

EVIDENCE SUMMARY

Reduce Tobacco Use



PROPOSED PAYER INTERVENTION

- 1 Expand access to evidence-based tobacco cessation treatments including individual, group, and telephone counseling and all Food and Drug Administration (FDA)-approved cessation medications (in accordance with the 2008 Public Health Service Clinical Practice Guideline¹).**
- 2 Remove barriers that impede access to covered cessation treatments, such as cost sharing and prior authorization.**
- 3 Promote increased utilization of covered treatment benefits by tobacco users.**



OPPORTUNITIES FOR PAYERS AND PROVIDERS

Payers can consider covering all evidence-based tobacco cessation treatments with few or no barriers and promote this coverage to ensure that tobacco users are aware of and use the covered treatments. As of June 30, 2015, Medicaid programs in 30 states currently cover all seven FDA-approved cessation medications.²

Specifically, payers can consider following the May 2014 HHS Frequently Asked Questions subregulatory guidance³ and ensure that tobacco users have access to individual, group, and telephone counseling and all FDA-approved cessation medications, including both over-the-counter and prescription medications and both nicotine and non-nicotine medications, without cost sharing, prior authorization, or other barriers.

Payers may promote adoption of the clinical and health systems interventions recommended in the 2008 Public Health Service Clinical Practice Guideline, and can encourage integration of tobacco dependence treatment into routine clinical practice as a standard of care.



KEY HEALTH AND COST EVIDENCE MESSAGES FOR PAYERS AND PROVIDERS

The CDC Community Preventive Services Task Force recommends policies and programs to reduce tobacco users' out-of-pocket costs for evidence-based cessation treatments based on strong evidence of effectiveness in increasing the number of tobacco users who quit.

Reducing tobacco users' out-of-pocket costs involves policy or program changes that make evidence-based treatments, including medication, counseling or both, more affordable and accessible. Payers can promote covered treatments to tobacco users and health care providers to increase awareness, interest in quitting, and use of evidence-based treatments.⁴

WHAT IS CDC'S 6|18 INITIATIVE?

The CDC is partnering with health care purchasers, payers, and providers to improve health and control health care costs. CDC provides these partners with rigorous evidence about high-burden health conditions and associated interventions to inform their decisions to have the greatest health and cost impact. This initiative aligns evidence-based preventive practices with emerging value-based payment and delivery models.

WHO'S AT RISK?

Smoking is the leading cause of preventable disease and death in the United States. It results in more than 480,000 premature deaths and more than \$300 billion in direct health care and lost productivity costs each year.^{5,6}

Cigarette smoking is high among certain groups of adults, particularly adults who are:

- male, age 25-44
- multiracial, or American Indian/Alaska Native
- less educated; live below the federal poverty level
- are insured through Medicaid or are uninsured
- have a disability or limitation, or are lesbian, gay, or bisexual⁷

CURRENT PAYER COVERAGE (AS OF AUGUST 2015)

MEDICARE

- ✓ Medicare does not currently cover group or telephone counseling or over-the-counter cessation medications.
- ✓ Counseling for asymptomatic Medicare enrollees is not subject to cost-sharing, but coverage for enrollees who have already developed tobacco-related diseases is subject to cost-sharing.

MEDICAID

- ✓ Varies by state.
- ✓ Under the 2010 Patient Protection and Affordable Care Act (ACA), traditional state Medicaid programs can no longer exclude FDA-approved cessation medications from coverage.⁸ However, some state contracts may still contain language such as cost sharing, medical necessity, or prior authorization, which may pose a barrier to patient tobacco cessation benefit access.⁹
- ✓ Traditional state Medicaid programs can cover tobacco cessation counseling services under a variety of Medicaid benefit categories, depending upon how states structure their Medicaid programs. Under a Centers for Medicare and Medicaid policy announced in 2011, state tobacco control programs can work with their state Medicaid programs to secure a 50 percent federal match for state quitline counseling provided to Medicaid enrollees.¹⁰
- ✓ Under the ACA, traditional state Medicaid programs must provide a comprehensive cessation benefit for pregnant women with no cost sharing.¹¹
- ✓ Under the ACA, state Medicaid programs receive 1% increase in the Federal Medical Assistance Program for certain preventive services if they cover all these services without cost sharing.
- ✓ Expansion Medicaid plans are subject to the ACA preventive services requirement. These plans are subject to the May 2014 HHS guidance interpreting this requirement, although this guidance leaves room for flexibility in coverage decisions.

COMMERCIAL/PRIVATE

- ✓ Varies by plan.
- ✓ Non-grandfathered plans are subject to the Affordable Care Act (ACA) preventive services requirement whether fully insured or self-insured. These plans are subject to the May 2014 Health and Human Services (HHS) guidance interpreting this requirement, although this guidance leaves room for flexibility in coverage decisions.
- ✓ Grandfathered plans are not subject to the ACA preventive services requirement. Little information is available on cessation coverage in these plans. While these plans still account for a substantial share of the market, this share is decreasing over time as people change plans in the individual market, or as plans are discontinued or make changes that result in their loss of grandfathered status.

SUPPORTING HEALTH AND COST EVIDENCE: SCIENCE BEHIND THE ISSUE

The Medicare Stop Smoking was the first large-scale demonstration designed to test the cost-effectiveness of Medicare coverage for smoking cessation therapy. Coverage of each quit attempt includes four tobacco cessation counseling sessions equal to or greater than 10 minutes (including telephone, group, and individual counseling) without cost sharing or prior authorization. In a longitudinal comparison trial of 7,354 seniors from seven states voluntarily enrolled in the Medicare Stop Smoking Program, the 12-month quit rates were 10.2% among patients using usual care (receiving smoking cessation information only), 14.1% among those using provider counseling, 15.8% among those using provider counseling plus pharmacy medications, and 19.3% among those using a telephone quitline (telephone users also received \$5 copay coverage for the nicotine patch). The results of this study suggested that a fully integrated benefit structured around low-cost pharmacotherapy in conjunction with available free quitline services would substantially reduce the prevalence of smoking and smoking-related illness among elderly beneficiaries motivated to quit, at a relatively modest cost.¹²



Fifteen studies of combinations of cessation medications and behavioral counseling were assessed in a CDC Community Guide economic review.

Cost-effective estimates were provided in five studies, with a median cost estimate of \$2,349/QALY (range of values: \$1,290 to \$24,647 in three studies), a cost per life year saved of \$5,990 (one study), and a cost per disability-adjusted life year (a measure of life lost to death and disability) averted of \$7,695 to \$16,559 (one study). Eight out of 10 studies found that benefits of these interventions exceeded costs within 10 years.¹³



In 2006, Massachusetts implemented a comprehensive, evidence-based Medicaid tobacco cessation benefit. The benefit covered up to 16 individual or group counseling sessions and two 90-day courses per year of FDA-approved cessation medications for smoking cessation, including over-the-counter and prescription medications. Prior authorization was not required for most medications. The crude smoking rate decreased from 38.3% in the pre-benefit period to 28.3% in the post-benefit period—which overall is a 26% reduction from the pre-benefit to the post-benefit period. These findings suggested that a tobacco cessation benefit that includes coverage for medications and behavioral treatments, has few barriers to access, and involves broad promotion can significantly reduce smoking prevalence.¹⁴ Every \$1 invested in the program was associated with \$3.12 in hospital cost savings for averted acute cardiovascular events alone, resulting in a return on investment of \$2.12.¹⁵

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