THE 6|18 INITIATIVE

EVIDENCE SUMMARY
Reduce Tobacco Use

PROPOSED PAYER INTERVENTION

1. Increase access to evidence-based tobacco cessation treatments, including individual, group, and telephone counseling and Food and Drug Administration (FDA)-approved cessation medications (in accordance with the 2008 Public Health Service Clinical Practice Guideline and the 2015 U.S. Preventive Services Task Force (USPSTF) tobacco cessation recommendation statement).

2. Remove barriers that impede access to covered cessation treatments, such as cost-sharing and prior authorization.

3. Promote increased use of covered treatment benefits by tobacco users.

KEY HEALTH AND COST INFORMATION FOR PAYERS AND PROVIDERS

PAYERS

As an important first step, payers can utilize multiple avenues to accurately and thoroughly identify plan members who use tobacco products to help health systems and providers understand and monitor the scope of their members’ tobacco use.

Reducing tobacco users’ out-of-pocket costs can involve policy or program changes that make evidence-based treatments, including medication, counseling or both, more affordable and accessible. The CDC Community Preventive Services Task Force found that reducing tobacco users’ out-of-pocket costs for evidence-based cessation treatments has strong evidence of effectiveness in increasing the number of tobacco users who quit.

Payers can maximize tobacco cessation by covering all evidence-based tobacco cessation treatments with no or minimal barriers and by promoting cessation coverage to ensure that tobacco users are aware of and use the covered treatments.

Payers can ensure that they are following cessation recommendations and current federal guidance by providing tobacco users access to individual, group, and telephone counseling and all FDA-approved cessation medications without cost sharing or prior authorization.

Payers can have an even greater impact on access and cessation by removing other coverage barriers such as limits on quit attempts.

Payers can further increase cessation by working with health care providers and practices to implement the clinical and health systems interventions recommended in the 2008 Public Health Service Clinical Practice Guidelines, the 2015 USPSTF tobacco cessation recommendation statement, and the CDC Million Hearts tobacco cessation protocol. These interventions allow health systems to integrate tobacco dependence treatment into routine clinical practice in order to ensure that this treatment becomes a standard of care.
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.

FAST FACTS

Smoking is the leading cause of preventable disease and death in the United States. It results in about 480,000 premature deaths and more than $300 billion in direct health care costs and lost productivity each year.12, 13 The prevalence of cigarette smoking is especially high among certain groups of adults, particularly persons of lower socioeconomic status and persons with mental illness or substance use disorders.

PROVIDERS

An important first step in implementing clinical cessation interventions is for providers to ask all patients about tobacco use at every visit. If patients are not identified as tobacco users, providers will not be able to intervene with them. In addition, health care systems will not have an accurate understanding of tobacco use prevalence in their patient population.

Once they have identified patients who use tobacco products and documented their tobacco use in electronic health records, providers should create a workflow or process where they:

- advise these patients to quit;
- assess their willingness to make a quit attempt;
- assist them in their quit attempts, either directly or by referring them to another cessation resource such as a telephone quitline; and
- arrange follow-up5,8

To increase efficiency and lessen the burden on physicians, these steps can be distributed among the health care team, including nurses, physician assistants, and medical assistants. Each member of the team should have a clear understanding of their roles during a patient visit for tobacco cessation.

Tobacco cessation services can be delivered by a multi-disciplinary health system team (e.g. identification of smokers at every office visit as part of the workflow, recording of readiness to quit into the electronic health record, team support for the quit attempt, prescribing medications and cessation counseling to support the quit attempt) can sustain cessation efforts and improve cessation rates.8

Having each member of a medical team contribute to the workflow or process of tobacco cessation visits can improve tobacco cessation rates of standard visit-based treatments.9 Proactively offering barrier-free treatments to known tobacco users, independent of their health care visits, has shown to be a feasible, cost-effective way to increase the reach of treatment (primarily Nicotine Replacement Therapy [NRT]) and to increase short-term quit rates.10

Payers can promote covered treatments to tobacco users and health care providers to increase awareness that these treatments are available, interest in quitting, and use of evidence-based treatments.11
CURRENT PAYER COVERAGE (AS OF MARCH 2017)

MEDICARE

✓ Covers individual cessation counseling, but not group or telephone cessation counseling.
✓ Asymptomatic persons are not subject to cost-sharing for counseling, but persons who have already developed a smoking-related disease may be subject to cost-sharing.
✓ Covers prescription medications, but not over-the-counter cessation medications.

MEDICAID

✓ Varies by state.
✓ As of October 2010, traditional (i.e., non-expansion) state Medicaid coverage is required to provide a comprehensive cessation benefit, including cessation counseling and medications, to pregnant women on Medicaid without cost-sharing.\(^\text{14}\)
✓ Under a Centers for Medicare & Medicaid Services policy announced in 2011, state tobacco control programs can work with their state Medicaid programs to secure a 50 percent administrative match rate for counseling provided to Medicaid enrollees by state quitlines.\(^\text{15}\)
✓ As of January 2013, traditional state Medicaid programs can cover, but are not required to cover, cessation counseling for non-pregnant enrollees.\(^\text{16, 17}\)
✓ As of January 2014, traditional state Medicaid coverage can no longer exclude FDA-approved cessation medications from coverage.\(^\text{18}\) However, this coverage can still impose barriers such as copayments or prior authorization on these medications.\(^\text{19, 20}\)
✓ As of January 2014, expansion Medicaid coverage is required to cover evidence-based preventive services, including tobacco cessation, without cost-sharing.\(^\text{14, 21}\)
✓ As of January 2017, Medicaid programs in ten states covered individual and group counseling and all seven FDA-approved cessation medications, while Medicaid programs in 32 states covered all seven FDA-approved cessation medications.\(^\text{22}\)
✓ As of January 2013, state Medicaid programs receive a 1% increase in the Federal Medical Assistance Percentage for certain preventive services, including tobacco cessation, if they cover all these services without cost-sharing.\(^\text{14}\)

COMMERCIAL/PRIVATE

✓ Varies by plan.
✓ Non-grandfathered plans, whether fully insured or self-insured, are required to cover evidence-based preventive services, including tobacco cessation, without cost-sharing. These plans can ensure that they are in compliance with this requirement by following the current federal guidance on this topic.\(^\text{14, 23}\)
✓ Grandfathered plans are not subject to the requirement to cover evidence-based preventive services without cost-sharing.\(^\text{24}\) 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 plans make changes that result in the loss of their grandfathered status.
**SUPPORTING HEALTH AND COST EVIDENCE: SCIENCE BEHIND THE ISSUE**

Five studies of interventions to reduce out-of-pocket costs for cessation medications and counseling were assessed in a CDC Community Guide economic review. Cost-effective estimates were provided in four studies, with a median cost estimate of $2,349/Quality-Adjusted Life Year saved (range of values: $1,290 to $2,647 in three studies) based on five estimates from two studies, a cost per life year saved estimate of $5,990 (one study), and a cost per disability-adjusted life year estimate (a measure of life lost to death and disability) averting of $7,695 to $16,559 (one study). Eight out of 10 studies found that benefits associated with these interventions exceeded costs. Thus, in all the studies that provided cost effectiveness estimates, the interventions were highly cost effective.

In 2006, Massachusetts implemented and widely promoted an evidence-based Medicaid tobacco cessation benefit. The benefit covered up to 16 individual or group cessation counseling sessions and two 90-day courses per year of FDA-approved cessation medications, including over-the-counter and prescription medications. More than one in three (37%) of smokers enrolled in the state Medicaid program used the benefit. 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. Annualized hospitalizations for heart attacks and other acute heart disease diagnoses fell by 46% and 49%, respectively. These outcomes were achieved within a three-year timeframe. Finally, every $1 invested in the program was associated with $3.12 in savings in hospital costs for averted acute cardiovascular events alone, resulting in a return on investment of $2.12. These findings suggest that a tobacco cessation benefit that includes coverage for medications and behavioral treatments, has few barriers to access, and is heavily promoted to smokers and their health care providers can be widely used, substantially reduce smoking prevalence, lead to improved health outcomes, and achieve a favorable return on investment by reducing health care costs.

For more information and resources, please visit [https://www.cdc.gov/sixeeighteen/tobacco/](https://www.cdc.gov/sixeeighteen/tobacco/).

**REFERENCES**


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