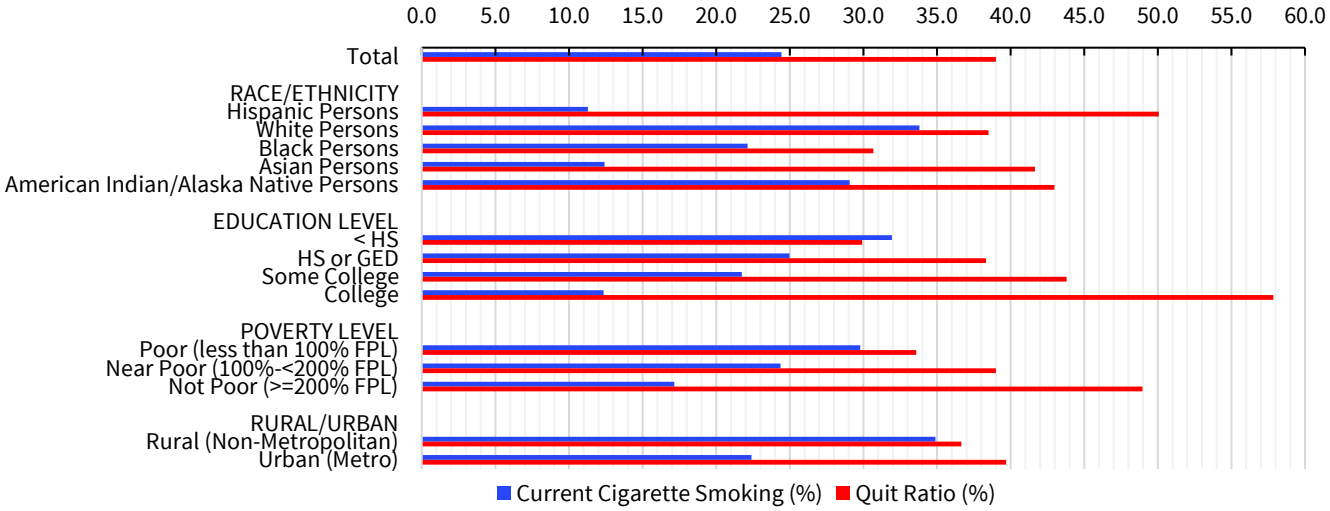
Medicaid Coverage of Tobacco Cessation Can Help to Address Health Disparities

In 2020, nearly 31 million adults used cigarettes and a disproportionate number of those individuals relied on Medicaid for their health care.[i] Smoking cigarettes significantly increases an individual's risk to get at least 12 cancers.[ii] The smoking rates for adults on Medicaid is 22.7%, which is more than double the 9.2% of individuals who smoke with private insurance or the overall 12.5% of adults who smoke.[iii] Many individuals on Medicaid have limited incomes and studies have identified that they are unable to pay out-of-pocket for this lifesaving treatment.[iv] Medicaid enrollees are more likely to need cessation support given their economic status and higher likelihood of tobacco use, yet not all Medicaid plans provide a comprehensive tobacco cessation benefit.

The current smoking rate among Medicaid insured US adults ages 18-64 years old is highest among individuals who reside in rural or non-metropolitan areas (34.9%), white persons (33.8%), individuals who have less than a high school education (31.9%), individuals with incomes less than 100% of the federal poverty level (29.8%) or are American Indian/Alaska Native persons (29.1%). The same data set indicates the proportion of Medicaid insured US adults ages 18-64 years less successful at quitting is lower among individuals with less than a high school education (29.9%), Black individuals (30.7%), individuals with incomes less than 100% of the federal poverty level (33.6%) or reside in rural or non-metropolitan areas (36.7%). Therefore, it's not surprising that cessation rates are lower among groups with higher tobacco use rates in comparison to all people who smoke.[v] In 2020, the percentage of successful quit attempts was less than 40% for individuals insured by Medicaid,[vi] whereas it was 65% overall.[vii] Eliminating tobacco-related disparities requires that Medicaid enrollees have access to comprehensive cessation benefits without cost-sharing or other barriers to quit tobacco.

Current Cigarette Smoking, Quit Ratio, Among Medicaid Insured Persons, 18-64 Years, NHIS 2019-2021 Pooled Data



Quit ratio: proportion of former smokers among ever smokers used to measure trends in cigarette smoking cessation in the population.
Source: U.S. Department of Health and Human Services. Smoking Cessation. A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2020. p 67.

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What Does a Comprehensive Tobacco Cessation Benefit Include?

Federal law requires Medicaid expansion plans and marketplace plans (except those that are grandfathered) to cover all preventive services that receive an A or a B rating from the United States Preventive Services Task Force (USPSTF) without cost to the patient. Traditional Medicaid programs must cover these services for pregnant persons only and are incentivized to cover them for all enrollees through a one percent increase in their federal dollar matching rate. The USPSTF recommends, with an A rating, that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)– approved medications to adults who use tobacco (except for pregnant persons). A comprehensive Medicaid tobacco cessation benefit includes coverage for all three different types of counseling (individual, group, and phone counseling-inclusive of the state's Quitline) and seven FDA-approved pharmacological interventions (e.g., five nicotine replacement therapies and two additional prescription medications). People respond differently to different interventions; therefore, coverage for a range of counseling types and medications is essential.

Comprehensive Cessation Benefits Should Include Coverage for:

- Individual counseling
- Group counseling
- Phone counseling
- Nicotine Replacement Therapy (NRT) gum
- NRT patch
- NRT lozenge
- NRT inhaler
- NRT nasal spray
- Bupropion
- Varenicline

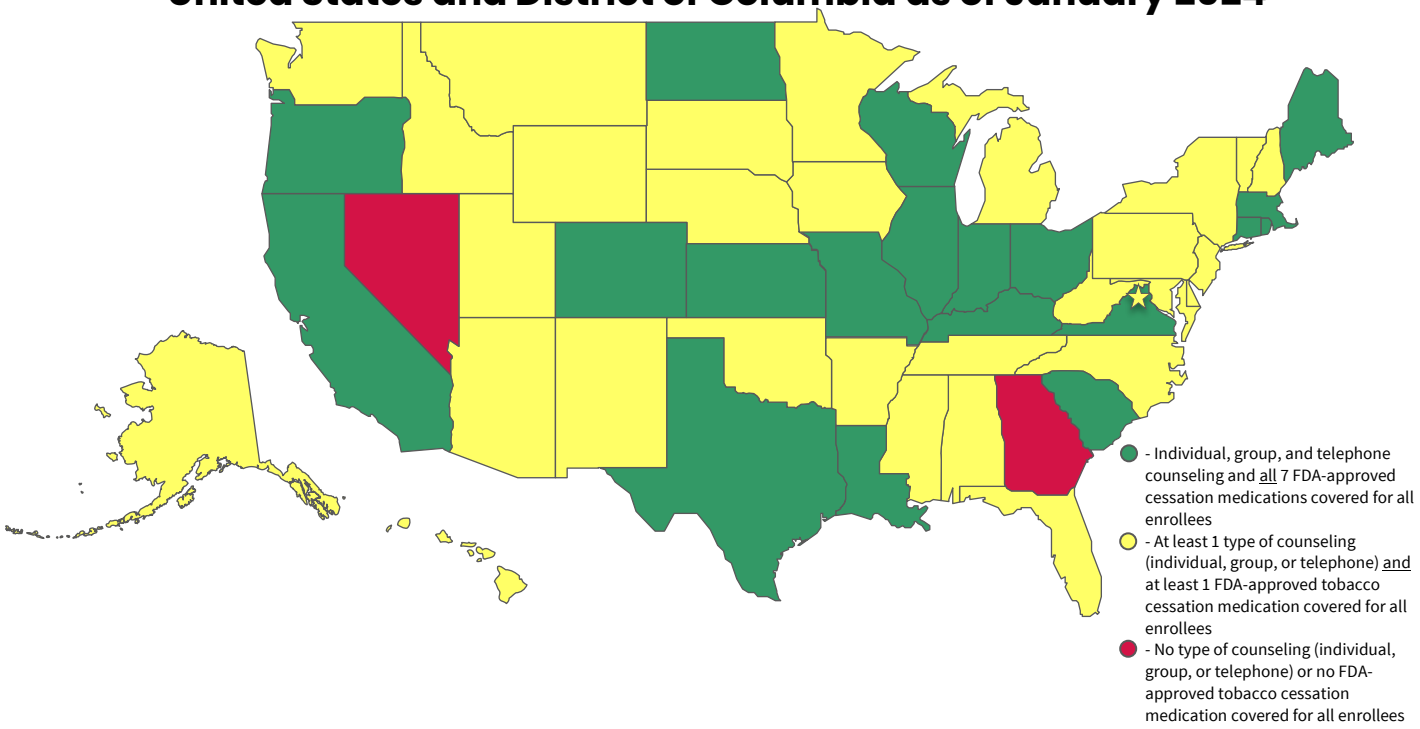
State Variations Exist in Adult Medicaid Enrollees Use of Cessation Medications and Counseling Services

The Surgeon General highlighted how approximately 44% of adults who smoke and visited with their healthcare professional were not given quitting advice in the 2020 Cessation Report.[vi] A 2021 study used available state Medicaid claims data to identify the extent fee for service Medicaid adult enrollees who smoke and attempted to quit accessed the seven FDA-approved cessation medications and cessation counseling services.[xii] Data from 37 states showed on average 9.4% of adults on Medicaid accessed cessation medications and that the average number of cessation medication claims per user was 2.5. Whereas cessation counseling claims data from 20 states identified on average only 2.6% of individuals on Medicaid who smoke received counseling services. Reducing preventable death and tobacco-related diseases among adults on Medicaid who smoke requires both increasing access and promotion of FDA-approved cessation medications and counseling services. These studies emphasize the continued need to widely promote comprehensive and barrier-free cessation services generally and especially for Medicaid enrollees to provide them with the tools to help them successfully quit.

How Does Tobacco Cessation Coverage Vary by State?

Throughout the 50 states and District of Columbia, Medicaid cessation benefits vary significantly by state, even within states, and by plan. **Nineteen** states provide a comprehensive tobacco cessation benefit that includes coverage for all three types of counseling and seven types of medication for all enrollees. Conversely, enrollees in **two** states do not have access to even one type of counseling. Changes in coverage are needed to ensure Medicaid enrollees in all states have access to a comprehensive tobacco cessation benefit.

Traditional Medicaid Cessation Coverage in the United States and District of Columbia as of January 2024



Barriers to Tobacco Cessation Services

Research shows that enrollees are more likely to quit successfully if their Medicaid coverage does not impose any barriers to care.[viii] There are six key barriers that can prevent individuals from accessing comprehensive cessation benefits: co-payments, prior authorization requirements, limits on treatment duration, yearly or lifetime dollar limits, step therapy, and required counseling for medications.

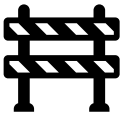
1. **Co-Payments**
   Some patients are required to visit their provider and pay a fixed dollar amount or co-payments at the time of service. Federal law prohibits marketplace plans and Medicaid expansion plans from charging co-pays for tobacco cessation treatment, but some traditional Medicaid plans still include co-pays for cessation services. Evidence shows that co-pays reduce the use of cessation medications and the overall success of quitting; therefore, states should not impose co-pays for tobacco cessation interventions in traditional Medicaid plans.[ix,x] Charging Medicaid enrollees a co-pay for the use of cessation service that may be available at no charge for higher-income individuals covered by marketplace plans further increases disparities in access to care.

2. **Prior Authorization Requirements**
   Prior authorization requires the physician or the patient to first get approval from their Medicaid program before receiving a prescription. This can lead to delays in treatment which could cause a patient to abandon treatment. It can also create an administrative burden for physicians and other providers, particularly if they provide care for a high volume of patients.

3. **Limits on Treatment Duration**
   For many people it takes multiple attempts to successfully quit smoking. Limiting the number of counseling visits or medication refills that Medicaid covers creates a disincentive for patients trying to quit who may need additional counseling sessions or medication to be successful. According to data cited by the USPSTF, brief in-person counseling sessions effectively increase the proportion of adults who remain abstinent from smoking for one year.

4. **Yearly or Lifetime Dollar Limits**
   Limiting the dollar coverage allowed for tobacco cessation is also a barrier to helping people who use tobacco quit. The cost of treatment depends on a variety of factors, including what type of medication and/or counseling a patient is using and the length of their treatment. Limits on the dollar amount Medicaid will spend on an individual enrollee prevents the enrollee from receiving the full course of treatment based on their individual needs for quitting successfully. Tobacco is incredibly addictive, and it may take many attempts to achieve the right treatment regimen that helps the patient successfully quit. Very few people achieve long-term success with an initial quit attempt.[xi]

A Comprehensive Cessation Benefit Should Not Include these Barriers to Accessing Services:



- Co-Payments
- Prior Authorization Requirements
- Limits on Treatment Duration
- Yearly or Lifetime Dollar Limits
- Step Therapy
- Requiring Counseling for Medications

5. **Step Therapy**
   Step therapy requires patients to try and fail using less expensive treatments before more expensive medications will be covered. This could force patients into a cycle of trying out treatments they have already deemed ineffective if they have to restart at the bottom of the ladder each time. The imposition of step therapy on tobacco cessation medications ignores the fact that some treatment modalities (e.g., patch, medications, etc.) are more effective for some enrollees than others. Personalized recommendations for the most effective treatment should be made for each enrollee, even if that means starting the enrollee on a more expensive medication.

6. **Requiring Counseling for Medications**
   While the best practice to help people stop tobacco use is a combination of counseling and medication, Medicaid plans should not require patients to receive counseling before obtaining cessation medications. This could deter patients from even attempting to quit. An enrollee's preferences should be prioritized, and counseling requirements should not present a barrier to accessing FDA-approved cessation medications.

Why Should Medicaid Reimburse Quitline Phone Counseling?

Phone counseling, often facilitated through a service known as *Quitline*, is typically free for patients to use. State quitlines are just as effective as individual or group counseling and may be more convenient. Currently, some states do not provide Medicaid coverage for quitlines, depending on state tobacco cessation programs for funding. Unfortunately, state tobacco control funds are limited and vulnerable to budget cuts. Medicaid reimbursement of quitlines for phone counseling increases the capacity of the quitline. Medicaid enrollees make up 39% of state quitlines users; therefore, it makes sense that Medicaid should provide reimbursement to the quitline for providing the service to enrollees. This allows the state tobacco control dollars to provide free telephone counseling as a last resort for those are not covered by another source. Medicaid can contract with existing state quitlines and either reimburse the quitline per user, like other services are reimbursed, or through an administrative match, where Medicaid pays a set amount to the quitline. It is financially beneficial for state budgets to have Medicaid reimburse quitlines because states receive a federal match for paying Medicaid expenses.

ACS CAN's Recommendations

ACS CAN recommends that Medicaid programs cover a comprehensive tobacco cessation benefit that includes access to all three types of counseling and all seven FDA-approved medications, without enrollee cost-sharing or other barriers. While federal law has been effective in increasing coverage of tobacco cessation services for pregnant persons enrolled in Medicaid as well as enrollees in most private insurances and Medicaid expansion plans, there are still gaps in coverage when it comes to enrollees in traditional Medicaid plans. Requiring traditional Medicaid plans to provide a comprehensive tobacco cessation benefit without barriers is key to helping people quit using tobacco. Ultimately this public health intervention will save money and lives. To achieve health equity, it is essential Medicaid enrollees are not left behind while individuals on other forms of insurance have comprehensive tobacco cessation coverage.

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