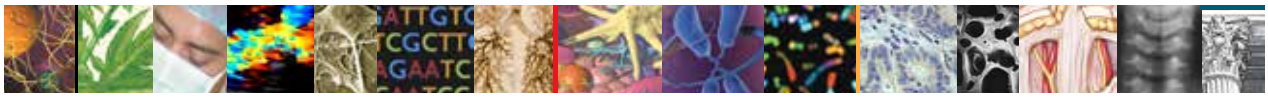

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Perspective

Helping Smokers Quit — Opportunities Created by the Affordable Care Act

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In its review of tobacco-dependence treatments, the 2008 clinical practice guideline of the U.S. Public Health Service concluded, "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."[1] The low utilization of clinical cessation interventions by smokers and physicians alike is partly attributable to inadequate insurance coverage[1,2]: many health insurers still fail to cover the evidence-based counseling and medication treatments recommended in the 2008 guideline.[2] Even when these treatments are covered, barriers to utilization such as copayments and prior-authorization requirements make obtaining them costly and inconvenient.[2] Furthermore, complex, unclear, and variable tobacco-cessation coverage can be confusing for both physicians and patients, making it harder for physicians to help patients quit smoking.[2]

Improved coverage of cessation treatments increases attempts to quit, treatment use, and rates of successful quitting.[1] In particular, coverage that reimburses cessation interventions may increase the chances that physicians will intervene with smokers. Methods that rapidly and easily connect smokers with cessation-treatment resources also increase treatment utilization and cessation rates.[1]

Several provisions of the Affordable Care Act (ACA) are designed to address the long-standing gap in cessation coverage and thereby increase rates of cessation. Though these provisions have received little publicity, they could contribute greatly to improving the quality of health care and achieving better health outcomes while reducing health care costs.

One major provision of the ACA requires nongrandfathered private health plans to cover, without patient cost sharing, preventive services that have received an A or B grade from the U.S. Preventive Services Task Force. These services include tobacco-cessation interventions.

On May 2, 2014, the Departments of Health and Human Services, Labor, and the Treasury jointly issued guidance on cessation coverage for insurers (www.dol.gov/ebsa/faqs/faq-aca19.html). This guidance, which is based on the 2008 guideline,[1] stated that insurers would be in compliance if they covered, without cost shar-

Affordable Care Act Guidance on Coverage of Tobacco-Cessation Treatment.*

A group health plan or health insurance issuer will be considered to be in compliance with the ACA's requirement to cover tobacco-use counseling and interventions if it covers the following, without cost sharing or prior authorization:

1. screening of all patients for tobacco use; and
2. for enrollees who use tobacco products, at least two tobacco-cessation attempts per year, with coverage of each quit attempt including
   - four tobacco-cessation counseling sessions, each at least 10 minutes long (including telephone, group, and individual counseling), and
   - any FDA-approved tobacco-cessation medications (whether prescription or over-the-counter) for a 90-day treatment regimen when prescribed by a health care provider.

* To date, the FDA has approved seven smoking-cessation medications: five nicotine medications (patch, gum, lozenge, nasal spray, and inhaler) and two non-nicotine pills (bupropion and varenicline). Information is adapted from www.dol.gov/ebsa/faqs/faq-aca19.html; additional information is available at www.ctri.wisc.edu/HC.Providers/reform/aca/hcrtobacco2010.pdf.

ing or prior authorization, two quit attempts per year, including individual, group, and telephone counseling and all medications approved by the Food and Drug Administration (FDA) for tobacco cessation (see box). Requiring coverage for this full range of proven cessation treatments allows smokers and their physicians to select the treatment that best suits their needs and will most likely increase utilization of these treatments. Before this guidance was issued, the specifics of how insurers were expected to implement the ACA's preventive-services provisions mandating tobacco-cessation coverage had not been defined, and coverage had varied widely.[2]

If fully implemented in insurance coverage, this guidance should substantially increase tobacco users' access to proven cessation treatments that could help thousands of smokers quit. Physicians, insurers' associations, and state health and insurance officials can play key roles in ensuring that health plans and insurers are aware of and follow this guidance. If all insurers provide such coverage, they will all benefit when people quit smoking, even when those people switch insurers.

The ACA also includes important provisions regarding cessation coverage for Medicaid and Medicare beneficiaries who smoke. A high percentage of Medicaid enrollees are smokers, and smoking-related disease is a major factor driving increases in Medicaid costs. Research suggests that more comprehensive state Medicaid coverage for cessation treatments is associated with higher quit rates among Medicaid enrollees,[3] but such coverage varies widely. The ACA's requirement that insurers cover certain specific preventive services with no cost sharing applies to newly eligible Medicaid beneficiaries in states that opt to expand Medicaid but not to beneficiaries with traditional, preexpansion Medicaid coverage.

A separate ACA provision prohibits states from excluding FDA-approved cessation medications from traditional, preexpansion Medicaid coverage. If states fully implement this provision, it could substantially improve access to cessation treatments for Medicaid enrollees. The impact of this provision could be further enhanced if state Medicaid programs removed barriers to obtaining cessation medications such as copayments and prior authorization, placed these medications on preferred drug lists, and covered cessation counseling. Another provision requires traditional state Medicaid coverage to include a comprehensive cessation benefit for pregnant women; this provision has increased state Medicaid coverage of cessation counseling and medications for this population.[4] The ACA also eliminates cost sharing for the cessation treatments covered by Medicare — individual counseling and prescription medications — for asymptomatic Medicare beneficiaries.

Finally, another ACA provision allows some health insurers to charge tobacco users premiums up to 50% higher than those charged to nonusers. The ACA requires insurers in the small-group market to waive the increased premium if smokers participate in a cessation program. Although imposing higher premiums on tobacco users might motivate them to quit, it could also cause them to conceal their tobacco use, avoid seeking cessation assistance, or forgo health insurance altogether. Such unintended consequences may be more likely to occur in the absence of comprehensive cessation coverage. It will be important for health insurers, employers, and federal and state health authorities to closely monitor the implementation and effects of this provision. If negative effects become evident, states have the authority to prohibit insurers from charging tobacco users higher premiums or to reduce the maximum allowable surcharge increase. At least six states and the District of Columbia have

already barred insurers from imposing higher premiums on smokers (www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html).

The ACA has the potential to dramatically increase coverage of evidence-based cessation treatments, making these treatments available to millions of Americans. However, these potential benefits will be realized only if both smokers and physicians are aware of the opportunities the law affords. Promotion was essential to the impressive outcomes of the 2006 Massachusetts Medicaid tobacco-cessation benefit. The promotions used ranged from extensive outreach and materials distribution targeting physicians to radio and transit ads and mailings targeting Medicaid enrollees. Over a 3-year period, the benefit was used by 37% of Massachusetts smokers who were covered by Medicaid (more than 70,000 smokers),[5] the smoking rate among state Medicaid enrollees fell from 38% to 28%,[5] hospitalizations for myocardial infarction fell by almost half, and $3.12 in medical savings were realized for every dollar spent on the benefit. Promotional activities also prompt increases in quit attempts even among smokers not using cessation assistance, because such messages normalize quitting and reassure smokers that help is available should they need it. Physicians from every specialty, public health entities, insurers, and health care organizations can all play vital roles in making patients who use tobacco aware of the expanded cessation-coverage options now available to them.

Comprehensive, barrier-free, widely promoted tobacco-cessation coverage makes it easier for smokers to quit and for physicians to help them do so. By covering and publicizing the availability of proven cessation treatments, insurers can reduce smoking rates, smoking-related disease, and health care costs. Over time, such coverage could accelerate the end of the epidemic of tobacco-related disease. If the ACA's tobacco-cessation provisions are fully implemented, they could turn out to be one of its greatest legacies.

The views expressed in this article are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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