helping benefit Oregon smokers

Collaborating to help Oregon tobacco users quit.

Background for Collaboration

Oregon Tobacco Control

Oregon has a long history of leadership in tobacco control and tobacco cessation. Oregon was one of the first states to increase the tobacco tax and dedicate some of the revenue to programs and services to help prevent and treat tobacco use. Since the program began in 1996, cigarette consumption among Oregon adults has declined by nearly half, smoking among teens has been cut in half, and smoking among Oregon adults has declined by 28% from 23.7% in 1992 to 17% in 2007. Yet, nearly one out of five deaths in Oregon is tobacco-related and costs to Oregon exceed $2.2 billion annually.[1]

Treatment for tobacco dependence is effective and smokers can and do quit. An important focus of Oregon Tobacco Control has been to involve health plans in the development of coverage and services to help smokers quit. Oregon is a leader in providing coverage for tobacco cessation for Medicaid recipients through the Oregon Health Plan and to pioneer a cooperative system between health plans and the telephone quitline in 1998. Since then, many of our insurers have offered some support for people who want to quit smoking. But most did not include tobacco dependence treatment as a core benefit, and some provided no coverage.

The passage of SB 734 creates an opportunity to come together and provide renewed leadership for establishing effective and high quality services to help Oregon smokers quit. The new law requires Oregon's health plans to provide tobacco cessation programs for persons age 15 and older. Now, nearly all Oregonians with private health insurance have access to benefits and many states have passed or are supporting similar legislation. Seven states have some requirements requiring commercial or private insurers to offer tobacco use cessation benefits, now including Oregon. Forty-eight states have added tobacco dependence treatment as part of the core coverage in their Medicaid benefit plans.

Tobacco Cessation Benefits in Oregon

The Oregon Coalition of Health Care Purchasers (OCHCP) conducted a survey of health plans and employers prior to the implementation of SB 734.[2] Among the eight health plans that responded, three were covering cessation services as a core benefit. The other five plans offered cessation coverage as a rider (2), as a “value added” benefit (1), as a negotiated benefit with large groups only (1), or as part of a wellness program (1). After January 1, all the plans have modified their benefits to include cessation coverage, some limiting coverage to a $500 lifetime maximum. In some cases new medications were added to the formulary. Some plans may require a pre-program assessment and most have co-pays. Health plans identify smokers via health risk appraisals (5), claims data (2) intake assessments and questionnaires (4) health coaches (1), and PCP referrals (1).

Eight employers responded to the OCHCP survey. Of these, two provide tobacco cessation as a benefit; four did not know if there was coverage, and two did not provide coverage. Three employers knew about the mandate. But, seven employers were interested in offering cessation services and thought their employees would consider tobacco cessation benefits a positive addition to the benefit package.

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Tobacco Dependence

Nicotine from tobacco is a central nervous system active compound that causes significant, long-term changes in brain and body chemistry, and is primarily responsible for dependence on tobacco. When smokers quit, or even cut down, the reduced amount of nicotine that binds to nicotine receptors in the brain and elsewhere causes major disruptions experienced as nicotine withdrawal. Some tobacco users can tolerate reduced nicotine levels, continue to function more or less normally, and may need little or no treatment to quit. For the majority of smokers, the effect of nicotine withdrawal is so disruptive they are unable to function normally. Relapse to smoking is common and these smokers need treatment to successfully quit.

The most effective tobacco cessation benefits combine use of an FDA approved medication (or combinations of medications) together with multiple, person-to-person counseling or coaching sessions. The medications help manage withdrawal, giving smokers enough relief so they are more likely to benefit from behavioral counseling/coaching and make the necessary adjustments in their lives. In general, the more comprehensive and intensive the treatment, the better the result (see Table 1). Smokers who get effective treatment are 2 to 3 times more likely to quit.[3]

There are multiple risk factors for developing tobacco dependence. Genetics are a factor along with early exposure and family history. Persons with mental health disorders are more likely to initiate smoking, in part to manage their illness, and find it significantly more difficult to stop. It has been estimated that just under half of all cigarettes smoked in the US are smoked by people who have had a mental illness or substance use disorder in the last 30 days.[4] In a recent study of callers to the California Smokers' Helpline, 42% had been diagnosed by a health care provider as depressed in the last year.[5]

Smokers who use nicotine to help manage their co-morbidities (pain, depression), need more comprehensive and intensive treatment for tobacco dependence and their treatment may need to be coordinated with other health care.

Table 1

Program Intensity	% Quit Rates
Low[a]	16%
High[b]	32%

[a] Clinician advice + NRT
[b] Clinician advice + multiple counseling sessions + variety of medications

National Tobacco Cessation Benefit Recommendations

Covering tobacco cessation benefits improves access to services and increases the chances that smokers will get the treatment they need. Treating tobacco dependence, especially among smokers with co-morbidities, is similar to treatment for chronic disease. Several types of treatments may need to be tried before a treatment is found that can stabilize the disorder and help patients recover. Flexibility is important. The design and administration of the benefit will significantly affects outcomes. Based on existing research, the Centers for Disease Control and Prevention recommend a benefit[6] that:

1. Covers at least four counseling sessions of at least 30 minutes each, including telephone and individual counseling sessions;
2. Covers all FDA approved medications;
3. Provides coverage for both medications and counseling/coaching for at least two quit attempts annually;
4. Eliminates or minimizes co-pays or deductibles for counseling and medications.

Role of Health Plans

2008 eValue8 Employer Report[7] outlines the key responsibilities for health plans.

Identification: Effective methods for identifying smokers lead to more opportunities to provide treatment.

Counseling: Offering programs and services that enable patients to access recommended counseling/coaching (Tobacco Quitlines are often part of the solution for employers).

Medication: Offering key treatments and diverse options to match patient needs and reducing barriers to medications and treatments through payment incentives and other strategies.

Tracking: Measuring the number of smokers identified compared to the expected rate in the population; measuring success of identification, referral, and treatment programs.

Outcomes: Measuring effectiveness of identification and treatment programs.

About Tobacco Quitlines

Quitlines provide evidence-based interventions for tobacco cessation via the telephone. Quitlines in the US collectively serve about 400,000 tobacco users a year. They represent a public health model of tobacco dependence treatment but also can bridge public health and clinical models. Quitline counselors and coaches help callers devise an individualized plan to prepare to quit and, in many cases, make proactive follow-up calls to support quitting.

Quitlines vary, but most are open early morning through late evening (M-F), with some weekend hours. First-time callers are taken through a brief set of questions to determine the appropriate service. Callers are typically given a choice of services: Self-help materials, referrals to face-to-face programs, and telephone counseling for tobacco cessation. Counseling/coaching occur on-the-spot when possible, otherwise an appointment is scheduled. Quitlines are geared toward the general tobacco using population, but significant numbers of tobacco users with co-morbidities call quitlines.

The Oregon and Washington Tobacco Quitlines are handled through Free & Clear, Inc. in Seattle, WA.
The toll free number is 1-800-Quit Now (1-800-784-8669).

Economics of Cessation Benefits

Smoking cessation programs are low cost and generate a positive return on investment. The relative costs and returns depend on the benefit design, utilization, and cost sharing. However the benefits are structured, they are consistently demonstrated to be cost effective for both employers and health plans.

Smoking cessation programs vary in comprehensiveness and intensity. As intensity increases, efficacy increases, and costs also increase – see Table 2. The investment for health plans and employers will depend on the design of the program and any cost sharing by employees. Utilization of smoking cessation programs in any year is usually modest since there are a limited number of smokers who are ready to quit at any time and even fewer who are ready to seek treatment. By sustaining and promoting the benefit over time, more smokers quit over time, health outcomes improve, and the return on investment increases.

There are some differences in the net financial returns for health plans and employers. The higher intensity/higher cost interventions produce more quitters than lower-intensity/lower cost interventions so are more beneficial for employers. But the health plan ROI PMPM is somewhat higher for the lower-intensity/lower cost interventions (see Table 2). For employers, more smokers quitting means more savings, so the higher intensity/higher cost interventions produce the best results. Health plans and employers will need to discuss how to equitably distribute the costs and benefits of the intervention program.

Table 2: Estimated Outcomes and Costs by Program Intensity

Program Intensity	Quit Rates[a]	Enrollment Rates[b]	PMPM[b]	ROI[c]	
				Year 2	Year 5
Low	16%	6%	$.19	$.43	$.1.96
High	32%	6%	$.45	$.23	$1.77

[a] Fiore MC, Jaén CR, Baker TB; et al. *Treating Tobacco Use and Dependence: 2008 Update.* Rockville, MD: US Dept of Health and Human Services; May 2008.
[b] Covering Smoking Cessation as a Health Benefit: A Case for Employers. Milliman, Inc. 2006. http://www.legacyforhealth.org/PDFPublications/Milliman_report_ALF_-_3.15.07.pdf
[c] *A Good Investment in a Bad Economy: The ROI Case for Helping Your Members and Employees Quit Smoking.* America's Health Insurance Plans Virtual Seminar. September 17, 2009 , Jeffrey L. Fellows, PhD, Center for Health Research , Kaiser Permanente Northwest.

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