State of Maine
Department of Health and Human Services

Partnership for a Tobacco Free Maine,
Maine Center for Disease Control and Prevention
and
Office of MaineCare Services

Final Report
on
Resolve, Regarding Tobacco Cessation and Treatment

December 15, 2008

TABLE OF CONTENTS

Page

Summary

Resolve 2007, c. 34 (**Appendix A**) directed the Department of Health and Human Services to "undertake a study of best practice treatment and clinical practice guidelines for tobacco cessation treatment" and to "use the most recent available clinical practice guidelines ("Guidelines") of the U.S. Department of Health and Human Services Public Health Service".

The study included development of a model tobacco cessation treatment program in the public and private sectors and was conducted by the Partnership For A Tobacco-Free Maine ("PTM"), Maine Center for Disease Control and Prevention ("ME CDC") and the Office of MaineCare Services ("Medicaid"). PTM and Medicaid reported back in a preliminary report to the Joint Standing Committee on Health and Human Services ("the Committee") on January 15, 2008: **http://mainegov-images informe.org/dhhs/reports/tobacco.pdf** The workgroup's request to be permitted to provide a final report by December 15, 2008 was accepted by the Committee.

This final report pursuant to the Resolve is submitted by Medicaid and PTM.

A workgroup consisting of staff from Medicaid, PTM and PTM partner organizations (or sub-groups) met nine times during the spring, summer and fall of 2008 on April 10, May 2, May 28, June 26 (full group), July 16, August 12, August 14 (full group), August 26 and September 23 to finalize discussion, planning and recommendations for the final report. Workgroup members, including those providing information in this report who did not attend meetings, are listed in **Appendix B**.

Private Sector

1) Survey of Maine employers[1]. A survey of a relatively large (50) group of Maine based private employers representing 19% of Maine employees was conducted by PTM through Maine Health Management Coalition (MHMC) to better understand the coverage currently available in Maine through self-funded and other insurance plans. The recent increase in the number of self funded plans, not generally subject to state regulation, made this information more difficult to obtain. Member organizations were surveyed in December,2008 and the survey and a summary of results are attached as **Appendices C** and **D**, respectively. At the end of the survey, information on the 'gold standard' for tobacco dependence treatment coverage was provided to member organizations. A 'baseline' survey assessing tobacco dependence coverage of all 30 MHMC members, was conducted in 1998 by Susan Swartz Woods, MD, MPH. Excerpts from the earlier survey executive summary are included as **Appendix E**.

2) Wellness programs. There has been a large increase, nationally as well as in Maine in employer based wellness programs which include tobacco cessation cost incentives in an effort to reduce health care costs of employees. Dozens of bills have been introduced across the country to spur introduction of wellness programs in the public and private sectors. In Maine, in the past year, two bills (not enacted) provided incentives to encourage wellness programs[2]. Some large employers in Maine, such as Maine Health, Barber Foods, L.L. Bean and Cianbro, have established worksite wellness policies that include tobacco free grounds and wellness programs with cash or other incentives to quit such as free counseling and nicotine patches. Cianbro's policy is notable in that it includes disincentives for violating the smoke free policy in the form of lost wages and eventual dismissal for multiple violations.

An informal survey of worksite wellness programs in June, 2008 of small businesses (50 or fewer employees) randomly selected in Kennebec County, was conducted by Healthy Communities of the Capitol Area. Of the 27 who responded,

[1] A 2007 national survey of 502 employers' perceptions about the business impact of smoking was conducted by the National Business Group on Health. The report, "Smokers in the Workplace", noted that, 85% of small and large employers believed that offering smoking cessation benefits would improve employees' health and decrease health care costs but only 2% of companies surveyed provided comprehensive smoking cessation benefits (62%/61% covered counseling/prescription medications; only 37% covered over the counter NRT, only 27% eliminated or minimized co-pays or deductibles). The survey online :http://www.calquits.org/page_attachments/0000/0036/NBGH_Employer_Survey_Summary_Report.PDF

[2] LD 1890 (2008) would have required all carriers to offer a discount on premiums for non-smokers and would have required small and large group carriers to offer a discount on premiums for participants in wellness programs. The Dirigo Health Maine Quality Forum would have been required to develop certification standards for eligible workplace wellness programs. LD 2059 (2007) would have allowed businesses to take a tax credit for instituting a wellness program that included a smoking cessation class.

67% supported employees who want to quit by offering insurance coverage, counseling, classes, medications or simply posting Helpline posters in employee areas. 89% said that they had a worksite tobacco policy and the majority reported that they were moving to incorporate a wellness policy as a part of that. There is no known information as to the efficacy of these programs in Maine.

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Public Sector

The following is a summary of the results of the study and final actions by Medicaid and PTM on preliminary proposals:

1) **Guidelines**

The final 2008 Guidelines published in May differ little from the draft 2008 Guidelines issued in November, 2007. The final Guidelines did note that only 25% of Medicaid patients reported any practical assistance with quitting or any ensuing follow up. The 2008 Guidelines focus much more heavily on the need for systemic delivery of tobacco dependence treatment (recognizing that physicians and other providers are only one, important part of a larger system), on emerging evidence of the efficacy of treating special populations and perhaps most importantly, on comparative, evidence based analyses of the efficacy of new (varenicline) and multiple pharmacotherapies. The last is particularly useful as a guide for purchasers. See **Appendix F** for comparative data on the efficacy of pharmacotherapies (source: 2008 Guidelines).

2**) Model Program**

The workgroup determined (and this finding was not revised for the final report) that a model tobacco dependence treatment program in either the public or private sector includes:

1. Screening, identification and intervention for tobacco use by every practice with referral as necessary for further counseling
2. Evidence based pharmacotherapy is readily available to all
3. Pharmacotherapy and counseling are not linked in a payment scheme; one can be reimbursed without the other
4. Cost sharing and deductibles are minimal; the duration of treatment reimbursed reflects successful quit patterns
5. Benefits are targeted to those most in need such as pregnant smokers and those with behavioral health problems such as major depression
6. Providers are given adequate reimbursement for counseling
7. Education is conducted about benefits offered and evaluation of the treatment provided is conducted on a regular basis

Model program implementation

- Model directive (1): Medicaid does not require by contract that each patient be identified, documented, assessed and addressed by all clinicians in every clinical setting at every visit
- ✓ (½) Model directive (2): Medicaid covers all FDA approved meds, individual but not group counseling and has not eliminated modest co-pays (mail order scripts have no co-pays, however, the mail order pharmacies often do not carry over the counter medications, mail order is not promoted by MaineCare and is not a significant part of claims processed), step therapy, duration or single medication limits on its coverage for medications, due to fiscal constraints.

    - **Utilization.** Medicaid data for FY08 illustrates that total payments for pharmacotherapy have increased by nearly $1 million, likely due to the new preferred status of varenicline and to its heavy promotion

by Pfizer in early 2008[3]. FY08 data on counseling demonstrates, by contrast, that fewer claims are being paid ($35,612 in FY08 vs. $62,612 in FY05) for fewer members (2,312 members in FY05 vs. 1,600 in FY08). Projected costs associated with waiving co-pays, opening a new 'screening' code for reimbursement or covering more intensive counseling are outlined in **Appendix G.**

NOTE : American Lung Association (ALA), in its annual report on state tobacco control activities, to be published in January, 2009, analyzes the conformity of states' tobacco cessation treatment with the recommendations of the Guidelines. ALA gives Maine an average grade and its Medicaid program figures prominently. The program received good marks for providing coverage for all FDA approved medications but deductions for numerous barriers to access including imposition of co-pays, time limits and no coverage for group counseling. The absence of a state mandate that requires a standard coverage for tobacco treatment for private insurers was also noted.

- ✓ Model directive (3): Medicaid does not require counseling to be offered with medication or vice versa, in conformity with model plan directive 3 (unlink benefits as best practice)

- Model directives (4), (5): Medicaid has not eliminated cost sharing or limits on duration of treatment that reflect successful quit patterns, due to questions as to relative efficacy and to current fiscal constraints

- Model directive (6): Medicaid has not expanded the types of providers, such as tobacco treatment specialists, or offered reimbursement for screening and counseling, due to fiscal constraints

- ✓ Medicaid, in compliance with model directive (7) (education and evaluation offered to raise awareness and to encourage utilization), has instituted a program that will be reporting feedback to all primary care providers including Federally Qualified Health Centers and hospital based providers on their tobacco counseling and medication use, by year end. Also, Medicaid will be providing a physician incentive payment to primary care practices that have the highest percentages of tobacco treatment counseling claims only (there is a cost associated with collecting other claims data). A December, 2008 newsletter to MaineCare primary care practices will be announcing the physician incentive payment, using tobacco dependence counseling as a performance measure.

3) **Best Practice**

- ✓ (1/2) Best practice for PTM as a tobacco control program, according to the US CDC, requires funding at the *recommended* level.

  The revised U.S. CDC budget recommendations are based on a funding formula adjusted for changes in state population and inflation, attainable rates of quitline usage and provision of NRT to callers. Maine's recommended level of funding for cessation intervention in FY07 was $5.1 million with a range of $2.9 to $7.7 million. Actual spending on helpline cessation treatment and community medication vouchers by Maine's Tobacco program was about $3 million in FY08, below the recommended level but above the minimum recommended.

- ✓ (3/4) Best practice also requires that the Guidelines system strategy changes be adopted (yes), that quitline services be sustained and expanded (yes), that treatment for face to face counseling be supported (yes) and that cost and other barriers to treatment for the uninsured and populations disproportionately affected by tobacco use be eliminated.
  - o PTM has met 3 of the 4 above criteria through its consistent level of funding of the Helpline and the expansion of funding for services for new face to face treatment programs. PTM is focusing strategic planning on eliminating barrier through more comprehensive coverage for the uninsured, MaineCare members and other populations disproportionately effected by tobacco use.

4) **Preliminary proposals and final action**

[3]From $1.25 million in FY02 to $2.2 million in FY08; $1.2 million of which was for varenicline (Chantix). In FY07 varenicline claims were only about 10% of all claims. (The percentage of claims for varenicline has declined in the third quarter of calendar year 2008, however.) Medicaid will be doing a survey to assess quit success with varenicline for its members. The cost per member has actually declined from $152/member in FY2005 to $136/ member in FY08; the additional total expense is due to the additional members served: 11,154 in FY05 to 19,570 in FY08

1. MaineCare's Physician Incentive Payment for clinicians would include tobacco use screening, tracking, intervention and counseling as a performance measure. **Final**: **Adopted**. Enacted by Medicaid, but based on counseling claims only due to fiscal impact of need to hire staff to obtain data for other measures.
2. A fax referral system to the Tobacco Helpline implemented statewide with feedback to providers on the patients referred **Final**: **Adopted**. Still in process.
3. A demonstration project that emphasizes intensive counseling for youth, pregnant smokers and others who have co-morbidity or mental health issues would be offered through rural health centers. **Final: Adopted**. Enacted.
4. A pilot project would be implemented using a 'stepped care' approach that combines Helpline counseling with face to face treatment for youth and pregnant smokers and others who have co-morbidity or mental health issues requiring additional professional support to quit. **Final: Adopted**. Enacted.
5. MaineCare will explore increasing the reimbursement rate for more intensive counseling and certified tobacco treatment specialists and reimbursing others for this work **Final: Not adopted** due to budget constraints.
6. MaineCare will explore waiving co-pays and other patient cost sharing and step therapies for tobacco dependence treatment **Final: Not adopted** due to budget constraints.

Discussion

Resolve 34 was enacted due to concern that tobacco use continues to take a significant and yet largely preventable toll on the health of Maine residents[4] and continues to drain the economic resources of the state. Maine's demographics and socio-economic status contribute to the 'hardening' of this problem. The state has one of the highest percentages of civilian veterans in the nation, a higher than average percentage of persons with behavioral health issues, is overwhelmingly white and has lower than average educational attainment and income levels. All of these factors are associated with higher than average rates of tobacco use.[5]

While Maine's population with the highest income and educational attainment have experienced significant drops in smoking prevalence, the uninsured and MaineCare (Medicaid) members' smoking rates remain more than twice that of the insured population and twice that of the general population[6], as noted in the Preliminary Report. Moreover, despite a strong tobacco control program which supports a Tobacco Helpline[7] for all smokers including the uninsured, Maine's

[4] Maine was among the states with the highest incidence of lung and bronchial cancer among both sexes, despite significant overall decreases in lung and bronchial cancers reported nationally, during the period studied. CDC MMWR September 5, 2008 Surveillance for Cancers Associated with Tobacco Use; U.S., 1999-2004 (data from state cancer registries); Annual Report issued 11/26/08 to the Nation on the Status of Cancer, 1975-2005, Featuring Trends in Lung Cancer, Tobacco Use and Tobacco Control, Journal of the National Cancer Institute, last accessed online on 11/26/ 08 at: http://jnci.oxfordjournals.org/cgi/content/full/djn389v1 "Although the decrease in overall cancer incidence and death rates is encouraging, large state and regional differences in lung cancer trends among women underscore the need to maintain and strengthen many state tobacco control programs." [Maine is one of only two states not in the south or midwest where lung cancer rates among women have *increased*, rather than leveled off, during the time period examined]

[5] See Maine State Health Plan, April, 2008, accessed at: http://maine.gov/dhhs/boh/phdata/Additional%20Reports%20Pdf%20Doc/2008-2009%20State%20Health%20Plan.pdf

[6] Maine Adult Tobacco Survey, 2004 32% or about 69,000 of all adult smokers (210,100) in Maine receive MaineCare benefits at any given time during a calendar year

[7] The Maine Tobacco Helpline reported (report unpublished, available from PTM) that in 2007 33% of callers quit who also used medication (reported 7 months after assistance from Helpline). The Helpline reached 8,885 Maine residents (3.5% of adult smokers). The Helpline is an important resource for helping, at no cost, uninsured Mainers who want to quit.

overall adult smoking rate (20.2%) is above the national average of 19.8% and has not appreciably declined in four years.[8] Its smoking attributable expenditures are significantly higher than the national state average and are summarized in Table 1.

Table 1									
	Maine	U.S.							
	$208	$129	Average Medicaid costs per capita (adult)						
	$6.37	$5.31	Average medical costs per pack of cigarettes						
	$5.23	$5.16	Average productivity costs per pack of cigarettes						
	$2.29	$1.63	Average medical costs per pack of cigarettes						
	$660	$630	Average/ household cost: state/ federal tax burden from smoking-caused gov't expenditures						
Source: US CDC: Sustaining State Programs for Tobacco Control: Data Highlights 2006 (2004 dollars)									

According to recent reports from national public health organizations[9], including the U.S. Public Health Service Clinical Practice Guidelines (2008), offering treatment and eliminating barriers to help with quitting has proven very effective at reducing tobacco use. Barriers encountered by those tobacco users attempting to quit include the absence of a coordinated, integrated delivery system for assessing and treating tobacco dependence[10] and the lack of consistent, barrier free coverage for the costs of treatment. The cost of quitting using varenicline, the nicotine patch, gum or lozenges (excluding any additional private counseling cost) is roughly equal, on a short term basis, to smoking a pack of Marlboro's a day ($155/month). If one smokes roll your own tobacco or little cigars, the cost to quit, due to their lower price, would be 2-5 times more expensive (short term) than to continue to use tobacco in these forms. From a purely short term, financial perspective, there is no incentive to quit, without help from insurance.

The limitations of private insurance coverage and Maine's Medicaid coverage are particularly vivid if one accepts the principle, adopted by a growing number of medical practitioners, that tobacco dependence, especially in the case of older, heavy users, is a chronic condition and shares similarities with diabetes and asthma, both of which are routinely classified as 'medical' (whereas tobacco use classification remains unclear—is it medical, behavioral health, substance

[8]Maine ranks 31st among states (and DC) in adult smoking prevalence. 2007 BRFSS (CDC MMWR October 2008) By contrast, Maine's current youth smoking rate (14%) reflects plummeting use, the state has already exceeded its *Healthy Maine 2010* goal of 15% and has one of the lowest youth smoking rates in the country. 2007 YRBS; Maine's Healthy Maine target rate for 2010 is 20% for smoking rates among pregnant women on Medicaid; the current rate is 33%, which has declined only modestly from 36.5% in 2002. PRAMS 2005 Annual Report issued 11/26/08 to the Nation on the Status of Cancer, 1975-2005, Featuring Trends in Lung Cancer, Tobacco Use and Tobacco Control, Journal of the National Cancer Institute, last accessed online on 11/26/ 08 at: http://jnci.oxfordjournals.org/cgi/content/full/djn389v1 "Although the decrease in overall cancer incidence and death rates is encouraging, large state and regional differences in lung cancer trends among women underscore the need to maintain and strengthen many state tobacco control programs." [Maine is one of only two states not in the south or midwest where lung cancer rates among women have *increased*, rather than leveled off, during the time period examined]

[9] CDC MMWR, February 8, 2008, State Medicaid coverage for Tobacco –Dependence Treatments-Us, 2006, noted that only one state (Oregon) covered all treatments recommended by the Guidelines and barriers in Medicaid coverage were common. American Lung Association, Tobacco Policy Trend Report, Helping Smokers Quit, State Cessation Coverage, November 13, 2008 notes that Maine is not in the top ranks in addressing tobacco cessation as a state: although the Maine state employee health plan has good coverage, Maine has no statutory mandate for minimum standard coverage by private insurance and barriers to full coverage under Medicaid exist including co-pays, duration limits and prior authorization requirements. See: http://www.lungusa.org/atf/cf/%7B7A8D42C2-FCCA-4604-8ADE-7F5D5E762256%7D/HELPING%20SMOKERS%20QUIT%20-%20STATE%20CESSATION%20COVERAGE%2011-13-08.PDF)

[10] See Health Coach Program in a Medical Group Improves Self-Care and Decreases Readmissions for High-Risk, Chronically Ill Patients at http://www.innovations.ahrq.gov/content.aspx?id=1747#a3;

abuse, preventive care?). Asthma and diabetes have standard coverage with no duration limitations on long term use of medications in public and private insurance and are increasingly systematically treated using self-care management models within many health care practices.[11]

There is consensus as to the elements necessary in a model system and acknowledgement that, although the Maine system has its strong points, notably a highly regarded, effective Tobacco Helpline, good coverage through some private plans and better than average Medicaid coverage, it does not have a model program. But it will require political will and corporate leadership to fix it, especially in these hard economic times. One approach which has shown promise in Massachusetts would be to enact legislation that requires barrier free tobacco dependence coverage through the Medicaid program[12], with periodic reporting to the legislature of utilization and efficacy rates. A second provision would require all private insurers (those subject to state regulation) to offer comparable coverage and would establish tax credits or a state grant program for small businesses (most likely to have insurance subject to a state mandate) who implement benefits or wellness programs which include tobacco dependence treatment for their employees.

Available information indicates that in Maine there has been improvement in coverage of tobacco dependence treatment in recent years but there remain numerous barriers to smokers accessing affordable help with quitting. Since many tobacco users need much encouragement to make an attempt to quit and to maintain that effort, erecting barriers (time limits on coverage, etc.) to those users accessing help is highly counter-productive. Tobacco dependence treatment as a preventive service within an insurance benefit is **not** over-utilized by the patient, there is strong evidence that, with rare exception, it is highly under-utilized.

In closing, it is important to acknowledge a central issue: effective tobacco dependence treatment requires, above all, a *systemic* approach: removing cost barriers to treatment in Medicaid coverage alone, while beneficial, will not fully solve the problem if formularies remain highly variable from public/private sector plan to plan, if physicians and other providers as well as tobacco users aren't fully aware of what is available and don't consistently assess and follow up with tobacco using patients and if there are an insufficient number of adequately trained counselors to offer appropriate more intensive counseling for tobacco users who need more help.

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11 Medicare tobacco dependence coverage for older or disabled patients with a chronic illness and the Maine Tobacco Helpline for all enrolled callers do offer up to 4 months (two 8 week courses) vs. 3 months (MaineCare) of coverage for medications and counseling, in a calendar year. The case for treating tobacco dependence as a chronic disease, *Ann Inten Med*. 2008; 148:554-556 http://www.annals.org/cgi/content/full/148/7/554?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=tobacco+2008&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT

[12] Massachusetts' experienced a 8% drop in its adult smoking prevalence rate (now 16.5%) after the Health Care Reform Act established a two year pilot program (funding and program were extended in the FY09 budget) with $7 million each year for the Medicaid program tobacco dependence treatment program, required all residents to be insured (and increased its cigarette tax by $1). The executive office must report annually on the number of enrollees who participate in smoking cessation services, number of enrollees who quit smoking, and Medicaid expenditures tied to tobacco use by Medicaid enrollees. See c. 58, section 108 of the Act at: http://www.mass.gov/legis/laws/seslaw06/sl060058 htm See also: http://www.wickedlocal.com/lexington/news/lifestyle/health/x1936634263/Smoking-reported-down-8-percent-in-state;

Appendix A

PLEASE NOTE: The Office of the Revisor of Statutes *cannot* perform research, provide legal advice, or interpret Maine law. For legal assistance, please contact a qualified attorney.

Resolve

123rd Legislature

First Regular Session

Chapter 34
S.P. 499 - L.D. 1421

Resolve, Regarding Tobacco Cessation and Treatment

Sec. 1 Best practice and model treatment programs. Resolved: That the Department of Health and Human Services, through the Partnership for a Tobacco-Free Maine, Maine Center for Disease Control and Prevention and the Office of MaineCare Services, shall undertake a study of best practice treatment and clinical practice guidelines for tobacco cessation treatment. The study must use the most recent available clinical practice guidelines available from the United States Department of Health and Human Services Public Health Service and must include development of a model tobacco cessation treatment program for use in the public sector and private sector. The department shall report back to the Joint Standing Committee on Health and Human Services by January 15, 2008. The committee may submit legislation to the Second Regular Session of the 123rd Legislature related to best practice treatment and clinical practice guidelines for tobacco cessation treatment.

Effective September 20, 2007

Appendix B
Resolve 34: Workgroup Members

Department of Health and Human Services
Office of MaineCare Services (MaineCare)

Brenda McCormick	Director, Division of Health Care Management
Roderick Prior, MD	Medical Director, MaineCare
Nicole Rooney	Comprehensive Health Planner II
Jennifer Cook	Acting Manager, Pharmacy Unit, Div of Health Care Management
Kristin Cowing	Management Analyst 2 Division of Policy and Performance
M. Ouellette	Pharmacist, Goold Health Services

Partnership for a Tobacco Free Maine, Maine Center for Disease Control and Prevention

Dorean Maines	Tobacco Control Program (Acting) Manager, PTM
MaryBeth Welton	Tobacco Control program Manager, PTM
Molly Schwenn, MD	Cancer Registry, Director
Andrew Spaulding	Worksite Health Specialist, Maine CDC/Cardiovascular Health program

Maine Coalition on Smoking or Health/Health Policy Partners of Maine

Pamela MB Studwell	Senior Policy Analyst (American Lung Association of Maine)
Becky Smith	Executive Director (Medical Care Development)

Maine Health Management Coalition

Elizabeth Mitchell	CEO

Center for Tobacco Independence

Allesandra Kazura, MD	Medical Director, Helpline, Center for Tobacco Independence
Ken Lewis	Executive Director, Maine Health, Center for Tobacco Independence

Healthy Communities of the Capitol Area

Joanne Joy	Director
Amy Wagner	Worksite Wellness program manager

Appendix C

Dear Employer,
Maine Health Management Coalition (MHMC) is helping to facilitate the distribution of a survey on employer tobacco dependence treatment benefits. The survey has been designed by the Partnership for a Tobacco-Free Maine (PTM), Maine Center for Disease Control and Prevention and Health Policy Partners who are working in partnership to address the harm tobacco causes the people of Maine. As part of a statewide effort to gather information about services available to people to help them quit commercial tobacco use, we are asking you to complete this survey by December 5, 2008.

This survey is 22 questions and should take you less than 10 minutes to complete. All responses will be kept confidential and results will be made available on an aggregate basis to MHMC by January, 2009.
Thank you in advance for completing this survey. Questions can be directed to Pamela Studwell, Senior Policy Analyst, Health Policy Partners/American Lung Association of Maine (207-624-0325).

Are you a hospital or non-hospital?

Is your plan an HMO or a Point of Service plan?

Is health care coverage provided by your company self-insured?

How many employees does your company have? How many employees are enrolled in your health coverage?

Are employees subject to an annual deductible? What is the deductible amount for office visits?

What is the deductible amount for prescribed medication? What is the deductible amount for counseling?

For the following tobacco cessation treatments, do your health benefits include full coverage (no co-pay), co-pay, or no coverage?

Does this smoking cessation benefit coverage also apply to covered dependents? Is there an age restriction for dependents?

Is there an ANNUAL limit to the number of total quit attempts covered per person?

Is there a LIFETIME limit to the number of total quit attempts covered per person?

Is there a requirement that the person participate in counseling to obtain reimbursement for OVER THE COUNTER (OTC) quit medications?

Is there a requirement that the person participate in counseling to obtain reimbursement for PRESCRIPTION quit medications?

For OTC Nicotine Replacement Therapy, is there a dollar amount limit?

For OTC Nicotine Replacement Therapy, is there a limit on the number of quit attempts?

For prescription quit medications, is there a dollar amount limit?

For prescription medication, is there a limit on the number of quit attempts?

Do you know how many of your employees and covered dependents have obtained smoking cessation medications in the last year?

Is there anything else you would like to tell us about your tobacco cessation benefits?

Appendix D Tobacco Dependence Treatment Survey Results Summary

The survey asked twenty two questions on tobacco dependence treatment coverage under insurance plans in an internet based survey of the members of the Maine Health Management Coalition (MHMC). The deadline for response was December 10.

MHMC has 52 members (as of Dec.10, 2008): 13 hospitals, 4 health plans, 16 physician practices and 19 employers, including LL Bean's, Hannaford's, Barber Foods, Bowdoin College, and the City of Portland, representing more than 200,000 employees, some of whom may be residents of other states*.

**Maine's workforce, full and part-time employees was about $1 million in 2007.. Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements).*

Employer, Employees, Types of plans

- 13 of 52 Employers responded to the tobacco dependence coverage survey (25% response rate)
- 141,817 Employees with possible access to coverage described by survey responses (70%of members' employees)
- 103,526 Employees insured (average of 73% of total employees working for each employer; range was 47% to 100%)
- 5-120,000 Number of employees, each employer respondent (85% had more than 200)
- 77% Respondents who were non-hospital employers
- 46%/53% Split between health maintenance organization plans (HMO's) and 'point of service' (POS) (more flexible variant of HMO's) plan coverage described**
- 69% Self insured* employers as % of total employers who responded to survey

**Plan generally governed by federal ERISA, not state, law where the employer assumes the risk of liability for costs under the plan, the insurer is the administrator only; the employer negotiates with the insurer for particular coverage*
*** MHMC employer members may offer more than one type of plan; only one plan was described in this survey per employer (27% of employers surveyed in 1998 offered more than one plan)*

Plan limits

- 92% No annual limit to # of quit attempts in reimbursement for counseling
- 84.6% No lifetime limit on # of quit attempts in reimbursement for counseling
- 92% Don't require counseling to get over the counter medication (patch, gum, lozenges)
- 85% Don't require counseling to get prescription meds (varenicline, buproprion, spray, inhaler)
- 77% Don't have dollar limits on annual or lifetime over the counter medication
- 91.7% Don't have (annual) dollar limits on prescriptions
- 76% Don't have (lifetime) dollar limits on prescriptions

Plan Benefit Coverage

- Office visit: 38% $15-25 co-pays
  38% no co-pays
  23% other
- Medications: 30.7% tiered co-pays
  30.7% $10-$20 co-pays
  23% no-co pays
  15% other
- Counseling: 46% $15-25 co-pay or other minimal co-pay
  30.7% no co-pays
  23% other

Comments

1 large employer commented that just under 9% of its employees smoked; the company offers free on site tobacco cessation classes and free nicotine patch and gum. As further incentive, if the employee quits for 6 months, she receives ½ day off with pay; after 1 year, a full day off with pay.1 insurer respondent offers no tobacco dependence coverage in its standard HMO or POS plans

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Comparison between 1998 survey and current survey

It was impossible to directly compare the 1998 survey of MHMC members and the current survey for the following reasons:
(1) current survey did not have access to member identity although 3 members voluntarily self-identified, (2) members have changed in ten years, (3) the prior survey had 30 respondents, current survey had 13 who self-selected; (3) the prior survey looked at worksite smoking policies, (4) the prior survey compared managed care plan benefits with other (mostly indemnity) plan benefits; current survey does not compare plans, asking for HMO or POS plan information only and also self-insured status, (5) the prior survey included onsite counseling as well as plan counseling and considered 'full access' to a type of benefit to include benefits with a minimal ($10) co-pay but did not look at benefits offered at no cost, (6)this survey looked at cost free benefits and actual cost of co-pay and considered only insurance derived, not onsite benefits. [It is now the standard based on PHS Guidelines research to consider even modest co-pays as limiting access.] Having said this, the 1998 survey does provide an interesting backdrop to the results of the current survey.

General observations

74% members surveyed in 1998 were non-hospitals: a percentage split comparable to the current survey

13% plans in current survey with no coverage for counseling (phone, individual or group) vs. 33% in 1998
16% plans in current survey with no coverage for medications (varenicline, buproprion) vs. 25% (buproprion only) in 1998
41% plans in current survey with no coverage for OTC (patch, gum lozenge) vs. 50% in 1998 (patch only)
76.7% offer counseling (individual, group, telephonic) at minimal/ no cost [33% at no cost] vs. 47% in 1998 at minimal/no cost
61% offer OTC (nicotine patch, gum, lozenges) (46% at no cost) vs. 50% in 1998 (patch only)
83% offer prescription medication (varenicline, buproprion) (33% at no cost) vs. 50% in 1998 (buproprion)
75% offer spray/inhaler prescriptions – not offered in 1998
7 % offer coverage for OTC, all prescription medication and all forms of counseling in current survey (at no cost to employee) vs. 0% in 1998

Appendix E
Excerpts from Executive Summary of 1998 Tobacco Treatment Benefit Survey of MHMC members

The survey was conducted to evaluate worksite smoking policies and health insurance benefits for tobacco cessation among members of the Maine Health Management Coalition (MHMC). Completed by all 30 MHMC members in 1998, this report describes worksite smoking policies and variations in cessation benefits.

All MHMC employers have a worksite smoking policy. The majority of employers offer outdoor designated smoking areas, and only 10% have an entirely smoke-free worksite. Policies that increasingly restrict smoking are generally viewed as being successful. It is uncommon (10%) for an employer to generate higher insurance premiums for smoking employees.

Among 30 employers, a total of 44 employers' insurance "products" were evaluated; 34 of which were hospital employers. The over distribution of hospital employers (who would be more likely to offer these benefits) was controlled for and noted in assessing results. Cessation counseling at the worksite was provided by 33% of employers, and availability of worksite counseling was inversely related to employer size.

Counseling through health plans was available in 47%, and only 18% had full access to plan-level counseling resources. When both worksite counseling and health plan-level counseling were taken into consideration, 36% of employers' products remained without counseling benefits.

Pharmacotherapy for tobacco cessation was more readily available, with 77% of insurance products providing some coverage for nicotine patch and bupropion. Coverage for both medications was similar. Full access to medications occurred in 50% of employers' products.

20.5% of all insurance products had coverage for both counseling and pharmacotherapy with full access; 16% had no coverage for either.

Many MHMC insurance products do not offer comprehensive cessation benefits recommended by the Agency for Health Care Policy and Research. [*The AHCPR Smoking Cessation Clinical Practice Guideline was developed in 1996, the AHCPR guideline is a comprehensive literature review of effective cessation treatments and the first AHCPR guideline directed at insurers, purchasers, and administrators as well as clinicians*.]

[The first set of questions was about worksite smoking policy. The second series of questions revolved around the availability of health benefits for tobacco cessation, including cessation resources at the worksite. Any type of cessation counseling available to employees was determined, including the counseling format, co-payments and deductibles, and limitations that apply to the benefit. Coverage for tobacco-related pharmacotherapy, including prescription and non-prescription nicotine patch and buproprion (Zyban) were assessed for each employer's insurance product. The survey also identified whether cessation resources were fully accessible or had reduced access.

Access to benefits were identified as being *full* = readily available, or *reduced* = requiring employee payment or linked to utilization of another resource. The latter, "reduced access" was defined as resources requiring significant out-of-pocket payment by the employee (NOT small co-payments) or linkage to another resource. Examples include (a) full payment of nicotine patch reimbursed at a later date, (b) coverage for nicotine patch linked to cessation counseling, and (c) access to telephonic behavioral counseling linked to treatment with nicotine patch.]
Full unpublished executive summary available from: pstudwell@lungme.org

Appendix F
Efficacy of medication compared to placebo at 6-months post-quit

Combination therapies	#*ARM*	*odds ratio*	*efficacy*
Patch (long-term; >14 weeks) + ad lib NRT (gum or Spray)	3	3.6 (2.5, 5.2)	36.5 (28.6, 45.3)
Patch + Bupropion	3	2.5 (1.9, 3.4)	28.9 (23.5, 35.1)
Patch + Nortriptyline	2	2.3 (1.3, 4.2)	27.3 (17.2, 40.4)
Patch + Inhaler	2	2.2 (1.3, 3.6)	25.8 (17.4, 36.5)
Second generation antidepressants (paroxetine, venlafaxine) & patch	3	2.0 (1.2, 3.4)	24.3 (16.1, 35.0)

Efficacy of medication and medication combinations compared to patch at 6-months post-quit

Combination therapies	*ARM*	*odds ratio*
Patch (long-term; >14 weeks) + NRT (gum or Spray)	3	1.9 (1.3, 2.7)
Patch + Bupropion	3	1.3 (1.0, 1.8)
Patch + Nortriptyline	2	0.9 (0.6,1.4)
Patch + Inhaler	2	1.1 (0.7, 1.9)
Second generation antidepressants & patch	3	1.0 (0.6, 1.7)
SSRI	3	0.5 (0.4, 0.7)
Naltrexone	2	0.3 (0.1, 0.6)

Efficacy of medication, long term meds compared to placebo at 6-months post-quit

Medication		
Placebo	1.0	13.8
Monotherapies		
Varenicline (2 mg/day)	3.1 (2.5, 3.8)	33.2 (28.9, 37.8)
Nicotine Nasal Spray	2.3(1.7, 3.0)	26.7 (21.5, 32.7)
High dose nicotine patch >25 mg; standard/long term	2.3 (1.7, 3.0)	26.5 (21.3, 32.5)
Long-Term Nicotine Gum >14 weeks	2.2 (1.5, 3.2)	26.1 (19.7, 33.6)
Varenicline (1mg/day)	2.1 (1.5, 3.0)	25.3 (19.6, 32.2)
Nicotine Inhaler	2.1 (1.5, 2.9)	24.8 (19.1, 31.6)

Source: Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence.*Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.: http://www.surgeongeneral.gov/tobacco/treating_tobacco_use.pdf

Appendix G – Fiscal Impact

MaineCare Coverage

Estimate of fiscal impact per year: reducing 3 current barriers in coverage for smokers who want help to quit

1. Waiving co-pays for medications

$133,536[13]

2. Counseling : Opening new screening code for primary care practices only* (99406: 3-10 mins)

$25,700[14]

3. Counseling : Reimbursement for more intensive counseling code for primary care practices only* (99407: more than 30 mins)

$50,976[15]

Total: $210,212

*Federally qualified health centers are also paid for tobacco use counseling in addition to their standard per visit rate under a different code at the same rate as primary care practices but far fewer claims have been filed.

NOTE: Reimbursement (in FY08) under only codes available to primary care practices, 99401, 99402, 99403 (tobacco use prevention counseling, 15-45 mins @$20) was $35,612.

[13] 11,128 claims x $3/co-pay =$33,384 (1st quarter cal. year 2008) x 4 quarters/year=$133,536; does not include waiver of co-pays for counseling (total claims for FY2007=2,124); fiscal impact of current waiver of co-pays for mail order claims = $2,208 (based on waiver of co-pay for 184 mail order claims for 1st quarter calendar year 08 (offset in part by reduction given to MaineCare by mail order pharmacies on claims, less than 1% of total claims) NOTE: Federal law requires that MaineCare members receive medication even if they don't or can't pay co-pay

[14] (2,124 x $12.10):average # claims for FY 05, 06, 07 and if Maine adopts 100% of Medicare rate for code 99406, based on southern tier in physician office rate

[15] (2,124 claims x $24) based on 100% o f Medicare rate for code 99407

Appendix H CURRENT TOBACCO TREATMENT COVERAGE OVERVIEW - MAINE

Insurance Coverage for Nicotine Replacement Therapy, Varenicline, Buproprion & Counseling

Updated:
December 5, 2008

Source of coverage	Nicotine Patch	Nicotine Gum	Spray	Lozenge	Inhaler	Zyban/Buproprion	Chantix (varenicline)	Smoking Cessation Programs	Counsel-ing
Medicaid* (MaineCare)	up to 3 months/year w/ provider script (although over the counter medication) $3 co-pay	up to 3 months/year w/ provider script (although over the counter medication) $3 co-pay	w/prior authorization, if gum and patch tried and failed due to lack of efficacy or intolerable side effects or if presence of a condition that prevents usage of preferred drug or interaction with another drug and preferred drug exists, $3 co-pay	up to 3 months/year w/ provider script (although over the counter medication); available to patients not able to tolerate patch or gum w/prior auth; $3 co-pay	w/prior authorization, if gum and patch tried and failed due to lack of efficacy or intolerable side effects or if presence of a condition that prevents usage of preferred drug or interaction with another drug and preferred drug exists $3 co-pay	bupropion SR 100 and 150mg covered (generic of Zyban), no limit on usage, $3 co-pay	preferred without prior authorization up to 6 mos. continuous use per lifetime, Chantix and other preferred drug prescribed at same time becomes non-preferred drug; $3 co-pay	not covered	Preventive Counseling, in 5 min increments up to 45 mins 99401-3 $20; (3x/patient/ calendar year); dental code for prevention counseling is D 1320 1 x yr for patient aged up to 21 $20; $3 co-pay for patient
Dirigo**	w/script; no yearly/lifetime limit; $10/15/30/50 co-pay tiers	w/script; no yearly/lifetime limit; $10/15/30/50 co-pay tiers	w/script; no yearly/lifetime limit; $10/15/30/50 co-pay tiers	w/script; no yearly/lifetime limit; $10/15/30/50 co-pay tiers	NO	w/script; no yr/lifetime limit; $10/15/30/50 co-pay tiers	w/script; no yr/lifetime limit; $10/15/30/50 co-pay tiers	$35/program; $70 cap/lifetime	2 office visits/year; $25/co-pay for "in network" MD; $35 out of network MD

Anthem	yes, with prescription cap of $200 / year, $400 / lifetime. $10 co pay	yes, with prescription cap of $200 / year, $400 / lifetime. $10 co pay	yes, with prescription cap of $200 / year, $400 / lifetime. $10 co pay	yes, with prescription cap of $200 / year, $400 / lifetime. $10 co pay	yes, with prescription cap of $200 / year, $400 / lifetime. $10 co pay	yes, with prescription cap of $200 / year, $400 / lifetime. $10 co pay	yes, with prescription cap of $200 / year, $400 / lifetime. $10 co pay	Smoking cessation classes provided through a hospital or MD's office $35/class, $70 lifetime	Base coverage includes 2 physician visits annually
Self-insured Plan ***	covered w/no co pays, annual or lifetime limits or deductibles	covered w/no co pays, annual or lifetime limits or deductibles	covered w/no co pays, annual or lifetime limits or deductibles	covered w/no co pays, annual or lifetime limits or deductibles	covered w/no co pays, annual or lifetime limits or deductibles	covered w/no co pays, annual or lifetime limits or deductibles	covered w/no co pays, annual or lifetime limits or deductibles	100% of cost; no lifetime limits on classes	unlimited MD visits
Maine Tobacco Helpline	free up to 8 weeks, 2 refills/year for uninsured	free up to 8 weeks, 2 refills/year for uninsured	not covered	free up to 8 weeks, 2 refills/year for uninsured; 2d course of treatment 6 mos after last call	not covered	not covered	not covered	not covered	free for any caller; initial assessment plus 4 proactive follow up calls; unlimited add'l support calls (if caller calls)
Medicare (updated 8/08)*****	Not covered b/c OTC	Not covered b/c OTC	may be covered - depends on Part D drug plan	Not covered because over the counter	may be covered - depends on Part D drug plan	may be covered - depends on Part D drug plan	may be covered - depends on Part D drug plan	not covered	2 attempts per year - each up to 4 sessions (up to 8 in 12 mo period).New prevention codes 99406 3-up to 10 mins (intermed); and 99407 10+ mins (intensive)

*Pharmacotherapy coverage based on Prescription Drug List (PDL) last revised 10/31/08
**Harvard Pilgrim insurer for Dirigo health plan as of 1/1/08
***Self insured plan of Maine Health through Anthem
Note: Buproprion hydrochloride is sold in generic form under brands Wellbutrin (for depression) and Zyban (for smoking cessation).
Although Wellbutrin and Zyban contain same active ingredient only generic bupropion and Zyban are approved by the FDA for smoking cessation Rx.
****Counseling covered if has illness caused/ complicated by smoking or other tobacco use, such as heart disease; or is taking medications that tobacco use interferes with (including meds for diabetes, high blood pressure)
Prepared for Partnership for a Tobacco-Free Maine re: PL2007
Resolve 34 by Pam Studwell, last revised 12/08

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(3) *Adoption of System Strategies for Tobacco Cessation by State Medicaid Programs,* Bellows, Nicole M. et al, Medical Care, Vol. 45, Number 4, April, 2007

(4) *Ending the Tobacco Problem: A Blueprint for the Nation*, Institute of Medicine Report, May 24, 2007
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(5) *Low Use of Preventive Care including Tobacco Cessation Treatment*, August, 2007 Partnership for Prevention Report:
http://www.prevent.org/content/view/129/72/