Smokers' Health Fund mentioned below could serve as a source of funding for this initiative. Alternatively, DHHS could propose funding these activities as new initiatives beginning in FY 2005.

Recommendation: Invest in a new, broad, and balanced research agenda (basic, clinical, public health, translational, dissemination) by FY 2005 to achieve future improvements in the reach, effectiveness and adoption of tobacco dependence interventions across both individuals and populations.

Action Steps:
- DHHS will establish and fund a new research initiative, housed at Federal research agencies, with the goals of increasing long-term successful cessation rates to at least 50%, reducing disparities in cessation rates, and training new tobacco scientists.

- As part of this research initiative, DHHS should establish and maintain approximately 30 Centers for Tobacco Dependence Research. This number reflects the Subcommittee's appraisal of the availability of scientists to staff such Centers, future tobacco research training needs, and the magnitude of effort required to achieve marked new successes in tobacco dependence research. This initiative should be managed by the Federal research agencies (e.g., NIH, AHRQ, CDC) with first grants awarded in 2005. If established, the Centers for Tobacco Dependence Research will provide an infrastructure to ensure that treatments are highly effective, as well as widely available and accessible at both the individual and population levels.

Statement of Need:
The steps recommended in the National Action Plan for Tobacco Cessation will produce immediate reductions in tobacco use and these reductions will be followed by profound reductions in tobacco-related death and disease. However, these accomplishments will not ensure cumulative progress in the campaign to eliminate tobacco dependence and its consequences. Only the funding and support of a broad and balanced set of research initiatives will improve treatments for tobacco dependence and train the next generation of tobacco scientists.

While funding is currently available for tobacco dependence research from such agencies as the National Institutes of Health and the Centers for Disease Control and Prevention, the Subcommittee believes that optimal progress in understanding and treating tobacco dependence, including all facets of research (basic, clinical, public health, translational, and dissemination), requires a substantial investment of new research dollars. One specific means of ensuring that these new research endeavors are maximally effective is through a new initiative to establish and maintain approximately 30 Centers for Tobacco Dependence Research, housed within Medical Schools, Schools of Public Health, Universities, and other public domain research centers across the U.S including institutions that train historically underrepresented health professionals. Current research support is not adequate to achieve sufficiently rapid progress in tobacco dependence science. Funding is too limited given the enormity of the health and economic impact of tobacco use. The Subcommittee believes that ensured five year renewable funding for Centers for Tobacco Dependence Research will result in more ambitious, comprehensive and programmatic science on tobacco dependence and its treatment. In this way, progress can be made towards achieving two specific goals outlined by the Subcommittee. First, within 10 years to develop interventions that produce long-term success in over 50% of smokers treated in a given quit attempt. Second, within 10 years to identify treatments for underserved tobacco-users including adolescents, racial and ethnic minorities, pregnant smokers, highly addicted smokers, and those with other addictions or psychiatric comorbities. Thus far, little research has been conducted on targeted or specially tailored treatments aimed at members of these populations who are tobacco dependent.

Supporting Evidence:
- Current treatments for tobacco dependence, while more effective than unassisted quit attempts, still result in only 10% to 30% of smokers achieving long-term success. These quit rates, while comparable or superior to the effectiveness of treatments for other chronic diseases, discourage some clinicians from more actively intervening in tobacco dependence. Failure also discourages smokers from making new quit attempts. Smokers typically wait months or years to mount a new quit attempt following a failure.

- The population and clinically based strategies outlined in this action plan (e.g., the quitline, the mass media campaign) will yield tremendous public health benefits, but a substantial number of current smokers will not quit successfully even with such interventions. This is because certain populations either are not aided by current treatments, or are not adequately exposed to them. For example, treatments may not be adequately accessible to certain populations, or these populations may not have adequate information and motivation to seek treatment and benefit from it. Populations that are less likely to benefit from current treatments include, among others, those with psychiatric comorbidities (e.g., psychosis, depression), pregnant women, racial and ethnic minorities, adolescent smokers, and individuals with very high levels of nicotine dependence.

- Both the PHS Clinical Practice Guideline and the Guide to Community Preventive Services identified many future research questions pertaining to successful treatment of tobacco dependence that, if answered, could dramatically improve cessation rates and reduce health disparities due to tobacco use.

- The Subcommittee received testimony documenting the need for an enhanced research agenda for tobacco dependence treatment. This testimony recommended research addressing priority populations, including but not limited to racial and ethnic minorities, low-income smokers, youth, and pregnant smokers. Additionally, many individuals cited the need for improved cessation treatment effectiveness.

Cost and Funding Source:
These Centers would be awarded grants on a competitive basis involving peer review, and each Center would be funded via five-year renewable grants with a budget of approximately $15 million/year. Based on testimony and the cost of similar programs, the total funding required to implement this recommendation would be about $500 million per year. The Smokers' Health Fund mentioned below could serve as a source of funding for this initiative. Alternatively, DHHS could propose funding these activities as new programs beginning in FY 2005.

Recommendation: Invest in training and education by FY 2005 to ensure that all clinicians in the United States have the knowledge, skills and support systems necessary to help their patients quit tobacco use.

Action Steps:
- The Secretary of Health and Human Services should convene a group of experts, representing universities, healthcare professional schools, education scientists, tobacco researchers, clinicians and others, to ensure that competency in the evidence-based treatment of tobacco dependence is a core graduation requirement for every new physician and other key healthcare professionals (e.g., nurses, nurse practitioners, physicians assistants, dentists, dental hygienists, pharmacists, clinical psychologists) in the United States beginning with the incoming health professions classes of 2004.

- DHHS will give grants to medical and other healthcare professions schools to develop, implement and evaluate curricula for evidence-based treatment of tobacco dependence for healthcare professions students. The goals of such training will be broad and will establish a standard of care for treating and referring patients who use tobacco. Curricular components will include how to intervene effectively with tobacco using patients, how to implement systems changes to facilitate intervention, and how to access more intensive services for their patients.

- DHHS will partner with healthcare professions organizations and licensing bodies to ensure that licensure and certification examinations for healthcare professionals are modified to include assessments of knowledge on treatment of tobacco dependence.

- DHHS will give grants to medical and healthcare professions schools to develop and evaluate advanced curricula for evidence-based treatment of tobacco dependence for tobacco dependence treatment specialists.

- DHHS will fund a research initiative to promote the development of uniform standards in training and certification of tobacco treatment specialists and measure the effectiveness of these standards and certification programs in the delivery of tobacco dependence treatments.

Statement of Need:

Clinicians-in-training and Practicing Clinicians: During the public hearings, the Subcommittee heard from healthcare professionals, students, and others about the lack of availability of training in the treatment of tobacco dependence. Although research has questioned the long-term benefits of tobacco cessation training in the absence of systems-level changes, many individuals providing testimony recommended that the Department take action to ensure that all healthcare professionals receive training in the delivery of evidence-based tobacco dependence treatment. A substantial body of evidence shows that many clinicians believe that they are not adequately trained, which likely has an adverse impact on intervention with patients who use tobacco.

Tobacco Cessation Specialists: U.S. Public Health Service guidelines recommend that clinicians not only provide advice and brief interventions to their patients who smoke, but also refer patients for follow-up care by those who specialize in the treatment of tobacco dependence. An infusion of new resources to support tobacco cessation as described in this National Action Plan will create a demand for services from specialists, who will need advanced training in behavioral treatment, pharmacotherapy, relapse prevention, and smoking cessation in special populations such as pregnant women, adolescents, and persons with co-morbidities including psychiatric illness and other chemical dependencies. Quitline counselors may also require this specialized training. Programs must be developed to train these specialists, and such programs should be available regionally or at the state level. Ongoing training opportunities would ensure that specialists keep abreast of state-of-the-art treatment as new research findings and new cessation products become available.

Certification: Certification is one strategy that could assure that specialists have the competencies needed to delivery evidence-based treatment. The evidence base regarding the effectiveness of certification is currently limited.

Supporting Evidence:

- The PHS Clinical Practice Guideline states that both clinicians and clinicians-in-training should be trained in the delivery of evidence-based tobacco dependence treatment to improve clinician knowledge and help remove barriers to intervening with patients who use tobacco.

- The Guide to Community Preventive Services states that multicomponent interventions, consisting of both provider education programs and provider reminder systems, increase successful cessation.

- The PHS Clinical Practice Guideline also identified several research questions with regard to clinician training and supportive healthcare system changes that, if answered, could dramatically enhance existing and new clinician training programs.

Cost and Funding Source:
The total funding required for this training initiative is approximately $500 million per year, with half ($250 million) to fund training within the 145 accredited allopathic and osteopathic medical schools in the U.S. and half ($250 million) to fund training within other healthcare professional schools. The Smokers' Health Fund mentioned below could serve as a source of funding for this initiative. Alternatively, DHHS could propose funding these activities as new programs beginning in FY 2005.

Recommendation: Establish a Smokers' Health Fund by FY 2005 by increasing the Federal Excise Tax on cigarettes by $2.00 per pack (from the current rate of $0.39 to $2.39) with a similar increase in the excise tax on other tobacco products. At least 50% of the new revenue generated by this tax increase (at least $14 billion of the estimated $28 billion generated) should be earmarked to pay for the components of this action plan.

Action Steps:
- By FY 2005, the Federal excise tax on cigarettes will be increased by $2.00 per pack (from the current rate of $0.39 to $2.39). The Federal excise tax on other tobacco products will also be increased by a similar proportion.

- By FY 2005, Federal legislation, modeled on the Highway Trust Fund, will establish a Smokers' Health Fund, earmarking at least 50% of the revenue generated by the $2.00 per pack excise tax increase (at least $14 billion of the estimated $28 billion generated) to pay for other components of the National Action Plan for Tobacco Cessation.

Statement of Need:
There are two reasons to increase the Federal excise tax on tobacco products. First, a significant increase in the excise tax will directly reduce smoking prevalence and will therefore reduce the harm caused by tobacco use. Second, the proposed tax, by itself, will raise sufficient monies to fund all other plan elements; i.e., this plan will be self-funded in that one element of the plan, the excise tax increase, will fund all other elements. Certainly other plan elements could be funded through sources other than the excise tax increase and these elements would yield significant public health benefit without the excise tax increase. However, the excise tax increase has the following virtues: (1) of all the recommended components of the National Action Plan for Tobacco Cessation, research suggests that the excise tax increase would have the largest immediate impact on tobacco use; (2) it would pay for all other plan elements; and (3) it would satisfy the need expressed repeatedly in public testimony for a stable, dedicated funding source for tobacco cessation initiatives.

Supporting Evidence:
- *Impact on Cessation:* A great body of research shows that increases in cigarette taxes and price lead to reductions in cigarette purchases and smoking. This research shows that each ten percent increase in price results in about a four percent decrease in overall cigarette consumption. This reduction is due to smokers quitting, former smokers not restarting, reductions in amount smoked by those continuing to smoke, and youth not becoming smokers.

- *Regressivity of Tobacco Use and Tobacco Caused Harms:* The morbidity and mortality that result from tobacco use are disproportionately felt among the economically disadvantaged and among certain racial and ethnic minorities in the United States because of their higher rates of smoking. As a result, in our society today, these groups experience much higher rates of illness and death caused by tobacco. Therefore, efforts to discourage tobacco use will disproportionately benefit these individuals at risk. Consistent with economic theory and existing evidence, raising the price of tobacco increases quit rates disproportionately among those with fewer financial resources. Research shows that smokers with family incomes below the median are at least four times more sensitive to price than are those with incomes above the median. Similarly, teenage smokers are about three times more sensitive to price increases than are adult smokers, with each ten percent increase in cigarette price leading to a reduction in smoking prevalence of nearly seven percent.

- *Impact on Prevalence and Consumption:* Available data suggest that a $2.00 per pack increase in the Federal cigarette excise tax would reduce total cigarette sales by over four billion packs each year, and would, by itself, achieve a 10% reduction in adult smoking prevalence; an estimated 4.7 million smokers would quit in response to such a tax increase.

- *Impact on Youth Smoking:* Available data suggest that this tax increase would deter an estimated 6 million current youth from becoming regular smokers as adults.

- *Impact on Mortality:* The estimated benefits of such smoking reductions are profound; a $2.00 per pack tax increase would likely prevent 3 million premature deaths (due to smoking cessation and prevention of smoking initiation). Importantly, any significant increase in the tobacco excise tax would produce substantial public health benefit. For instance, it is estimated that a $1.00/pack increase would lead more than 2.3 million current smokers to quit and prevent nearly 1.5 million premature deaths in the U.S. and a $3.00/pack increase would lead more than 7 million current smokers to quit and prevent nearly 4.4 million premature deaths.

- *Impact as Part of a Comprehensive Program:* Empirical evidence strongly supports the finding that combining an excise tax increase with a comprehensive program results in a sustained decline in tobacco use prevalence. The experience of states such as California and Massachusetts demonstrates the importance of coupling cigarette excise tax increases with funding for comprehensive tobacco control programs. When implemented, this comprehensive strategy has resulted in a greater impact by both reducing overall consumption and slowing smoking initiation among young people. Unfortunately, few states have such programs, and it is unlikely that many states will devote the resources required to achieve meaningful tobacco reduction. In fact, many states, in order to address their unanticipated budget deficits, have reduced or eliminated the allocation of Master Settlement Agreement funding or other state funds dedicated to tobacco control.

- *Public Support for a Cigarette Excise Tax Increase:* National survey data show that the American public will support an increase in the cigarette excise tax if the revenues are dedicated to helping smokers quit and preventing kids from starting to smoke. In written testimony provided to the Subcommittee, the Campaign for Tobacco-Free Kids cited data from a survey conducted in 2002 indicated that 61% of a random sample of adult Americans would favor a "$2 increase in the Federal excise tax on cigarettes to discourage kids from starting to smoke with the revenue used to provide every smoker who wants to quit with the full range of smoking cessation products and services to help them succeed."

- *Potential of a Dedicated Tobacco Excise Tax Increase to Pay for a Comprehensive Federal Program to Help Smokers Quit – The Smokers' Health Fund:* A secure Federal funding source linked to the sale of tobacco is an ideal mechanism to pay for elements in the National Action Plan for Tobacco Cessation in that both the level of funding and the need for the programs will decline over time as tobacco use declines. Moreover, Federal statutory mechanisms are available to ensure that the funding for these programs is permanently earmarked and not subject to year-to-year budgetary consideration. The model for such a secure source of funding is the Highway Trust Fund where a proportion of revenue from Federal gasoline taxes is earmarked exclusively for highway building and maintenance. By similarly and permanently earmarking at least 50% of the funds generated by a $2.00 per pack increase in the Federal cigarette excise tax (and a similar increase in the excise taxes for other tobacco products), a Smokers' Health Fund can be secured that will pay for the science-based programs outlined in this action plan. As a result of this mechanism, for the first time, smokers can be assured that a portion of the tax revenue that they generate will be dedicated to helping them quit through direct services, treatment, and cutting-edge research.

- *Overall Economic Impact:* Testimony before the Subcommittee indicated that, as a result of the $2.00 per pack excise tax increase and the resultant decline in tobacco consumption, there would be a substantial decrease in smoking-caused healthcare and other costs, both public and private. Given that the estimated economic burden resulting from tobacco use is currently more than $150 billion per year in the U.S., the potential economic savings from a 10% or greater decline in smoking prevalence could be substantial.

- *Economic Impact on the States:* Testimony before the Subcommittee reported that a $2.00 per pack increase in the cigarette excise tax and the resultant decline in consumption would impact state revenues. Totaling the impact across all 50 states, there would be an estimated $2.2 billion decline in state excise tax revenue, a $1.6 billion decline in Master Settlement Agreement payments, and a $0.9 billion increase in state sales tax revenue for a net revenue impact of $3.0 billion less received by the states per year. Of course, such a decline in prevalence will provide other significant economic benefits to the states including reduced health care expenditures and improved workforce productivity. Moreover, funds from the tax increase could be used to offset all or part of this decline in state revenue.

- *Tax as a Percentage of Retail Price:* Taxes imposed on cigarettes in the U.S. are much lower, relative to the retail price of cigarettes, than those in most other developed countries. In 2002, taxes accounted for approximately 30% of the average retail price of cigarettes in the U.S., compared to approximately 70-80% in most other developed countries. If the federal cigarette excise tax were increased by $2.00 per pack, then the proportion of the average retail price devoted to taxes would rise to about 54%.

- *Revenue Generation:* Testimony to the Subcommittee indicated that an estimated $28 billion in new Federal tax revenues would be generated by a $2.00 per pack increase in the cigarette excise tax. Additional revenue would be generated by the similar excise tax increases on other tobacco products. This revenue could then be used to fund the other elements of this comprehensive action plan for tobacco cessation such as a national quitline and mass media efforts to curb tobacco use. Research indicates that each element of the National Action Plan for Tobacco Cessation will produce significant and sustained decreases in tobacco use. Therefore, along with the excise tax increase, all plan elements will continue to reduce tobacco-related death and disease as long as they are in place.

Public-Private Partnership Opportunities

Recommendation: The Secretary will challenge and engage all insurers, employers, and purchasers that pay for or provide health coverage to include barrier-free coverage for evidence-based tobacco dependence treatment (counseling and pharmacotherapy) as part of the basic benefits package offered to all individuals and groups seeking insurance coverage.

Action Steps:

- Consistent with the PHS Clinical Practice Guideline recommendations, the Secretary will advocate for health insurance coverage of tobacco dependence treatment as part of the basic benefits package (both medical and dental) and urge purchasers to inform their employees of the availability of such coverage.

- The Secretary will issue a challenge to Fortune 500 companies to show leadership by covering barrier-free tobacco use treatment within their basic benefits packages and to inform their employees of the availability of such coverage.

- DHHS will bring together leading insurers and employers for roundtable discussions on incorporating tobacco dependence treatment into all basic insurance benefits packages.

- DHHS will work with insurers and employers to identify best practices and model programs for offering comprehensive, evidence-based treatments. These model programs should address concerns raised by insurers and employers (e.g., costs, turnover).

- DHHS will fund research to monitor the impact of cessation coverage on employer and insurer costs.

- DHHS will establish a recognition program to highlight the accomplishments of insurers, employers and labor unions with regard to evidence-based tobacco dependence treatment.

- DHHS will award grants or support tax incentives to employers and labor unions to establish and evaluate evidence-based tobacco cessation programs.

Statement of Need:
The evidence is clear and compelling that using evidence-based treatments (both counseling and pharmacotherapy) dramatically increases the likelihood of a successful cessation attempt. Yet, in many instances, the health insurance sector does not include coverage for tobacco dependence treatments as part of basic benefit packages offered to subscribers. Employers are also key stakeholders in the effort to promote tobacco use cessation. They have a significant fiduciary interest in this issue as they purchase the majority of private health insurance in the United States. Moreover, employers bear a significant cost due to employee tobacco use (i.e., reduced productivity, increased absenteeism, increased healthcare costs). Therefore, they have a major interest in the types of programs and services that are offered to employees as part of their benefits packages.

Supporting Evidence:

- A way to significantly increase the use of effective cessation treatments and increase the number of successful quitters is to ensure that insurance covers the cost of tobacco

cessation services. The Healthy People 2010 goals call for universal insurance coverage, both public and private, of evidence-based treatment for all patients who smoke.

- A study that ranked preventive services based upon the disease impact, effectiveness of treatment, and cost-effectiveness of treatment found that tobacco use treatment delivered in healthcare settings by healthcare providers was the top-ranked preventive service for adults (and second overall), and yet was the least provided top-ranking service.

- The PHS Clinical Practice Guideline reviews the strong empirical evidence regarding the efficacy of tobacco dependence medications and clinician's counseling to quit.

- The Guide to Community Preventive Services states that there is substantial scientific evidence that reducing out-of-pocket costs for effective cessation therapy increases utilization of therapy as well as rates of tobacco cessation.

- In addition to improving the health of employees, providing coverage for tobacco dependence treatment will result in lower rates of absenteeism and lower utilization of healthcare resources.

Recommendation: The Secretary will advocate for systems-level changes and quality improvement strategies to expand the delivery of evidence-based tobacco dependence treatments and engage decision-makers in the public and private sectors to achieve those aims.

Action Steps:

- DHHS will work in partnership with all health care stakeholders including managed care organizations, hospitals, integrated delivery systems, medical groups, other health care providers and federally-funded clinics to ensure that systems changes are implemented that encourage use of effective tobacco dependence treatments. These changes include: implementing tobacco-user identification and reminder systems; providing education and resources to providers to intervene effectively with patients; dedicating staff to providing tobacco dependence treatment; and promoting hospital policies to support and provide tobacco dependence treatment in the inpatient setting.

- DHHS will provide technical assistance funding to healthcare organizations and institutions to design, implement and evaluate systems-level strategies that promote tobacco dependence treatment.

- The Secretary will advocate for the adoption of the systems-level strategies outlined in the PHS Clinical Practice Guideline and encourage healthcare organizations and health insurers to adopt these steps to improve the health of their patients and enrollees.

- The Secretary will direct federally-funded clinics to adopt systems-level strategies outlined in the PHS Clinical Practice Guideline to improve the health of their patients.

Statement of Need:

Traditionally, efforts to increase tobacco use intervention in the healthcare setting have targeted the individual clinician. However, to be truly effective, cessation interventions need broad support and participation from all stakeholders (managed care organizations, hospitals, medical groups, federally-funded health centers, integrated delivery systems, and other health care

organizations such as medical specialty societies) throughout the healthcare system. A repeated theme in public testimony was the need for technical assistance and funding to create, implement and evaluate the office, practice, and organizational systems of care required for the delivery of evidence-based tobacco dependence treatments.

Supporting Evidence:

- The PHS Clinical Practice Guideline states that the influence of healthcare system administrators, insurers and purchasers can be used to encourage and support the consistent and effective identification and treatment of tobacco users.

- The PHS Clinical Practice Guideline identifies several system-level strategies to foster the delivery of evidence-based tobacco dependence treatment. These strategies include: implementing tobacco-user identification systems; providing education and resources to providers to effectively intervene with patients; dedicating staff to provide tobacco dependence treatment; and promoting hospital policies to support and provide tobacco dependence treatment in the inpatient setting.

- The PHS Clinical Practice Guideline found that reminder systems tripled the rate at which clinicians intervened with smoking patients; the Guide to Community Preventive Services also found that reminder systems increase the provision of advice to quit smoking.

- The Institute of Medicine (IOM) report *Crossing the Quality Chasm: A New Health System for the 21st Century* emphasizes the critical requirement for systems-level changes to close gaps between best practice care and usual care that exist for many healthcare problems, including tobacco dependence treatment.

- In the IOM report *Priority Areas for National Action: Transforming Healthcare Quality*, the IOM selected "tobacco dependence treatment in adults" as one of the top 20 priorities for national healthcare quality improvement, citing specifically the need to improve systems of care for the delivery of tobacco cessation counseling in pregnancy.

Recommendation: The Secretary will work in partnership with national quality assurance and accreditation organizations and other healthcare stakeholders to ensure that provision of evidence-based tobacco dependence treatment is established as a standard of care and is measured uniformly in all healthcare delivery settings.

Action Steps:

- DHHS should continue to work with key accreditation and quality assurance organizations such as the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to establish and refine performance measures for provision of tobacco cessation services.

- DHHS should call on JCAHO and other accrediting bodies to include provision of PHS recommended tobacco dependence assessment and intervention services in their accreditation standards.

- DHHS should bring together a roundtable of healthcare system leaders to discuss how to develop quality assurance programs focused on incorporating cessation into routine clinical care.

Statement of Need:
The evidence is clear and compelling that using evidence-based treatment (both counseling and pharmacotherapy) dramatically increases the likelihood of a successful cessation attempt.

The establishment of performance measures is critical to foster the implementation and evaluation of systems changes to promote the provision of tobacco cessation services. However, at present the provision of effective tobacco cessation interventions is not consistently and universally assessed in healthcare settings. The development and use of standardized performance measures will help health systems establish baseline levels of performance, determine areas for improvement, and evaluate the impact of quality improvement efforts. Such activities should encompass both outpatient and inpatient healthcare settings to ensure a comprehensive understanding of the delivery of tobacco dependence treatment.

Supporting Evidence:
- The National Committee for Quality Assurance's report on "The State of Managed Care Quality, 2001" indicates that in 2000, only 66% of smokers aged 18 years and older in the "average managed care plan" were advised to quit during a visit with their physician.

- According to the Surgeon General's 2000 report on tobacco use, only 15% of smokers who saw a clinician in the past year were offered assistance with quitting, and only 3% were given a follow-up appointment to address the problem. In 1992, about half of all adult U.S. smokers visited a dentist, but only 25% were advised to quit by their dentist.

- The PHS Clinical Practice Guideline recommends that every clinic implement an office-wide system that ensures that every patient at every visit has his or her tobacco use status queried and documented.

- The Guide to Community Preventive Services recommends the implementation of systemic efforts to identify tobacco using patients, prompts for providers to address tobacco use with their patients and advise them to quit, or a combination.

Recommendation: The Secretary will initiate and support partnerships between DHHS and community organizations (e.g., schools, employers, voluntary health agencies, and faith-based organizations) to put in place programs and policies that foster tobacco users' motivation to quit, success in quitting, and use of evidence-based treatments, and that address disparities in treatment participation and success.

Action Steps:
- DHHS will award grants to enable community-based public-private partnerships or coalitions to strategically supplement the cessation policies, campaigns and treatment services available through state and national tobacco control programs, and through the national Quitline and other activities proposed in this Action Plan. Funded efforts should address community-level disparities in tobacco use and quit rates, and maximize the reach and impact of effective cessation interventions.

- DHHS will awards grants to monitor and evaluate the impact of comprehensive community cessation initiatives on community smoking prevalence and quit rates, especially in traditionally underserved populations.

- DHHS will establish a recognition program to highlight the accomplishments of community-based public-private partnerships, and to stimulate replication of effective model efforts.

- The Secretary will challenge employers and businesses to demonstrate leadership by expanding their existing smoking restrictions and bans, and supporting efforts in the communities where they operate by helping to shape and finance local efforts to raise motivation to quit using tobacco and improve awareness and use of evidence-based tobacco dependence treatments.

Statement of Need:
Recognizing that Federal, state and local governments and private sector stakeholders all have important authorities, responsibilities and resources, community-level partnerships among them can broaden the leadership and resources for local cessation policies and campaigns, particularly to promote and provide effective treatment services for underserved minority and low-income populations. Focusing at the community level cannot be overlooked because municipalities and local health departments, healthcare organizations, and employers have jurisdiction over many of the decisions that can make tobacco cessation cues and supports persistent and accessible. Furthermore, community partnerships are essential for tailoring national and state-level programming to local needs.

A recurring recommendation in testimony provided to the Subcommittee was to strengthen supportive environments for cessation in communities, schools and worksites, and to improve treatment demand, access and use. The need for community-based campaigns to spur use of quit lines and healthcare-based tobacco dependence treatment was noted, especially for targeted outreach efforts. Many also stressed the need to supplement quit line and healthcare-based tobacco cessation services with smoking cessation counseling programs located in alternative delivery sites (e.g., schools, worksites, cultural centers, tribal centers and faith-based organizations), especially to reach underserved youth, racial and ethnic minorities, blue-collar and low-income populations, and tobacco users with limited access to the healthcare system. And, many who testified emphasized the need for and the power of clean indoor air laws to create social norms and smokefree environments to bolster tobacco users' motivation and support to quit and stay quit.

Supporting Evidence:
- Growing evidence supports the need for local public-private partnerships and coalitions to integrate a variety of quitting policies and programs at the community level, making quitting cues persistent and inescapable and assuring that no tobacco user is left behind with respect to access to publicly- and privately-funded, effective treatment services available through national, state and local tobacco control initiatives. CDC's Best Practices for Comprehensive Tobacco Control Programs and Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs delineate opportunities at the state and local level for such policies and programs.

- The Guide to Community Preventive Services concludes that worksite and public smoking restrictions and bans reduce tobacco consumption and increase quit attempts and quit rates. Expanding smokefree worksites and public places help to shape an overall community environment that motivates and supports quitting and sustained abstinence.

- Health promotion campaigns are most effective when mass media messages are combined with interpersonal communications to change norms in communities and primary social networks. For example, a targeted cessation campaign designed to raise quitting motivation

and quit line calls among African American smokers combined paid and donated television and radio ads with efforts to disseminate cessation videotapes through influential community-based organizations in the African American community and proved successful in 7 northeastern, southeastern and southwestern communities. A similar public-private campaign targeting adolescent smokers in Tucson, Arizona significantly increased youth use of local quitting clinics and quit lines.

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Potential Conflict of Interest

Each member of the Subcommittee on Cessation was asked to disclose any potential conflicts of interest within the past three years in order to assure that the credibility of the Subcommittee, its report, and science itself is upheld.

Robert T. Croyle, Ph.D.: None.

Susan J. Curry, Ph.D.: Dr. Curry has served as a consultant, given presentations sponsored by, participated on advisory boards, or conducted grant reviews sponsored by MD Anderson Cancer Center, Duke University, Brown University, University of Wisconsin, Memorial Sloan-Kettering Cancer Center, National Cancer Institute, The Robert Wood Johnson Foundation, Research Triangle Institute, Center for the Advancement of Health, Society for Behavioral Medicine, Pinney Associates, Group Health Cooperative, Consumer Health Products Association. Dr. Curry is a member of the Scientific Advisory Board for Health Media, Inc., and is eligible to receive company stock as compensation for board service. She has not received any stock to date. Dr. Curry has received research funding as Principal Investigator from the National Cancer Institute, the National Institute on Alcohol and Alcoholism, the National Heart, Lung and Blood Institute, and The Robert Wood Johnson Foundation.

Charles M. Cutler, M.D. M.S.: None.

Ronald M. Davis, M.D.: Dr. Davis has received grants from the National Cancer Institute, Flight Attendants Medical Research Institute, Community Foundation for Southeast Michigan, and the Robert Wood Johnson Foundation. He has served as an expert witness for tobacco-related lawsuits. He serves on the Board of Trustees of the American Medical Association. Dr. Davis does not receive any personal income from any of these activities. All stipends or reimbursements are given to his employer (Henry Ford Health System).

Michael C. Fiore, M.D. M.P.H.: Dr. Fiore has served as a consultant, given lectures sponsored by, or has conducted research sponsored by GlaxoSmithKline, Pharmacia, Pfizer, and Sanofi-Synthelabo. In 1998, the University of Wisconsin (UW) appointed Dr. Fiore to a named Chair, made possible by an unrestricted gift to UW from GlaxoWellcome. Dr. Fiore has served as Principal Investigator or Co-Investigator on grants and/or contracts from the National Institutes of Health, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, and The Robert Wood Johnson Foundation.

Catherine Gordon, R.N. M.B.A.: None.

Cheryl Healton, Dr. PH: None.

Rosemarie Henson, M.S.S.W. M.P.H.: None.

Howard K. Koh, M.D., M.P.H., FACP: None.

James S. Marks, M.D. M.P.H.: None.

C. Tracy Orleans, Ph.D.: None.

Dennis Richling, M.D.: Dr. Richling has received honoraria for speaking engagements from Pfizer and Merck. On February 1, 2003, Dr. Richling joined the Midwest Business Group on Health as COO. The following organizations are members of this organization: Abbott Laboratories; AstraZeneca; Aventis; Bristol-Myers Squibb; Genentech; GlaxoSmithKline; Lilly; Pfizer; Pharmacia; Roche; and Schering-Plough.

David Satcher, M.D.: Dr. Satcher served as a fellow, Kaiser Family Foundation, March 2002-February 2003, is a Member, Board of Trustees, Johnson and Johnson; is a senior advisor, University of Rochester, Project Believe; and has a speaker's contract with American Program Bureau. Dr. Satcher served as Surgeon General and Assistant Secretary for Health from 1998-2002, and chaired the Interagency Committee on Smoking and Health during his tenure as Surgeon General.

John Seffrin, Ph.D.: None.

Christine Williams, M.Ed.: None.

Larry N. Williams, D.D.S. MAGD: None.