Barriers to Tobacco Cessation Treatment in Standard State Medicaid Programs, 2019

Medicaid enrollees smoke at more than twice the rate of privately insured individuals. This places Medicaid enrollees at increased risk of disease and premature death. It also increases state and federal spending on health care for this population. The 2020 Surgeon General's Report on Smoking Cessation concluded that insurance coverage for comprehensive cessation treatment with no barriers increases utilization, which in turn leads to higher rates of successful quitting and is cost-effective.[1] This conclusion is in line with research that focuses specifically on Medicaid coverage of tobacco cessation treatment, including medications and counseling.[2,3,4,5]

Current law requires state Medicaid programs to cover all tobacco cessation medications approved by the U.S. Food and Drug Administration (FDA), but not cessation counseling, for all Medicaid enrollees.[6,7] Unlike Medicaid expansion plans, standard (non-expansion) state Medicaid programs are allowed to impose cost-sharing for tobacco cessation services.[*] Therefore, even when they provide comprehensive coverage of medication and counseling, state standard Medicaid programs often impose barriers that can make it harder for Medicaid enrollees to access tobacco cessation treatments and to quit smoking.

Methodology

Between August 1, 2019 and December 31, 2019, the American Lung Association collected data on state Medicaid (standard, not expansion) tobacco cessation coverage from state Medicaid programs and Medicaid managed care plans, member and provider handbooks, provider websites, policy manuals, formularies, preferred drug lists, Medicaid state plan amendments, and other relevant regulations and laws. To verify the collected data, the American Lung Association contacted Medicaid agencies and state health departments, allowing for updates to documents and corrections of data interpretation.

The American Lung Association reviewed these documents to assess coverage of nine tobacco cessation treatments and the following seven barriers:

1. Limits on duration
2. Annual limits on quit attempts
3. Lifetime limits on quit attempts
4. Prior authorization required
5. Copayments required
6. Stepped-care therapy
7. Counseling required for medications

Comprehensive Tobacco Cessation Benefit:

Seven FDA-Approved Medications:

- NRT Gum
- NRT Patch
- NRT Lozenge
- NRT Inhaler
- NRT Nasal Spray
- Bupropion
- Varenicline

Three Forms of Counseling:

- Individual
- Group
- Phone

[*] The ACA requires Medicaid expansion programs to cover preventive services with an "A" or "B" rating from the U.S. Preventive Services Task Force (USPSTF) without cost-sharing. The USPSTF assigns adult tobacco cessation an "A" grade. Federal guidance defines coverage for tobacco cessation to include two quit attempts per year, with each quit attempt including four sessions of tobacco cessation counseling of at least 10 minutes and a 90-day regimen of all FDA-approved cessation medications with no cost-sharing and with no prior authorization.

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Findings

Although state standard Medicaid programs are required to cover all seven FDA-approved tobacco cessation medications for all enrollees, most, but not all do. Forty-seven state standard Medicaid programs cover all seven FDA-approved cessation medications for some or all standard Medicaid enrollees, and more than half cover two types of counseling (individual and group)[†] for some or all standard Medicaid enrollees. As of December 31, 2019, only two states' standard Medicaid programs, Kentucky and Missouri, covered all seven FDA-approved medications and both individual and group counseling without any barriers. Barriers to accessing these covered treatments are common; these barriers are described in greater detail below (summarized in Table 1).[‡]

Table 1: Coverage of and Barriers to Tobacco Cessation Treatments in Standard Medicaid Programs

		Barriers*						
Type of Treatment	Coverage**	Duration Limit	Lifetime Limit	Annual Limit	Prior Authorization	Copay	Step Therapy	Counseling Required
Nicotine Replacement Therapy Gum	50	29	1	27	9	19	0	14
Nicotine Replacement Therapy Patch	50	28	1	27	9	19	1	15
Nicotine Replacement Therapy Lozenge	49	28	1	26	9	19	0	12
Nicotine Replacement Therapy Inhaler	47	26	1	24	26	20	20	11
Nicotine Replacement Therapy Nasal Spray	47	27	1	24	28	19	20	12
Bupropion	51	30	1	29	11	21	0	13
Varenicline	50	34	1	32	15	21	9	12
Individual Counseling	45	19	1	23	0	2	1	2
Group Counseling	28	8	0	13	0	1	0	1

*Numbers represent states with barriers to tobacco cessation treatment for some or all Medicaid enrollees
**Numbers represent states with tobacco cessation treatment covered for some or all Medicaid enrollees

[†] Data on phone counseling were not considered in this report.
[‡] Information may have changed from the time this data was collected. For the most up-to-date available information, visit: https://www.cdc.gov/statesystem/factsheets/medicaid/Cessation.html#anchor_1562854662

Coverage Limitations

Coverage limitations impede quitting smoking because most smokers try to quit multiple times before succeeding.[8,9,10] These limitations include the specific barriers described below:

- Duration limits restrict the number of days a treatment can be used.
- Annual limits place limits on the number of covered quit attempts a person can make in a year.[§]
- Lifetime limits place limits on the number of covered quit attempts a person can make during their lifetime (or at least while they are enrolled).

In 2019, more than half of states imposed duration limits or annual limits on tobacco cessation medications for at least some Medicaid enrollees. The most common barriers for individual and group counseling were duration limits and annual limits. While lifetime limits are rare, Washington state still imposes this barrier on all cessation medications for some enrollees.

Prior Authorization

Prior authorization occurs when plans require that either the Medicaid enrollee or their clinician contact the insurance plan to obtain authorization for using a medication, which can delay or prevent access to the medication.[11] States were most likely to impose prior authorization requirements on the nicotine nasal spray and inhaler, with 28 states and 26 states, respectively, doing this.

Copayments

Copayments (copays) are out-of-pocket costs that may discourage tobacco users from trying to quit, especially if they cannot afford cessation treatments. Research suggests that copayments, low or high, lead people to be less likely to use cessation treatments.[12,13,14] As of December 31, 2019, many states still required copays for cessation medications for some or all enrollees, ranging from 19-21 states depending on the medication. Bupropion and varenicline were the medications that were most likely to carry a copay under some or all plans. Copays for counseling were uncommon, with Massachusetts and New Hampshire requiring copays for individual counseling for some Medicaid enrollees. Massachusetts also requires copays for group counseling for some Medicaid enrollees.

Stepped-Care Therapy

Stepped-care therapy requires persons to try to quit with one tobacco cessation medication before they are allowed to try other medications.[15] This can deter smokers from using tobacco cessation medications and trying to quit. This is especially true if they have already tried to quit and were unsuccessful using the first medication. States most commonly require stepped-care therapy for the nicotine inhaler and nasal spray (with 20 states each imposing this barrier for these medications).

[§] Some states may impose coverage limits as a result of dosing recommendations that they [their Medicaid programs?] follow.

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Counseling Requirements

Counseling requirements occur when Medicaid programs or Medicaid managed care plans require beneficiaries to enroll in counseling in order to obtain tobacco cessation medication. These requirements are likely motivated in part by a desire for Medicaid beneficiaries to use cessation counseling and medication together, which is the approach that gives smokers the best chance of quitting. However, this requirement can have the unintended effect of discouraging smokers from using cessation medication and from attempting to quit. Evidence suggests a negative association between state Medicaid counseling requirements and Medicaid enrollees' use of cessation medications.[16] As of 2019, at least 11 states required Medicaid beneficiaries to enroll in counseling in order to obtain any cessation medications under some or all Medicaid plans.

Discussion

As of December 31, 2019, 24 state standard Medicaid programs cover all seven FDA-approved tobacco cessation medications and both individual and group counseling. However, state Medicaid programs commonly impose one or more barriers on these covered treatments for some or all Medicaid enrollees. Barriers to tobacco cessation treatment can discourage Medicaid enrollees from making quit attempts and can make it more difficult for them to quit successfully.

Standard state Medicaid programs can encourage and help more Medicaid enrollees to quit smoking by removing barriers to accessing tobacco cessation treatments. These programs can increase quitting among Medicaid enrollees by promoting coverage of tobacco cessation treatment to enrollees and health care providers in order to increase awareness of the covered cessation treatments. These actions are in line with the *2020 Surgeon General's Report on Smoking Cessation* conclusion that a comprehensive, barrier-free and widely promoted coverage for smoking cessation treatment will increase the use of these services and lead to higher rates of successful quitting.

Conclusion

Tobacco cessation coverage is only one factor in increasing access to cessation services; coverage is a necessary condition, but not a sufficient one. Moving forward, it is important to recognize that people who smoke may take 30 or more quit attempts on average before successfully quitting.[17] Also, because Medicaid enrollees are by definition low-income, they are often unable to afford to pay for cessation treatment out of pocket. By providing a comprehensive tobacco cessation benefit with no barriers, states can increase Medicaid enrollees' use of proven cessation treatments and help more Medicaid enrollees quit smoking, thus reducing smoking rates and smoking-related disease, death, and health care costs in the Medicaid population.

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[1] 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.
[2] Bailey SR, Hoopes MJ, Marino M, et al. (2016) Effect of Gaining Insurance Coverage on Smoking Cessation in Community Health Centers: A Cohort Story. Journal of General Internal Medicine, 31(10), 1198-1205.
[3] Land T, Warner D, Paskowsky M, et al. (2010) Medicaid Coverage for Tobacco Dependence Treatments in Massachusetts and Associated Decreases in Smoking Prevalence. PLOS ONE, 5(3): e9770
[4] Department of Health and Human Services, Office of the Surgeon General. (2014). The Health Consequences of Smoking–50 Years of Progress: A Report of the Surgeon General. Available at: https://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf.
[5] McCallum DM, Fosson GH, Pisu M. Making the case for Medicaid funding of smoking cessation treatment programs: an application to state level health care savings. J Health Care Poor Underserved, 2014; 25(4):1922–40
[6] American Lung Association. Tobacco Cessation Treatment: What Is Covered? Available at: http://www.lung.org/our-initiatives/tobacco/cessation-and-prevention/ tobacco-cessation-treatment-what-is-covered.html
[7] 9PPACA Sec. 2502
[8] Department of Health and Human Services, Office of the Surgeon General. (2014). The Health Consequences of Smoking–50 Years of Progress: A Report of the Surgeon General. Available at: https://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf
[9] American Lung Association. Barriers to Accessing Tobacco Cessation Treatment in Medicaid. Available at: http://www.lung.org/assets/documents/tobacco/barriers-to-accessing-tobacco.pdf
[10] A Clinical Practice Guideline for Treating Tobacco Use and Dependence: 2008 Update: A U.S. Public Health Service Report. American Journal of Preventive Medicine, 2008; 35(2): 158-176.
[11] Galaznik A, Cappel, K, Montejano L, et al. (2013). Impact of access restrictions on varenicline utilization. Expert review of Pharmacoeconomics & Outcomes Research, 13(5), 651-656.
[12] Greene J, Sacks RM, McMenamin SB. (2014). The impact of tobacco dependence treatment coverage and copayments in Medicaid. American Journal of Preventive Medicine, 46(4), 331-336.
[13] Zeng F, Chen CI, Mastey V. (2011). Effects of copayment on initiation of smoking cessation pharmacotherapy: an analysis of varenicline reversed claims. Clinical Therapeutics, 33(2), 225-234.
[14] Michael Chernew, et. al., "Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care," *Journal of General Internal Medicine* 23, 8 (August 2008):1131-1136.
[15] Heath, Sara. "How Prior Authorization Affects Timely Patient Treatment Access." Patient Care Access News. https://patientengagementhit.com/news/how-prior-authorization-affects-timely-patient-treatment-access
[16] Ku L, Brantley E, Bysshe T, et al. (2016). How Medicaid and Other Public Policies Affect Use of Tobacco Cessation Therapy, United States, 2012-2014. Preventing Chronic Disease, E150.
[17] Chaiton M, Diemert L, Cohen JE, *et al* Estimating the number of quit attempts it takes to quit smoking successfully in a longitudinal cohort of smokers. *BMJ Open* 2016;**6**:e011045. doi: 10.1136/bmjopen-2016-011045