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HEALTH INSURANCE COVERAGE FOR TOBACCO DEPENDENCE

Part I. Background Literature Review, Legal and Policy Analysis

Ronald Scott, J.D., LL.M.
Phyllis Gingiss, Dr.P.H.

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Ron Scott, J.D., LL.M., is Research Professor, University of Houston Law Center, Health Law and Policy Institute. The author is presently working with the Texas Legislature on a variety of legal and policy issues related to health law and policy, with an emphasis on regulation of tobacco, telemedicine and e-healthcare issues.

Phyllis Gingiss, Dr.P.H. is Professor of Public Health Education, University of Houston, and Adjunct Professor of Family and Community Medicine, Baylor College of Medicine. She is Director of the Health Network for Evaluation and Training Systems (NHETS), University of Houston and serves as Principal Investigator for the Texas Tobacco Prevention and Control Research and Evaluation Project conducted at the University of Houston.

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I. Prologue

The respected U.S. Public Health Service 2000 Clinical Practice Guideline, *Treating Tobacco Use and Dependence*[1] (PHS Guideline) noted the following:

> In America today, tobacco stands out as the agent most responsible for avoidable illness and death. Millions of Americans consume this toxin on a daily basis. Its use brings premature death to almost half a million Americans each year, and it contributes to profound disability and pain in many others. Approximately one-third of all tobacco users in this country will die prematurely because of their dependence on tobacco. Unlike so many epidemics in the past, there is a clear, contemporaneous understanding of the cause of this premature death and disability—the use of tobacco.
>
> It is a testament to the power of tobacco addiction that millions of tobacco users have been unable to overcome their dependence and save themselves from its consequences: perpetual worry, unceasing expense, and compromised health. Indeed, it is difficult to identify any other condition that presents such a mix of lethality, prevalence, and neglect, *despite effective and readily available interventions*."[2]

II. Introduction

There are well-known and widely reported public health and economic consequences resulting from tobacco use.[3] And there are clearly medical and other benefits associated with cessation of tobacco use.[4] Reducing tobacco use benefits both individuals and society in a variety of significant, measurable ways.[5]

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[1] Fiore MC, Bailey WC, Cohen SJ et al. *Treating Tobacco Use and Dependence*, Clinical Practice Guideline. Rockville, Maryland: U.S. Dept. of Health and Human Services, Public Health Service (June 2000). [hereafter "PHS Guideline"]. The full text is available in PDF format at http://www.surgeongeneral.gov/tobacco/treating_tobacco_use.pdf. *See* Summary available at http://www.surgeongeneral.gov/tobacco/smokesum.htm [hereafter "PHS Guideline Summary"]..

[2] *Overview*, PHS Guideline Summary (emphasis added). For Texas data on health impact and costs resulting from tobacco use, see Adult Tobacco Use in Texas at www.cdc.gov/tobacco/statehi/pdf/tx_sh.pdf.

[3] *See generally The Complete Text of the Report of the Koop-Kessler Advisory Committee on Tobacco Policy and Public Health*, http://www.lungusa.org/tobacco/smkkoop.html.

[4] *See generally* PHS Guideline.

[5] *See generally* PHS Guideline.

Until recently, the *addictive* nature of tobacco was debated, at least by tobacco companies. Now, even the tobacco companies concede that their products are addictive.[6] In fact, "[m]ost smokers are addicted and meet diagnostic criteria for the medical disorder known as dependence in the *Diagnostic and Statistical Manual* of the American Psychiatric Association."[7] However, treatment for tobacco dependence is less likely to be covered by insurance than treatment for other addictions.

One objective in *Healthy People 2010* is to "[i]ncrease insurance coverage of evidence-based treatment for nicotine dependency to 100 percent."[8] Tobacco dependence is often not treated adequately in the health care setting, largely because insurers and other health care plans do not routinely reimburse providers for tobacco cessation therapy.[9]

Until recently, health care plans may have erroneously believed that tobacco cessation therapies are not effective—or at least not cost-effective. However, the release of the 2000 PHS Guideline now provides compelling evidence of the efficacy (medically and economically) of both pharmacotherapies and behavioral interventions.[10] Some performance measurements of health plan quality such as HEDIS now address availability of smoking cessation services, but mostly measure whether physicians advise

[6] *Tobacco Executives Admit Nicotine Is Addictive* at http://www.no-smoking.org/jan98/01-30-98-4.html.
[7] *Tobacco dependence treatment; scientific challenges; public health opportunities*, Tob. Control 2000;9 (Suppl. 1);i3-i10 (Spring).
[8] PHS Guideline at p. 42 *citing* US Department of Health and Human Services, Healthy People 2010 (Conference Edition, in Two Volumes). Washington DC. 2000.
[9] PHS Guideline at p. 41. *See generally* Susan J. Curry, Michael C. Fiore, Marguerite E. Burns, *Community-Level Tobacco Interventions*, *Perspective of Managed Care,* Am J Prev Med 2001;20(2S); Eric Aakko, Thom Piasecki, et al, *Smoking Cessation Services Offered by Health Insurance Plans for Wisconsin State Employees*, Wisconsin Medical Journal (Jan.-Feb. 1999); Lisa A. Faulkner, Helen Halpin Schauffler, *The Effect of Health Insurance Coverage on the Appropriate Use of Recommended Clinical Preventive Services*, Am J Prev Med 1997;13(6).
[10] Cost Effectiveness of Smoking Cessation Treatment, Section III (D) *infra*.

patients to quit.[11] In Texas and some other states, Medicaid provides more coverage for tobacco cessation pharmacotherapies than most private health care plans.[12]

Arizona, Michigan, and North Carolina have innovative programs that encourage health plans to *voluntarily* increase coverage for tobacco cessation treatment.[13] Michigan and North Carolina publish "report cards" that rate health plans on tobacco cessation services.[14] The Texas Cancer Plan concluded that pharmacotherapies should be covered by health plans for smokers who are trying to quit.[15] The Koop-Kessler report[16] and the PHS Guideline both recommend that states *require* health plans to provide better coverage for tobacco cessation treatment. Legislation to mandate coverage of smoking cessation programs was introduced in New York, Maryland, and Wisconsin[17] but failed to pass. A survey reported that California, Colorado, New Jersey, and North Dakota require private health insurers or MCOs to provide a smoking cessation benefit (as discussed more fully in Section VI (C) below), but a careful review of the statutory "mandates" shows they are quite limited in scope and application.[18]

A literature search revealed little data about the extent or nature of tobacco cessation treatment coverage by health plans in Texas. Therefore, the University of Houston Health Network for Evaluation and Training Systems (HNETS), Department of

[11] Health Plan Coverage of Smoking Cessation Therapy, Performance Measurements for Health Plans, Section V (A) *infra*.
[12] Medicaid Coverage, Section IV *infra*.
[13] Other State's Efforts to Promote Tobacco Cessation Services, Section VII *infra*.
[14] *Id.*
[15] Texas Cancer Plan (3d ed.1998) available at http://www.texascancercouncil.org/tcplan/goal1/goal1_objc_frames.html. (visited April 3, 2002). (hereinafter Texas Cancer Plan).
[16] *The Complete Text of the Report of the Koop-Kessler Advisory Committee on Tobacco Policy and Public Health*, http://www.lungusa.org/tobacco/smkkoop.html.
[17] S.B. 518, 414th Leg. (Md. 2000), S.B. 6461, 223rd. Leg. (N.Y. 1999), S.B. 115, (Wis. 1999).
[18] *See* Thomas J. Glynn, Dorothy K. Hatsukami, *Reimbursement for Smoking Cessation Therapy-A Healthcare Practitioner's Guide*, available at

Health and Human Performance is conducting a survey of Texas managed care organizations.[19]

III. PHS Clinical Practice Guideline

A. Summary

In 2000, the U.S. Public Health Service issued its updated Clinical Practice Guideline, *Treating Tobacco Use and Dependence* (PHS Guideline) "in response to new, effective clinical treatments for tobacco dependence that have been identified since 1994."[20] The PHS Guideline represents the efforts and research of several government and nonprofit organizations including the Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), National Cancer Institute (NCI), National Heart, Lung, and Blood Institute (NHLBI), National Institute on Drug Abuse (NIDA), Robert Wood Johnson Foundation (RWJF), and the University of Wisconsin Medical School's Center for Tobacco Research and Intervention (CTRI).[21]

The PHS Guideline concluded that treatment for dependence on tobacco often requires repeated intervention, but that effective treatments are available. The PHS Guideline addresses treatments for those patients seeking to quit tobacco use as well as those not yet committed to quitting. Further, it is recommended that health care providers should "institutionalize" the "identification, documentation, and treatment of every tobacco user seen in a health care setting."[22] Research documents that although brief

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http://www.endsmoking.org/resources/reimbursementguide/main.htm. *See also* Examples of State-Level Benefit Requirements, Section VI (C) *infra*.

[19] Texas Survey of Managed Care Organizations & Recommendations, Section VIII *infra*.

[20] PHS Guideline Summary. The new PHS Guideline updates a 1996 guideline issued by the Agency for Health Care Policy and Research (now Agency for Healthcare Research and Quality).

[21] PHS Guideline Summary.

[22] *Id*.

treatment may be effective, increased intensive counseling is more effective at ensuring long-term cessation efforts.[23]

A comparison of the 2000 PHS Guideline with the 1996 version found "considerable progress made in tobacco research over the brief period separating these two works."[24] Specifically, the 2000 PHS Guideline:

- provides increased evidence in favor of intensive counseling as well as evidence of the effectiveness of such counseling strategies as telephone counseling and programs that help smokers find support outside the treatment context;
- identifies seven effective drug therapies, thereby, giving patients and physicians more treatment options; and
- provides evidence that drug therapy and counseling smoking cessation treatments are as cost-effective as other medical interventions usually covered by health plans such as mammography screening.[25]

B. Pharmacotherapies

There are seven effective pharmacotherapies for smoking cessation treatment. Five are considered first line and two are second line approaches. In most cases, it is recommended that pharmacotherapy be used for every patient attempting to overcome tobacco dependence.[26] The PHS Guideline identified five "first line" drugs that "reliably increase long-term smoking abstinence rates."[27] The five drugs of choice are:

- bupropion SR;
- nicotine gum;
- nicotine inhalers;

[23] *Id*.
[24] *Id*.
[25] *Id*.
[26] *Id*.
[27] *Id*.

- nicotine nasal spray; and
- nicotine patch.

The only non-nicotine drug in the first line list is bupropion SR. It is the first FDA approved non-nicotine medication for smoking cessation.[28] Bupropion SR is a prescription medication marketed under two names: Zyban and Wellbutrin. Zyban is available for smoking cessation, and Wellbutrin is sold as a treatment for depression.[29] The PHS Guideline concluded "the use of bupropion SR approximately doubles long-term abstinence rates when compared to a placebo."[30]

Some of the nicotine replacement therapies are available via prescription, and versions of the nicotine gum and patch are also available over-the counter.[31] The PHS Guideline analyzed thirteen studies comparing the effectiveness of nicotine gum to a placebo. Nicotine gum improves long-term abstinence rates by 30 to 80 percent compared with placebo. Further, use of 4mg gum rather than the more common 2mg gum is more effective in assisting "highly dependent" smokers.[32] While nicotine gum is available over-the-counter, the nicotine inhaler is available only by prescription. Studies show that the nicotine inhaler is also an effective aid to cessation. It is more than twice as effective as a placebo inhaler in improving long-term abstinence rates.[33] Nicotine nasal spray, also available only by prescription, is similarly effective at improving long-

[28] PHS Guideline at p. 72.
[29] *Id*. at p. 72.
[30] *Id*.
[31] *Id*. at p. 72-75.
[32] *Id*. at p. 73
[33] *Id*.

term abstinence.[34] The nicotine patch is available over-the-counter as well as by prescription. Use also doubles long-term abstinence rates.[35]

Two "second-line" pharmacotherapies, clonidine and nortriptyline, were recommended for consideration where the first-line pharmacotherapies are ineffective in certain patients.[36] Although second-line approaches are effective, these drugs have more side effects and have not been approved by the FDA for smoking cessation. Nonetheless, a physician could legitimately prescribe these drugs on an "off-label" use based on existing research.[37]

C. Counseling And Behavioral Therapy

Although pharmacotherapies increase the success rate of tobacco cessation attempts, counseling is also an effective treatment option. The best results have been found when a combination of counseling and pharmacotherapies are provided. The PHS Guideline states that "treatments involving person-to-person contact (via individual, group, or proactive telephone counseling) are consistently effective, and their effectiveness increases with treatment intensity (e.g., minutes of contact)."[38]

Three types of counseling that have been proven particularly effective are recommended for every patient. These include:

- practical counseling teaching problem solving skills and training;
- intra-treatment social support; and

[34] *Id*. at p. 74.
[35] *Id*.
[36] *Id*. at p. 75-76.
[37] Physicians routinely prescribe drugs for uses not specifically recommended in the FDA approved labeling, where research indicates that such "off-label" use is likely to be safe and effective.
[38] PHS Guideline at p. iv.

- extra-treatment social support.[39]

Practical counseling helps patients recognize situations or activities that increase the risk of smoking or relapse, develop coping skills, and understand basic information about tobacco use and successful quitting. Intra-treatment interventions encourage the patient in the quit attempt, communicate the clinician's caring and concern, and encourage the patient to talk about the quitting process. Extra-treatment interventions train the patient in support solicitation skills, prompt support seeking, and sometimes involve the clinician arranging outside support.[40]

The common elements of practical counseling, intra-treatment and extra-treatment social support are shown in Appendix 1.[41] The three types of counseling illustrated in the Appendix 1 tables have been reported to statistically increase abstinence rates compared to no counseling.[42] A fourth type of therapy using aversive smoking procedures such as rapid smoking, rapid puffing, and other smoking exposure has also been proven effective in some cases, but is rarely used because of the associated adverse health hazards. However, aversion therapies rarely provide approaches for dealing with smokeless tobacco.

Counseling provides benefits in addition to those provided by drug therapy.[43] Practical counseling/general problem solving and extra-treatment social support counseling for smokers each increased the estimated abstinence rate by approximately 50%. Intra-treatment social support counseling increased the rate by approximately

[39] *Id*.
[40] *Id*. at p. 68.69.
[41] *Id*. (These tables are reproduced from Tables 21, 22 and 23).
[42] *Id*.
[43] *Id*. at p. 66.

30%.[44] It is therefore clear that behavioral interventions provide a component of support and interference with dependence that pharmacotherapies alone cannot provide.

The PHS Guideline found that "tobacco dependence treatments are both clinically effective and cost-effective relative to other medical and disease prevention interventions."[45] Therefore, the PHS Guideline recommends that all health insurance plans should "include as a reimbursed benefit the counseling and pharmacotherapeutic treatments identified as effective…"[46] Further, health care providers should be reimbursed for providing tobacco dependence treatment in the same manner as for treating any other chronic conditions.[47]

D. Cost-effectiveness of Smoking Cessation Treatment

"Tobacco dependence treatments are both clinically effective and cost-effective relative to other medical and disease prevention interventions."[48] The PHS Guideline includes the following findings:

> The smoking cessation treatments are shown to be efficacious … (both pharmacotherapy and counseling) are highly cost-effective relative to other reimbursed treatments (e.g., treatment of hyperlipidemia and mammography screening) and should be provided to all smokers.
>
> Intensive smoking cessation interventions are especially efficacious and cost-effective, and smokers should have ready access to these services as well as to less intensive interventions.[49]

Smoking cessation therapy can be extremely cost effective, and may be considered the "gold standard" of preventative interventions.[50] Stopping smoking can

[44] *Id*. at p. 66, Table 20.
[45] PHS Guideline Summary.
[46] *Id*.
[47] *Id*.
[48] PHS Guideline at p. 5. *See also* Cyril F. Chang, COVERING RISK BUT NOT RISKY BEHAVIORS; A Critical Review of the Arguments for Insurance Coverage for Smoking-Cessation Therapies, Managed Care (May 2001) available at http://www.managedcaremag.com/archives/0105/0105.peer_smoking.html.
[49] PHS Guideline at p. 111.

prevent heart disease, cancer, bronchitis, and other chronic diseases that are expensive for health plans to treat.[51]

Patients who stop smoking during their hospital stay require less expensive short-term care and fewer future hospitalizations.[52]

Since pregnant smokers are more likely to have low birth weight babies and a higher frequency of perinatal deaths, smoking cessation treatments can be very cost-effective for this population.[53] Children born to mothers that smoke also experience more "physical, cognitive and behavioral problems during infancy and childhood"[54] and side-stream smoke affects all children in the home. Of course, the mothers also benefit.[55]

Evidence indicates that intensive interventions are even more cost-effective than "low-intensity" interventions.[56] Properly implemented public health interventions are perhaps even more cost-effective than individual treatment.[57]

IV. Medicaid and Medicare Coverage

A. Introduction

Individuals obtain health insurance from a variety of governmental and private sources. Almost 40 million people have coverage through Medicare, a federal health

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[50] PHS Guideline at p. 111, *citing* Eddy DM, *David Eddy ranks the tests,* Harv Health Lett 1992;11 ("gold standard").
[51] PHS Guideline at p. 111.
[52] *Id*. *citing* Lightwood JM, Glantz SA, Circulation 1997;96(4):1089-96.
[53] PHS Guideline at p. 111.
[54] *Id*. *citing* Lightwood JM, Phibbs C, Glantz SA, *Short-term health and economic benefits of smoking cessation: low birth weight*, Pediatrics 1999;104(6):1312-20; Marks JS, Koplan JP, Hogue CJ, Dalmat ME, *A cost-benefit/cost-effectiveness analysis of smoking cessation for pregnant women,* Am J Prev Med 1990; 6(5):282-9.
[55] PHS Guideline at p. 111.
[56] *Id*. *citing* Cromwell J, Bartosch WJ, Fiore MC, Hasselblad V, Baker T, *Cost-effectiveness of the clinical practice recommendations in the AHCPR Guideline for Smoking Cessation,* Agency for Health Care Policy and Research. JAMA 1997; 278(21):1759-66.
[57] PHS Guideline at p. 111, *citing* Warner KE, *Cost effectiveness of smoking-cessation therapies. Interpretation of the evidence and implications for coverage*, PharmacoEconomics 1997;11(6):538-49.

insurance program. Medicare provides coverage for individuals 65 years of age and older who have paid sufficient Medicare taxes during their working years. However, Medicare does *not* currently cover over-the-counter or prescription drugs such as those used in treating tobacco dependence.[58] Although smoking cessation therapy is not covered by Medicare, a pilot program in Alabama, Florida, Missouri and Ohio will test strategies for helping Medicare beneficiaries quit smoking.[59] Nancy-Ann DeParle, HCFA administrator noted that"[i]f the demonstration proves successful in identifying the most effective ways to help seniors stop smoking, this could prompt Congress to consider a Medicare benefit to cover smoking cessation."[60]

The Medicare demonstration cessation project will test specific strategies for helping older people quit smoking in states selected because of the prevalence of smokers 65 years and over in their populations. These states include Alabama, Florida, Missouri and Ohio, with additional states to be determined later. Medicaid is a joint federal/state medical assistance program offering coverage for low-income individuals.[61] Since Medicaid is partially funded by state contributions, states have some latitude in deciding what coverage to offer, and some states do offer coverage for drugs that treat tobacco dependence.

[58] Medicare also covers some people with disabilities under 65 years of age, and people with End-Stage Renal Disease. *See* Medicare, *The Official U.S. Government Site for People With Medicare* at http://www.medicare.gov. Prescription drug coverage is sometimes available in Medigap insurance policies (supplemental insurance policies that cover expenses not paid by Medicare.) *See id*.
[59] Medicare Pilot Will Help Seniors Stop Smoking at http://cms.hhs.gov/media/press/release.asp?Counter=218.
[60] *Id*.
[61] *See* 42 U.S.C. § 1396 *et seq*.

B. Prescription And Over-The-Counter (OTC) Drugs

The federal law governing Medicaid permits states to exclude or restrict coverage of drugs used to promote smoking cessation.[62] The relevant provision was added by the Omnibus Budget Reconciliation Act of 1990 (OBRA). At the time OBRA was passed, only one prescription drug for smoking cessation (nicotine replacement therapy) had been approved by the federal Food and Drug Administration.[63] Smoking cessation products were generally viewed as ineffective.[64] In the past decade, there have been dramatic changes in the availability of effective pharmacological treatments for nicotine addiction. According to the CDC, in 1998 a total of 24 states chose to provide some coverage for smoking cessation treatments under their Medicaid programs.[65] On June 27, 2000, President Clinton issued a statement urging Congress to enact a budget proposal ensuring that every state Medicaid program covers both prescription and non-prescription smoking cessation drugs.[66] In 2000, the number of states offering some Medicaid coverage for

[62] 42 U.S.C. § 1396r-8(d). For an overview of coverage issues, s*ee generally* working Group on Tobacco Dependence Treatment Policy, *Grant Results Report*, June 1998, available at http://www.rwjf.org/health/029354s.htm.

[63] Kelly N. Reeves, *Medicaid Recipients Denied Coverage for Smoking Cessation Pharmacotherapy,* 2 J. HEALTH CARE L. & POL'Y 102, 108 (1998).

[64] *Id*.

[65] *State Medicaid Coverage for Tobacco-Dependence Treatments*—United States, 1998 and 2000, CDC MMWR November 9, 2001/ 50(44);979-982, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5044a3.htm (visited April 3, 2002). A PDF version of the report suitable for printing is available at http://www.cdc.gov/mmwr/PDF/wk/mm5044.pdf (visited April 3, 2002).

[66] *Statement by the President*. Issued by the White House Office of the Press Secretary, June 27, 2000, available at http://www.surgeongeneral.gov/tobacco/Pres062700.htm (visited Sept. 18, 2000). Legislation was introduced May 9, 2001 (Senate Bill 854, the Durbin-Brownback tobacco cessation bill) that would require states to provide Medicaid coverage for smoking cessation drugs by removing the current provision that makes coverage of smoking cessation drugs by states an optional benefit. See *Summary of the Durbin-Brownback Tobacco Cessation Bill (S. 854)* at http://tobaccofreekids.org/research/factsheets/pdf/0162.pdf. The last action on the bill was its referral to the Committee on Finance May 9, 2001. *See* http://thomas.loc.gov/.

tobacco cessation treatments increased to 33.[67] The following CDC chart shows Medicaid coverage for smoking cessation in 1998 and 2000.[68]

TABLE 1. Changes in state Medicaid program coverage of pharmotherapy and counseling for tobacco dependence — United States*, 1998 and 2000

State	Any treatment	Over-the-counter medication		Prescription medication						Counseling			
		Gum	Patch	Any	Spray	Inhaler	Zyban	Wellbutrin	Bupropion†	Any	Group	Individual	Telephone
Arizona	YES§	+¶	+	–**	—	—	–	—	—	+	+	+	—
Arkansas	+	—	—	+	—	—	+	+	—	—	—	—	—
California††	YES	YES	YES	YES	YES	YES	YES	+	+	–	—	—	–
Colorado††	YES	YES	YES	YES	YES	YES	YES	+	+	—	—	—	—
Delaware††	YES	+	+	YES	YES	YES	YES	+	+	—	—	—	—
District of Columbia	YES	—	—	YES	YES	—	YES	+	+	—	—	—	—
Florida	YES	YES	YES	YES	—	—	YES	—	—	—	—	—	—
Hawaii	+	—	—	+	+	+	+	+	+	—	—	—	—
Illinois††	+	+	+	+	+	+	+	+	+	—	—	—	—
Indiana††	+	+	+	+	+	+	+	+	+	+	—	+	—
Kansas	YES	—	+	YES	—	—	YES	+	+	+	+	+	—
Louisiana	YES	–	—	YES	YES	YES	YES	+	+	—	—	—	—
Maine††	YES	YES	YES	YES	YES	YES	YES	+	+	YES	YES	YES	—
Maryland	YES	—	—	YES	YES	YES	YES	+	+	X§§	X	X	—
Massachusetts	+	—	—	—	—	—	—	—	—	+	+	+	—
Michigan	YES	YES	YES	+	—	—	+	+	—	—	—	—	—
Minnesota††	YES	YES	YES	YES	YES	YES	YES	+	+	YES	YES	YES	—
Montana	YES	YES	YES	YES	—	—	YES	—	—	—	—	—	—
Nevada††	YES	YES	YES	YES	YES	YES	YES	+	+	—	—	—	—
New Hampshire††	YES	YES	YES	YES	YES	YES	YES	+	+	+	+	+	—
New Jersey††	YES	+	+	YES	YES	YES	YES	+	+	—	—	—	—
New Mexico††	YES	YES	YES	YES	YES	YES	YES	+	+	X	X	X	X
New York††	+	+	+	+	+	+	+	+	+	—	—	—	—
North Carolina	YES	—	—	YES	YES	YES	YES	+	+	—	—	—	—
North Dakota	YES	YES	YES	YES	—	—	YES	+	+	—	—	—	—
Ohio	YES	YES	YES	YES	—	YES	YES	+	+	—	—	—	—
Oklahoma	YES	—	—	YES	—	—	YES	+	+	—	—	—	—
Oregon¶¶	YES	YES	YES	YES	YES	YES	YES	+	+	YES	YES	YES	YES
Rhode Island	+	—	—	—	—	—	—	—	—	+	+	+	—
Texas††	YES	YES	YES	YES	YES	YES	YES	+	+	—	—	—	—
Vermont††	YES	YES	YES	YES	YES	YES	YES	+	+	—	—	—	—
Virginia	+	—	—	+	+	+	+	+	+	—	—	—	—
West Virginia††	+	+	+	+	+	+	+	+	+	+	—	+	+
Wisconsin	YES	—	—	YES	YES	YES	YES	+	+	YES	—	YES	—
No. states in 2000	**34**	**22**	**23**	**31**	**23**	**23**	**31**	**29**	**27**	**13**	**10**	**11**	**3**
% states in 2000	67%	43%	45%	61%	45%	45%	61%	57%	53%	26%	20%	24%	6%

* States offering no coverage were Alabama, Alaska, Connecticut, Georgia, Idaho, Iowa, Kentucky, Mississippi, Missouri, Nebraska, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, Washington, and Wyoming.
† Bupropion question added in 2000.
§ Offered coverage in 1998 and 2000.
¶ Added coverage in 2000.
** Dropped coverage in 2000.
†† Offered all pharmacotherapy recommended in *Public Health Service Clinical Practice Guideline for Treating Tobacco Use and Dependence.*
§§ Covered pregnant women only.
¶¶ Offered all treatments.

Texas is not among the states that specifically exclude coverage for smoking cessation products by statute or regulation.[69] In fact, as shown in the above chart, Texas is one of fifteen states that provide all pharmacotherapy recommended by the PHS Guideline.[70] The Texas Medicaid Vendor Drug Program (VDP) formulary includes

[67] *State Medicaid Coverage for Tobacco-Dependence Treatments*—United States, 1998 and 2000, CDC MMWR November 9, 2001/ 50(44);979-982, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5044a3.htm (visited April 3, 2002). A PDF version of the report suitable for printing is available at http://www.cdc.gov/mmwr/PDF/wk/mm5044.pdf (visited April 3, 2002).
[68] *Id*.
[69] *E.g.*, Alaska, Iowa, and Missouri. ALA. ADMIN. CODE tit. 7, § 43.590; IOWA ADMIN. CODE § 441-78.1 (249A); 13 MO. CODE REGS. tit. 13 § 70-20.032.
[70] *See* PHS Guideline.

certain prescription and OTC drugs for treatment of tobacco or nicotine addiction, including nicotine replacement therapies.[71] However, provider and patient awareness of this benefit may be limited. The Texas Health and Human Services Commission now administers the VDP. The VDP administers drug coverage for Medicaid beneficiaries in managed care arrangements as well as traditional Medicaid.[72] Direct services to beneficiaries are provided through a network of approximately 3,500 participating pharmacies. These represent about 70 percent of all licensed pharmacies in Texas. Information on coverage of treatments for nicotine addiction is readily available through the Vendor Drug Help Desk's toll-free number. However, the number is for use by providers only, thereby excluding Medicaid patients interested in determining availability of benefits.[73] While some Medicaid beneficiaries may seek out a pharmacist and request a smoking cessation product on their own, many will not take this step without the intervention of a physician or other primary care provider. Information on Medicaid coverage is not readily available to primary care providers. For example, the index to the 2002 Texas Medicaid Provider Procedures Manual[74] has no entries for "tobacco," "smoking," "prevention," "preventive" or "preventative." If information on smoking cessation is contained in the Manual, it is difficult to find.

[71] Telephone call to Vendor Drug Help Desk, Sept. 27, 2000.
[72] As of September 1, 1999, the VDP also assumed responsibility for prescription drugs provided under the Children with Special Health Care Needs and Kidney Health Care programs. As of March 1, 2002 VDP now processes prescription drugs claims for Children's Health Insurance Program (CHIP) clients. *See* Texas Health and Human Services Commission, at http://www.hhsc.state.tx.us/HCF/vdp/vdpstart.html (visited April 3, 2002).
[73] *See* Texas Health and Human Services Commission *at* http://www.hhsc.state.tx.us/HCF/vdp/ecm.html. (visited April 3, 2002).
[74] The 1104 page manual is available at http://www.hhsc.state.tx.us/HCF/med_apls/MedAppl_home.html (visited January 31, 2003).

C. Comprehensive Prevention And Treatment Services

Texas does not provide any coverage for group, individual, or telephone counseling for tobacco dependence *through Medicaid, although tobacco settlement dollars are being used to provide a Tobacco Cessation Quitline in selected areas. Thirteen states provide Medicaid coverage for some form of counseling. Arguably, states should cover prevention and treatment services related to tobacco use in the form of counseling to the same extent as other kinds of health-related counseling. The federal law that describes the benefit categories that make up "medical assistance" includes preventive services.[75] Treatment for smoking is, at the very least, an essential aspect of good prenatal care.

Some state Medicaid agencies have adopted regulations that use a comprehensive approach to smoking cessation described in the PHS Guideline,[76] which supports insurance coverage for individual, group, and telephone counseling in addition to drug coverage. For example, the Smoking Cessation Treatment Policy in the Medicaid Services article of the Indiana Administrative Code, adopted in 1999, provides:

> 405 IAC 5-37-1. LIMITATIONS
> Sec. 1. (a) Reimbursement is available for smoking cessation treatment subject to the requirements set forth in this rule...and when provided in accordance with provider bulletins, provider manuals, and the provider agreement.
> (b) Reimbursement is available for one (1) twelve (12) week course of smoking cessation treatment per recipient per calendar year.
> (c) The twelve (12) week course of treatment may include prescription of any combination of smoking cessation products and counseling. One (1) or more modalities of treatment may be prescribed. Counseling must be included in any combination of treatment.
> (d) Prior authorization is not required for smoking cessation products or counseling.

[75] "Medical assistance" is defined at 42 U.S.C. § 1396d.
[76] Only one state (Oregon) covered all treatments recommended by the PHS Guideline. *See* CDC chart reproduced above.

405 IAC 5-37-2. SMOKING CESSATION PRODUCTS
Sec. 2. (a) Reimbursement is available to pharmacy providers for smoking cessation products when prescribed by a practitioner within the scope of his license under Indiana law.
(b) Products covered under this section include, but are not limited to, the following:
(1) Sustained release buproprion products.
(2) Nicotine replacement drug products (patch, gum, inhaler).

405 IAC 5-37-3. SMOKING CESSATION COUNSELING
Sec. 3. (a) Reimbursement is available for smoking cessation counseling services rendered by licensed practitioners under applicable Indiana law participating in the Indiana Medicaid program and listed in subsection (b).
(b) The following may provide smoking cessation counseling services when prescribed by a practitioner within the scope of his license under Indiana law and within the limitations of this rule...:
(1) A physician. (2) A physician's assistant. (3) A nurse practitioner. (4) A registered nurse. (5) A psychologist. (6) A pharmacist.

A review of the Texas Administrative Code found no similar provisions. As noted above, the 2002 Texas Medicaid Provider Procedures Manual offers little guidance on provision and/or coverage of smoking prevention or treatment services to Medicaid beneficiaries in general.

The availability of comprehensive services for children and adolescents enrolled in Medicaid is assured under the Early and Periodic Screening, Diagnosis, and Treatment or EPSDT program. In Texas, EPSDT services are delivered through the Texas Health Steps program. Chapter 3 of the 2002 Texas Medicaid Service Delivery Guide[77] devoted to Texas Health Steps states that adolescent preventive service visits are covered for Medicaid beneficiaries at ages 11, 13, 15, 17, and 19. Section 3.8.8.4, "Healthy Lifestyles," instructs providers to give eligible adolescents health guidance on avoidance of tobacco, among other things. Section 3.8.9.4, "Tobacco Use," instructs providers to

[77] 2002 Texas Medicaid Service Delivery Guide available at http://www.eds-nhic.com/forms.htm (visited January 31, 2003).

ask about use of cigarettes and smokeless tobacco. If an adolescent uses tobacco products, the provider is supposed to determine the patterns of use and develop a cessation plan.

In May 1999, the Texas Legislature enacted a law establishing a Children's Health Insurance Program (CHIP). This program provides health insurance for uninsured children who are not eligible for Medicaid up to 200 percent of the federal poverty level. Program materials indicate that smoking cessation services are covered; the Texas State Plan for CHIP includes a $100 annual limit for smoking cessation.[78]

V. Private Health Plan Coverage of Smoking Cessation Therapy

A. Performance Measurements for Health Plans

A number of measures are used to compare the quality of health plans. "Report cards" are issued by organizations such as *U.S. News & World Report* and *Consumers' Checkbook*. These report cards review such items as rates of immunizations, cervical cancer screening, mammograms, and cholesterol screening provided by plans. Some report cards are prepared by the plans themselves, usually based on Health Plan Employer Data Information Set[79] (HEDIS) data. HEDIS is a health plan survey that measures about 60 different health care areas to determine and quantify the quality of services offered by HMOs. HEDIS was developed by the National Committee for Quality Assurance (NCQA), an independent, non-profit organization that assesses and

[78] Texas State Plan as approved by the Health Care Financing Administration (now CMS) June 15, 1988 and amended November 5, 1999, available at http://www.texcarepartnership.com/CHIP-Legislative-Page.htm (visited April 3, 2002).
[79] The Health Plan Employer Data and Information Set (HEDIS®) at http://www.ncqa.org/Programs/HEDIS/.

reports on health plan quality of HMOs.[80] Some, but not all, plans have their report cards audited by the NCQA. Among other things, the HEDIS survey measures the efforts of health plans in advising smokers to quit. Some states also issue report cards based on HEDIS and other survey data.

1. Texas Office of Public Insurance Counsel

The Texas Office of Public Insurance Counsel (OPIC) issues a type of "report card" comparing the top 34 HMOs that operate in Texas.[81] The plans are selected based on market share and plan size within each service area. The HMOs rated account for ninety percent of the Texas commercial enrollment as of 1997. Texas legislation passed in 1997 requires OPIC to collect a variety of quality data on Texas HMOs and prepare a report card comparing Texas plans. Although HEDIS has recently added patient ratings of quality and satisfaction, the OPIC survey utilizes another measurement instrument known as the Consumer Assessment of Health Plans Study (CAHPS). CAHPS is similar to HEDIS, but places a greater emphasis on patients' assessment of the care process, including health care professionals, access, continuity, and coordination of care. The survey does not ask technical questions that would be difficult for patients to assess (such as how well a physician performs surgery) but instead focused on issues such as how quickly patients could obtain needed appointments, how well their physicians explain things in a way patients can understand, and whether patients are treated with respect and courtesy by office staff.

[80] *See generally* Tim McAfee, Neal S. Sofian et al, *The Role of Tobacco Intervention in Population-Based Health Care: A Case Study*, Am J Prev Med 1998;14(3S).
[81] *See generally* Ronald L. Scott, *Texas Issues New "Report Cards" Comparing HMOs* at http://www.law.uh.edu/healthlawperspectives/Managed/980909Texas.html.

OPIC rates plans on a "star" system, with three stars being better than average, two stars average, and one star below average. The survey also contains charts showing how plans compare to Texas state averages on a variety of issues. For example, a section captioned *Getting the care you need* shows answers to survey questions that asked patients how often they: (1) received tests or treatments they thought they needed; (2) saw a specialist when they thought they needed one; (3) were able to see their own physician when they wanted to, rather than someone else; and (4) received the medical help or advice they needed when they called a physician's office during regular daytime hours. Overall, 62 percent of patients said they always received care when needed, 18 percent said they usually received needed care, and 20 percent said they "sometimes or never" received needed care. The full text of the report is available at the OPIC web site.[82] However, the OPIC survey does not address whether the health plans provide smoking cessation treatments or whether the health plans advise smokers to quit.

2. Texas Health Care Information Council

Another state agency, the Texas Health Care Information Council (THCIC) also collects quality of care data from managed care organizations and issues reports available to the public.[83] The 2001 report, *Straight Talk on Texas HMOs: A Purchasers Guide*, *HEDIS 2001 Texas Subset* ("*Straight Talk*") is based largely on a subset of HEDIS data.

Straight Talk reported quality of care performance measurements for 25 HMOs in Texas during calendar year 2000. Many of the HMOs have multiple service areas, so there are 53 plans listed in the report. The HEDIS *Advising Smokers to Quit* measure

[82] Office of Public Insurance Counsel, Comparing Texas HMOs 1998, Ratings by Consumers at http://www.opic.state.tx.us/reportcard.pdf.

"estimate[s] the percentage of eligible health plan members that were advised to quit smoking during a visit with a physician during the measurement year."[84] Current smokers or those who recently quit are asked the following questions:[85]

- Have you smoked at least 100 cigarettes in your entire life?
- Do you smoke every day; some days or not at all?
- How long has it been since you quit smoking cigarettes?
- During the past 12 months, how many times have you visited a doctor or other health care professional in your plan?
- On how many of these visits were you advised to quit smoking by a doctor or other health care professional in your plan?

Of the 53 Texas plans surveyed in *Straight Talk*, only eight had enough eligible members (more than 30) to report their compliance with the HEDIS measure. In the eight plans, only 46.2% of those who were identified as smokers in the past year.[86] The Texas average has declined since 1997 and does not compare well to national standards. Interestingly, the most recent report on the quality of care provided by commercial Texas HMOs did not report on the "advising smokers to quit" measure.[87] The following table

[83] *Straight Talk on Texas HMOs: A Purchasers Guide*, *HEDIS 2001 Texas Subset* (Nov. 2001) [hereafter *Straight Talk*] is available at http://www.thcic.state.tx.us/HMOReports01/StraightTalk.pdf.
[84] NCQA, *The State of Managed Care Quality 2001: Advising Smokers To Quit*, [hereafter *Advising Smokers to Quit*] available at http://www.ncqa.org/somc2001/ADVISE_SM/SOMC_2001_ADVISE_SM.html. (*citing* NCQA, 1997). Survey research, is used for the advising smokers to quit measure. Members are surveyed by mail with a telephone follow-up to those not responding by mail. Consumers are asked to score various aspects of their experience with their health plan. See *Guide to Texas HMO Quality 2002* at p. 223 available at http://www.thcic.state.tx.us/Publications.htm#HMO (visited January 31, 2003).
[85] American Association of Health Plans, *Addressing Tobacco in Managed Care: A Resource Guide for Health Plans*, HEDIS 3.0 Tobacco Questions p. 6(Jan. 2001) available at http://www.aahp.org/atmc/ATMC_Toolkit.pdf.
[86] *Straight Talk* at pages 71, 72.
[87] See *Guide to Texas HMO Quality 2002* available at http://www.thcic.state.tx.us/Publications.htm#HMO (visited January 31, 2003). This guide is the successor to *Straight Talk*.

shows the Texas average compared to the "quality compass," a national database of performance information reported to NCQA.[88]

	1997	1998	1999	2000
Texas Average	55.7%	57.5%	58.6%	46.2%
Quality Compass®	64.0%	62.5%	68.3%	67.1%

Source: ***Straight Talk***

3. NCQA State of Managed Care Quality Report

Nationally, the NCQA reports that managed care plans are annually continuing to improve their performance in this area. In 2000, physicians or other health care professionals advised 66.0% of smokers in the average managed care plan to quit during an office visit.[89] However, the percentages in the following NCQA chart[90] show a significant variation in performance between the mean and 90th percentiles.

HEDIS Advising Smokers to Quit Rate

Year	N	Mean	10th percentile	25th percentile	Median	75th percentile	90th percentile
1996	250	59.06	48.50	56.10	61.80	65.96	69.90
1997	379	63.78	54.86	59.38	63.78	69.32	74.32
1998	441	62.45	52.83	58.33	63.16	67.65	71.43
1999	260	63.66	52.49	59.05	64.73	68.99	72.17
2000	220	66.26	57.30	62.03	66.02	71.40	74.06

Source: NCQA, Advising Smokers to Quit

In the NCQA 1998 report (considering 1997 data), NCQA calculated what would happen if all health plans performed as well as the best plans. The report noted:

> If industry-wide performance were brought up to the 90th percentile benchmark of 74.3%, an additional 4.2 million enrollees who smoke would be advised about the benefits of quitting, and nearly 26,000 more people would quit smoking each

[88] *Straight Talk* at page 71, (chart and footnote 2).
[89] *Advising Smokers to Quit*.
[90] *Advising Smokers to Quit*.

year, saving hundreds of lives and saving tens of millions of dollars in health care costs.[91]

The 1998 NCQA report also suggested measures health plans could implement to improve rates of advising smokers to quit. The NCQA suggests that plans should:

- encourage health care providers to talk openly with patients about smoking;
- offer programs that support members' cessation attempts;
- tracking smoking status as a "vital sign;" and
- offer tobacco cessation classes, stop smoking tool kits, and pharmacotherapies such as nicotine replacement therapy, without requiring a member co-payment.[92]

Note that the HEDIS measurement does *not* evaluate whether health plans offer pharmacotherapies or counseling to assist in smoking cessation attempts. But the measure is nonetheless important. The NCQA cites the following reasons, among others: (1) 70% of smokers say they want to quit, 34% try to quit each year, but only 2.5% succeed; (2) smokers say that they would more likely quit smoking if a doctor advised them to quit and more people who have been advised to quit by a physician quit than those who have not received such advice; [93] (3) even brief advice of a physician to quit can make a quit attempt more successful;[94] (5) patients expect their physician to inquire about smoking and advise them to quit;[95] and (6) three million U.S. smokers could be

[91] NCQA, *State of Managed Care Quality Report*, 1998 available at http://www.ncqa.org/communications/state%20of%20managed%20care/report98.htm#advising.
[92] *Id*.
[93] *Id*., *citing* US Department of Health and Human Services. *Smoking cessation clinical practice guideline*. Number 18. US Department of Health and Human Services, Public Health Service, Agency for Health care Policy and Research, 1996.
[94] *Advising Smokers to Quit*, *citing* PHS Guideline.
[95] *Advising Smokers to Quit*, *citing* Kviz FJ, Clark MA, Hope H, et al, *Patients' perceptions of their physician's role in smoking cessation by age and readiness to stop smoking,* Preventive Medicine 1997;26:340 - 349.

motivated to quit if 100,000 physicians advised all of their smoking patients to quit, even if only a small percentage of the smokers heeded such advice.[96]

B. Coverage for Smoking Cessation Interventions

Research by the Agency for Health Care Policy and Research [now AHRQ] and others indicates that smoking cessation intervention is as cost effective as other preventive services, such as treatment of high cholesterol.[97] Yet, few insurance providers include such coverage.[98] A Maryland health consulting firm, Pinney Associates, found that, as of 1994, insurance coverage for tobacco cessation was very poor.[99] In a 1995 survey of 105 HMOs (health maintenance organizations), one-third did not offer smoking cessation services because of the belief that these services were ineffective.[100] Among national HMOs' plans of coverage, no single plan unconditionally covers smoking cessation treatments.[101] Most specifically exclude coverage.[102] One regional HMO, Group Health Cooperative of Puget Sound, implemented full coverage of smoking cessation treatment in 1997, but few plans have since followed Puget Sound's example.[103]

Addressing Tobacco in Managed Care, a 1997 survey of managed care organizations (MCOs) was conducted with funding from the Robert Wood Johnson

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[96] *Advising Smokers to Quit*, *citing* Manley MW, Epps RP, Glynn TJ., *The clinician's role in promoting smoking cessation among clinic patients,* Medical Clinics of North America. 1992;76:477-94.
[97] *See*, *e.g.*, Kelly N. Reeves, *Medicaid Recipients Denied Coverage for Smoking Cessation Pharmacotherapy,* 2 J. HEALTH CARE L. & POL'Y 102, 105 (1998).
[98] *See id.*
[99] Working Group on Tobacco Dependence Treatment Policy, *Grant Results Report*, June 1998, available at http://www.rwjf.org/health/029354s.htm.
[100] *Id*.
[101] *See NC HMO Coverage- Smoking Cessation* at http://www.nciom.org/hmoconguide/O-SMOKE.html.
[102] *See id.*

Foundation. The survey provides national baseline data on insurance reimbursement for tobacco cessation treatments and related issues.[104]

Although 71% of responding MCOs were aware of the 1996 PHS smoking cessation clinical practice guideline,[105] only 51% had even reviewed the guideline. Of those that had reviewed the guideline, 9% had fully implemented the guideline recommendations and 39% had partially implemented the recommendations.[106]

Few MCOs provide broad coverage for smoking cessation treatments. MCOs were most likely to offer full coverage for self-help materials (54.1%), smoking cessation classes (35.7%), and telephone counseling (32.8%).[107] Fewer MCOs offered full coverage for pharmacotherapies.

The percentage of plans offering various types of smoking cessation interventions with full or partial benefit coverage is shown in the following table.[108]

Coverage for Smoking Cessation Interventions

Type of Intervention	Full Coverage %	Partial Coverage %
Self-help materials	54.1	11.1
Classes	35.7	20.5
Telephone counseling	32.8	7.0
Face-to-face counseling	26.6	10.7
NRT with enrollment in cessation program	25.0	13.1

[103] *Group Health on Quest to Show Skeptics That Smoking Cessation Helps Bottom Line,* NEWS AND STRATEGIES FOR MANAGED MEDICARE AND MEDICAID (Dec. 6, 1999) at http://www.mcareol.com/mcolfree/mcolfre1/ARTCL401.htm.

[104] Carol McPhillips-Tangum, *Results from the first annual survey on Addressing Tobacco in Managed Care*, Tob Control 1998;7(Suppl 1):S11-S13 (Winter) [hereafter ATMC Survey]. The article is available at http://tc.bmjjournals.com/cgi/content/full/7/suppl_1/S11. The reasons why health plans offer health-promotion and disease-prevention programs may be market-driven. *See* Helen Halpin Schauffler and Susan A. Chapman, *Health Promotion and Managed Care: Surveys of California's Health Plans and Population*, Am J Prev Med 1998;14(3).

[105] Fiore MC, Bailey WC, Cohen SJ, et al. Smoking cessation. Clinical Practice Guideline No 18. Rockville, Maryland: US Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, April, 1996. (AHCPR Publication No 96-0692.)

[106] ATMC Survey

[107] *Id*.

[108] Source, *Id*, Figures 3 and 4.

Bupropion	17.6	9.0
OTC reimbursement	6.6	15.2

Source: ATMC Survey

Providers identified a number of barriers to providing smoking cessation treatment. These included: (1) time constraints; (2) conflicting priorities-with tobacco use considered a relatively low priority; (3) frustration with low success rates; and (4) a lack of reimbursement for smoking cessation counseling.[109] Some MCOs responded to these barriers using a number of strategies. Forty-four percent increased education of providers and 20.1% issued prompts or reminders to providers.[110] Only 3.7% increased reimbursement, and 2.5% implemented incentives.[111]

Dr Jeffrey P. Koplan, director of the US Centers for Disease Control and Prevention cogently explained why many MCOs do not provided benefit coverage for tobacco cessation treatments.

> Unlike childhood [immunization programs], which have a high benefit-cost ratio, deliver their health benefits in close proximity to the investment required, and whose population at risk is every child, smoking cessation [programs] target only the approximately 25% of members who smoke, have considerable "upfront" expense, are uncertain as to the efficacy of the intervention, do not have a necessarily receptive target audience, and must deal with a longer interval from exposure until onset of major ill-health effects. In addition, current levels of plan membership turnover make it less likely that the member who smokes and is provided with a cessation [program] will remain in the plan long enough for the health (and presumed economic) benefits to occur.[112]

A new similar survey was conducted in 2000 showing that managed care plans have made progress in a number of key areas. Health plans are now better able to

[109] *Id*.
[110] *Id*.
[111] *Id*.
[112] Jeffrey P. Koplan, *Managed care and approaches to tobacco control*, Tob Control 1998;7(Suppl 1):S1-S2 (Winter). *See generally Best practices for comprehensive tobacco control programs; opportunities for managed care organizations*, Tob Control 2000;9(Suppl 1);i11-i14.

identify members who smoke or otherwise use tobacco.[113] In 2000, almost twice as many plans were able to identify individual smokers (14.9% to 27.1%).[114] Coverage for over-the-counter NRT has risen from 6.6% to 14.9%.[115] Coverage for Zyban has increased from 17.6% to 37.2%.[116] Intervention and counseling benefits have increased in a number of areas including: during pregnancy from 45% to 59%; during postpartum visits from 13.6% 30.5%; for patients suffering from chronic illnesses from 22.6% to 31.3%; and for adolescents from 17.6% to 24.2%.[117] Further, twice as many plans are designating a staff person for tobacco control activities and more plans are teaching health care providers techniques for effective tobacco cessation counseling.[118]

VI. State Mandated Coverage

A. Koop-Kessler Recommendations

In May 1997, Congress asked former Surgeon General Koop to compile a report on tobacco policy, public health, and recommendations for improvements. The Koop-Kessler Advisory Committee Report outlined the extent of the tobacco problem in the United States among youths and adults. One of the recommendations provided for mandated insurance coverage of smoking cessation programs.[119] The report describes coverage that should be provided as a "lifetime benefit rather than as a one-time

[113] *See Managed Care Plans Make Great Strides In Tobacco Control Programs* (Feb. 16, 2001), 2001 press release archive available at http://www.aahp.org. See also McPhillips-Tangum C, Cahill A, Bocchino C, et al., *Addressing Tobacco In Managed Care: Results Of The 2000 Survey*, Prev. Med. Manag. Care 2002 Jun. 25; 3(3):85-94.
[114] *Id*.
[115] *Id*.
[116] *Id*.
[117] *Id*.
[118] *Id*.
[119] *The Complete Text of the Report of the Koop-Kessler Advisory Committee on Tobacco Policy and Public Health* at http://www.lungusa.org/tobacco/smkkoop.html.

opportunity to 'kick the habit.'"[120] Specifically, the report suggests that "coverage for tobacco use cessation programs and services should be required under all health insurance, managed care, and employee benefit plans, as well as all Federal health financing programs."[121]

B. Texas Cancer Plan Recommendations

In addition to the Koop-Kessler Report, the Texas Cancer Council issued a Texas Cancer Plan in 1998 that reiterated many of the Koop-Kessler's findings concerning tobacco's effects and further reiterated the need, at least in Texas, for expanded insurance coverage. The Texas Cancer Plan found that "[n]icotine replacement therapy, along with other pharmacological agents, are important tools for smoking cessation that should be included under insurance coverage for smokers who are trying to quit."[122] The Texas Cancer Plan also noted that "attention needs to be given to financial barriers low-income Texans may face in obtaining nicotine replacement therapy, prescription medication, and access to cessation programs.[123] An "action step" in the plan is to "[a]dvocate for health insurance coverage of nicotine replacement therapy, other pharmacologic treatment, and tobacco use cessation programs.[124]

Texas law requires coverage of chemical dependency programs in group health insurance policies, but nicotine dependence is not included in the definition of chemical dependency.[125]

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[120] *Id.*
[121] *Id.*
[122] Texas Cancer Plan.
[123] *Id*.
[124] *Id*.
[125] TEX. INS. CODE ANN. art. 3.51-9 (WEST 2000).

C. Examples Of State-Level Benefit Requirements

Few states currently mandate that health insurance plans offer coverage of smoking cessation programs, though the issue has been debated in recent years. Legislation to mandate coverage of smoking cessation programs was introduced in New York, Maryland and Wisconsin[126] but failed to pass. Supporters argue that coverage should be included in health insurance and HMO plans, but opposition still remains heavy due to concerns about mandates generally, i.e., an undesirable increase in costs that may come with expanded coverage.

According to the 1998 Survey of State Policy on Nicotine Addiction ("State Survey") only four states (California, Colorado, New Jersey and North Dakota) reported that they require private health insurers or MCOs to provide a smoking cessation benefit.[127] These will now be described.

1. California

For California, the State Survey reported that "group disability policies covering hospital, medical, or surgical expenses must offer substance abuse treatment, including nicotine use…"[128] A close reading of the California statutes shows that the State Survey may have overstated the legislative "mandate" for California. The statutes require that certain classes of insurers offer coverage for the treatment of alcoholism, and provide that *if* coverage is offered for chemical dependency or nicotine use, the treatment may take

[126] S.B. 518, 414th Leg. (Md. 2000), S.B. 6461, 223rd. Leg. (N.Y. 1999), S.B. 115, (Wis. 1999).
[127] *See* Thomas J. Glynn, Dorothy K. Hatsukami, Reimbursement for Smoking Cessation Therapy-A Healthcare Practitioner's Guide at http://www.endsmoking.org/resources/reimbursementguide/main.htm.
[128] *Id*. at page 15.

place in certain licensed facilities. The relevant sections of the California statutes provide as follows.

Section 10123.6 of the California Insurance Code provides:

> …[E]very insurer issuing group disability insurance which covers hospital, medical, or surgical expenses shall offer coverage for the treatment of alcoholism under such terms and conditions as may be agreed upon between the group policyholder and the insurer. Every insurer shall communicate the availability of such coverage to all group policyholders and to all prospective group policyholders with whom they are negotiating.
> If the group subscriber or policyholder agrees to such coverage or to coverage for treatment of chemical dependency, or nicotine use, the treatment may take place in facilities licensed ….
> Treatment for nicotine use may be subject to separate deductibles, copayments, and overall cost limitations as determined by the policy.

Section 10123.14 of the California Insurance Code provides:

> … [E]very self-insured employee welfare benefit plan containing hospital, medical, or surgical expense benefits or service benefits may provide coverage for the treatment of alcoholism, chemical dependency, or nicotine use under such terms and conditions as may be agreed upon between the self-insured welfare benefit plan and the member, where the treatment may take place in facilities licensed….
> Treatment for nicotine use may be subject to separate deductibles, copayments, and overall cost limitations as determined by the plan.

Section 1367.2 of the California Health & Safety Code provides:

> (a) ….[E]very health care service plan that covers hospital, medical, or surgical expenses on a group basis shall offer coverage for the treatment of alcoholism under such terms and conditions as may be agreed upon between the group subscriber and the health care service plan. Every plan shall communicate the availability of such coverage to all group subscribers and to all prospective group subscribers with whom they are negotiating.
> (b) If the group subscriber or policyholder agrees to such coverage or to coverage for treatment of chemical dependency, or nicotine use, the treatment may take place in facilities licensed…

The legislative history section of the statute notes that Section 5 of Stats.1989, c. 688, provides:

> Nothing in this act shall be construed to establish a new mandated benefit or to prevent application of deductible or copayment provisions in an existing policy or plan. The Legislature intends in this act to provide that chemical dependency services are deemed to be covered if the policy or plan includes coverage for chemical dependency.

The State Survey also notes that some California residents are eligible for health insurance coverage for perinatal and infant care through the Access for Infants and Mothers Program, and that primary care services under the program include health education for tobacco use.[129] California has established a comprehensive perinatal outreach program[130] for low-income pregnant and postpartum women and women of childbearing age who are likely to become pregnant.[131] Health education services are required to be an integral part of each county's program to provide services to pregnant and postpartum women.[132] The statute requires assessment of smoking status and exposure to secondhand smoke, and also provides for:

> (3) Development and implementation of an individualized strategy to prevent smoking and exposure to smoke during pregnancy and the postpartum period, including counseling and advocacy services, public health nursing services, provision of motivational messages, cessation services, nonmonetary incentives to maintain a healthy lifestyle, and other cessation or tobacco use prevention activities, including child care or transportation in conjunction with those activities.[133]

2. Colorado

By regulation 4-5-6 issued by the Division of Insurance, Department of Regulatory Affairs, Basic Health Benefit Plans must include certain covered preventive services. The regulation stipulates that all health plan members are entitled to one "smoking cessation education program benefit under physician supervision or as

[129] *Id*.
[130] CAL. HEALTH & SAFETY CODE § 104560.
[131] *Id.* at § 104561.
[132] *Id.* at § 104565.
[133] *Id.* at § 104565.

authorized by plan per lifetime, not to exceed $150 payment by insurer.[134] Certain guaranteed issue small group plans are exempt from the requirement.[135]

3. New Jersey

The New Jersey Health Wellness Promotion Act was signed into law in April 2000. The law mandates that commercial health plans include annual physical examinations, disease screenings and "lifestyle behaviors" consultations (including smoking control) as part of their basic coverage.[136] The statute provides in pertinent part:

> a. Every hospital service corporation contract that provides hospital and medical expense benefits … shall provide benefits to any subscriber … for expenses incurred in a health promotion program through health wellness examinations and counseling, which program shall include…
>
> (8) For all persons 20 years of age or older, an annual consultation with a health care provider to discuss lifestyle behaviors that promote health and well-being including, but not limited to, smoking control, nutrition and diet recommendations…
>
> b. Every … contract … shall provide payment for the benefits set forth in subsection a. of this section in an amount which shall not exceed: $125 a year for each person between the ages of 20 to 39, inclusive; $145 a year for each man age 40 and over; and $235 a year for each woman age 40 and over…
>
> c. The Commissioner … shall annually adjust the threshold amounts provided by subsection b. of this section in direct proportion to the increase or decrease in the consumer price index…[137]

There are similar requirements for group policies,[138] individual policies,[139] medical service corporations[140] and health service corporations.[141]

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[134] Amended Regulation 4-6-5, Implementation Of Basic And Standard Health Benefit Plans (Amended regulation incorporating recommendations from the Health Benefit Plan Advisory Committee effective January 1, 2002) at http://www.dora.state.co.us/insurance/regs/4-6-5-02.pdf.
[135] COLORADO REV.STAT. §10-16-105.
[136] Julie A. Jacob, *New Jersey requires health plans to cover annual physicals*, American Medical News, (Feb. 19, 2001) at http://www.ama-assn.org/sci-pubs/amnews/pick_01/bisd0219.htm.
[137] N.J. STAT. § 17:48-6i.
[138] N.J. STAT. § 17B:27-46.1h.
[139] N.J. STAT. § 17B:26-2.1h.
[140] N.J. STAT. § 17:48A-7h.

4. North Dakota

The State Survey[142] reported that North Dakota's guaranteed issue statute requires both small and large employers to cover smoking cessation as a benefit up to $150 per member per lifetime if supervised by a physician.[143] In fact, the "mandate" is contained in the "standard form" insurance policy issued by the North Dakota Insurance Department, and is not supported by statute or formal regulation. When asked about the requirement, the North Dakota Insurance Department advised as follows:

> [North Dakota] does not mandate nor require this benefit under any statute or rule. The benefit, however, does appear in the standard benefit plan that all major medical insurers are required to make available to individuals or employers in the individual and group markets. Coverage is only available on a guaranteed-issue basis for the small (2-50)employer market and the employer has the option of purchasing any plan, including the standard plan, offered by the insurer.[144]

VII. Other States' Efforts To Promote Tobacco Cessation Services

Arizona, Michigan, and North Carolina have all established innovative programs to promote effective tobacco cessation services. However, the structure of the programs is quite different. Arizona's program is a government/academic/private collaboration. The program in Michigan is sponsored by an industry group that represents health plans. North Carolina's program is run through a nonprofit entity.

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[141] N.J. STAT. § 17:48E-35.6.

[142] *See* Thomas J. Glynn, Dorothy K. Hatsukami, *Reimbursement for Smoking Cessation Therapy-A Healthcare Practitioner's Guide* at page 15, available at http://www.endsmoking.org/resources/reimbursementguide/main.htm.

[143] The guide cited in the previous footnote does not contain a statutory or regulatory citation, and this writer was unable to find a current statute or regulation in North Dakota requiring this coverage, despite numerous WestLaw searches for "tobacco," "smoking," and "nicotine" in the North Dakota Century Code and insurance regulations, as well as a review of the mandated health insurance provisions in the North Dakota Century Code, §§ 26.1-36 *et. seq*. (West 2002).

[144] E-mail dated May 22, 2002 to Ronald L. Scott from Vance Magnuson, Sr. Life/Health Form & Rate Analyst, North Dakota Insurance Department.

1. Arizona

The Arizona Healthcare Partnership (AHP) was sponsored by the Arizona Tobacco Education and Prevention Program (TEEP), at the Arizona Department of Health Services.[145] AHP utilized a "working group" of stakeholders to provides support, resources and expertise. Part of its stated mission was to "[i]ntegrate comprehensive, innovative and evidence-based tobacco use prevention and treatment programs into Arizona healthcare systems to ensure effective tobacco use management."[146] AHP facilitated tobacco-related partnerships between TEPP Community-based Projects, the Arizona Smokers' Helpline and Arizona health care systems. AHP has also surveyed health plans and health care systems to assess existing tobacco control policies, guidelines and interventions. AHP sought to convince health plans to adopt tobacco cessation programs that include screening, pharmacotherapy and counseling benefits. AHP also educated health care professionals through a Speaker's Bureau with more than 70 speakers. They provided tobacco intervention training to a variety of health care professionals. The training often qualified for continuing medical education (CME) and other professional continuing education certifications.[147]

AHP apparently no longer exists as an entity, but many of the programs are still operated by TEEP through the Arizona College of Public Health.[148] The TEEP web site still lists a "Healthcare Partnership" whose mission is to integrate "comprehensive, innovative and evidence-based tobacco prevention and cessation into Arizona healthcare

[145] *See* Arizona Healthcare Partnership at http://www.azptnr.org. At the time this paper was being placed in final form (Sept. 6, 2002), this web site address was not functioning under the above name , but a GOOGLE search located the pages via URL numbers. The main page was http://128.196.174.134/resources/content_pages/Healthcare_Systems/hs_1.htm. Successive pages were accessible by a link to pages at the bottom of the home page.
[146] *Id*.
[147] *Id*.

systems."[149] TEEP also operates a speakers bureau that "trains Arizona healthcare professionals to apply best practices in tobacco control within healthcare systems."[150] TEEP also has a working group of over 100 stakeholder members.[151]

2. Michigan

The Michigan Association of Health Plans (MAHP) Foundation has established a program called Taking on Tobacco in Michigan (Taking on Tobacco). The initiative is noteworthy in part because it is sponsored by MAHP, "the industry voice for 26 health care plans, covering over 2.9 million Michigan residents, and 39 businesses affiliated with the health care industry."[152] The MAHP Foundation conducts research and analysis of a variety of initiatives in managed care. Taking on Tobacco encourages Michigan MCOs to adopt the PHS Guideline recommendations, and "to promote the institutionalization of a strategic plan, comprehensive benefits, provider training, monitoring and feedback mechanisms."[153] Taking on Tobacco provides education to health care providers about the PHS Guideline recommendations for treating tobacco dependence. Specifically, its objective is to "integrate the core recommendations into best practice models by educating health care providers, health care provider staff, and managed care plans to reduce the differences in clinical practice patterns and improve outcomes."[154] Taking on Tobacco publishes a "Michigan Insurers' Tobacco Cessation Benefits Grid," a report-card type document that shows the extent of coverage by

[148] *See* Arizona Tobacco Education and Prevention Program (TEEP) at http://www.tepp.org/.
[149] *See* Healthcare Partnership at http://www.tepp.org/actev/healthcare/index.htm.
[150] *See* Speakers Bureau at http://www.tepp.org/actev/healthcare/index.htm.
[151] *See* Working Group at http://www.tepp.org/actev/healthcare/index.htm.
[152] Michigan Association of Health Plans (MAHP) at http://www.mahp.org.
[153] MAHP Foundation at http://www.mahp.org/MAHP%20Foundation/foundation.htm.
[154] Taking on Tobacco at http://www.mahp.org/MAHP%20Foundation/smoking/coremeasures.htm.

Michigan health plans for the various forms of nicotine replacement therapy, Zyban and group or telephone counseling.[155]

3. North Carolina

North Carolina Prevention Partners (NCPP) is nonprofit organization located at the School of Public Health, University of North Carolina at Chapel Hill.[156] NCPP's goal is to "improve health across [North Carolina]" and to "assist employers identify the leading prevention issues in order to contain health care spending and boost employee productivity."[157]

One project of NCPP is the NC BASIC Preventive Benefits Initiative. The initiative seeks to encourage *voluntary* improvements in preventive benefits offered by health plans "without driving up costs by mandating benefits."[158] NCPP claims that in the last three years, North Carolina "has seen the greatest increase in the nation in coverage of tobacco use treatment benefits with growth from 0 to 60% of NC health insurers offering a smoking cessation benefit product."[159] NCPP creates a "prevention report card" for the state that is posted on their web site. In the year 2000, the state received a D for tobacco use, a D for nutrition, and a C- for physical activity.[160] NCPP

[155] Michigan Insurers' Tobacco Cessation Benefits Grid at http://www.mahp.org/MAHP%20Foundation/smoking/benefitsgrid.htm.
[156] Meg Malloy, *Making a Case for Prevention*, Business Leader, Vol. 13, Issue 6 (Dec. 2001) available at http://www.businessleader.com/bl/dec01/prevention.html.
[157] *Id*.
[158] *Id*.
[159] *Id*.
[160] Report Card at http://www.ncpreventionpartners.org/report/. The full report is available in PDF format at http://www.ncpreventionpartners.org/report/reportcard.pdf.

also publishes How NC HMOs Address Tobacco Use.[161] The web site contains information on plans that offer a full cessation benefit, pharmacotherapy, etc.[162]

VIII. Texas Survey of Managed Care Organizations

A literature search revealed little data about the extent or nature of tobacco cessation treatment coverage by health plans in Texas. Therefore, the University of Houston Health Network for Evaluation and Training Systems (H-NETS) conducted a survey of Texas managed care organizations. The survey was based on the instrument used by the American Association of Health Plans (AAHP) for national sampling every other year. The survey instrument has been modified for Texas. AAHP provided written permission for use of the survey instrument. This will also allow for state to national comparisons of data. Other states, such as Arizona, have also been using modified editions for their on-going surveys in this area. Results of that survey are found in Part II of this series.

[161] How NC HMOs Address Tobacco Use at http://www.ncpreventionpartners.org/basic/75.htm#smokplan.
[162] *Id*.

Contact Information:

Dr. Phyllis Gingiss, Principal Investigator. University of Houston, Department of HHP, Houston, TX 77204-6015. 713/743-9843 or 713/743-9954 (HNETS office). pmgingiss@uh..edu

Ron Scott, Health Law and Policy Institute, The University of Houston Law Center, Houston, TX 77204-6060. 713/743-2121. rscott@central.uh.edu.

Reports are available on the HNETS website: www.uh.edu/hnets

IX. Appendix 1

Practical counseling (problem solving/ skills training)

Practical counseling treatment component	Examples
Recognize danger situations Identify events, internal states, or activities that increase the risk of smoking or relapse.	❑ Negative affect. ❑ Being around other smokers. ❑ Drinking alcohol. ❑ Experiencing urges. ❑ Being under time pressure.
Develop coping skills. Identify and practice coping or problem solving skills. Typically, these skills are intended to cope with danger situations.	❑ Learning to anticipate and avoid temptation. ❑ Learning cognitive strategies that will reduce negative moods. ❑ Accomplishing lifestyle changes that reduce stress, improve quality of life, or produce pleasure. ❑ Learning cognitive and behavioral activities to cope with smoking urges (e.g., distracting attention).
Provide basic information. Provide basic information about smoking and successful quitting.	❑ The fact that any smoking (even a single puff) increases the likelihood of a full relapse. ❑ Withdrawal typically peaks within 1-3 weeks after quitting. ❑ Withdrawal symptoms include negative mood, urges to smoke, and difficulty concentrating. ❑ The addictive nature of smoking.

Source: PHS Guideline

Intra-treatment supportive interventions

Supportive treatment component	Examples
Encourage the patient in the quit attempt.	❑ Note that effective tobacco dependence treatments are now available. ❑ Note that one-half of all people who have ever smoked have now quit. ❑ Communicate belief in patient's ability to quit.
Communicate caring and concern..	❑ Ask how patient feels about quitting. ❑ Directly express concern and willingness to help. ❑ Be open to the patient's expression of fears of quitting, difficulties experienced, and ambivalent feelings.
Encourage the patient to talk about the quitting process.	Ask about: ❑ Reasons the patient wants to quit. ❑ Concerns or worries about quitting. ❑ Success the patient has achieved. ❑ Difficulties encountered while quitting.

Source: PHS Guideline

Extra-treatment supportive interventions

Supportive treatment component	Examples
Train patient in support solicitation skills	❑ Show videotapes that model support skills. ❑ Practice requesting social support from family, friends, and coworkers. ❑ Aid patient in establishing a smoke-free home.
Prompt support seeking	❑ Help patient identify supportive others. ❑ Call the patient to remind him or her to seek support. ❑ Inform patients of community resources such as hotlines and help lines.
Clinician arranges outside support	❑ Mail letters to supportive others. ❑ Call supportive others. ❑ Invite others to cessation sessions.. ❑ Assign patients to be buddies for one another.

Source: PHS Guideline