

UPDATE: STATE REPORT

Medicaid Coverage For Tobacco-Dependence Treatments

Although there has been an increase in coverage of these treatments, there is still a need for much improvement.

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ABSTRACT: This paper presents an update on the availability of tobacco-dependence treatments in Medicaid benefit packages from 1998 to 2003 and discusses variation in states' approaches for addressing tobacco cessation. In 2003 thirty-seven states had coverage for at least one evidence-based treatment. Since 1998, thirteen Medicaid programs have added coverage for at least one, while five programs have expanded coverage of these treatments. Overall, the coverage increases indicate a growing awareness of the treatments' importance for the health of Medicaid recipients, although further expansions are still needed. [*Health Affairs* 25, no. 2 (2006): 550–556; 10.1377/hlthaff.25.2.550]

TOBACCO USE CONTINUES to be a serious U.S. health problem; there were nearly forty-six million adult smokers in 2002.¹ Use of tobacco products has enormous health and financial consequences, resulting annually in approximately 438,000 deaths, 5.5 million years of potential life lost, and \$167 billion in economic and productivity losses.² Compared with the general population, smokers have decreased life expectancy and poorer health outcomes, and they use more health care services to combat the health effects of smoking.³

The consequences of smoking are especially salient for Medicaid programs. Smoking rates are much higher among low-income groups than among their higher-income peers, and therefore Medicaid programs bear a disproportionate share of the tobacco burden.⁴ In 2000, 23 percent of the general population smoked, compared with 36 percent of Medic-

aid recipients. Additionally, pregnant women enrolled in Medicaid have smoking rates that are higher than those of the larger population of pregnant women (25 percent versus 12 percent in 2000).⁵

One important way to address the problem of tobacco use is to provide access to effective treatments. The 2000 Clinical Practice Guideline (CPG) for Treating Tobacco Use and Dependence recommends that health care purchasers include effective tobacco-dependence treatments in all coverage packages.⁶

As preventive services, these treatments are “optional” Medicaid services according to the U.S. Department of Health and Human Services (HHS) and are not covered by all Medicaid programs as “core” services. The state agencies that administer Medicaid programs and state legislatures are the primary decision-makers on whether or not to cover the treatments. This paper presents an update on the

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availability of tobacco-dependence treatments covered by Medicaid from 1998 to 2003. It also discusses variations in states' approaches to tobacco-use cessation and the potential for improving Medicaid tobacco-dependence programs.

Study Methods

The Center for Health and Public Policy Studies (CHPPS) at the University of California (UC), Berkeley, conducted annual surveys of fifty-one Medicaid programs during 1998–2003. The surveys included questions on coverage for tobacco-dependence treatment; tobacco-use cessation benefits targeted at special populations; contractual requirements for providers and health plans; and data collection practices.

Before the surveys were sent out each year, all respondents from the previous year were contacted to confirm contact information and to secure their participation. In 1998, responses were collected from fifty Medicaid programs, while all fifty-one programs responded in 1999–2003.⁷

All surveys were examined for internal consistency and compared with documentation submitted by the Medicaid programs. Follow-up interviews were conducted when discrepancies occurred from year to year or between survey responses and the submitted documentation. The data were entered by the UC Berkeley Survey Research Center using double data entry protocols. Frequencies were calculated for each question, and cross-tabulations were examined to identify relationships that might explain variations in coverage.

Study Findings

■ **Coverage trends.** Tobacco-dependence treatment programs have expanded in the states since 1998 (Exhibit 1). Thirteen states added some form of tobacco-dependence coverage during the study period, bringing the total number of states offering some coverage to thirty-seven.⁸ Also, five states have expanded their levels of coverage since 1998.

Types of therapies covered. States also have expanded the types of therapies they cover: (1) nicotine replacement therapy (NRT), includ-

ing gum, patch, nasal spray, inhaler, and lozenge; (2) Zyban (also known as Bupropion SR and Wellbutrin), which works neurochemically to reduce withdrawal symptoms; and (3) smoking-cessation counseling (including individual, group, and telephone counseling). The 2000 CPG recommends both counseling and a pharmacological treatment.⁹

Prior to 1996, there was little Medicaid coverage for tobacco-dependence treatment.¹⁰ With Food and Drug Administration (FDA) approval of the NRT nasal spray and over-the-counter availability of the gum and patch in the mid-1990s, the number of Medicaid programs covering NRT jumped from one in 1995 to eighteen in 1996. In addition, with FDA approval of Zyban in 1997, twenty programs offered coverage for Zyban in 1997. Coverage for both NRT and Zyban continued to climb from 1997 to 2002. Coverage for counseling also rose steadily, and by 2003, fourteen programs offered this coverage.

Although coverage for all tobacco-dependence treatments rose during 1998–2003, there was no increase from 2002 to 2003. This could indicate either that coverage had leveled off or that 2003 was an anomalous year because of severe state budget constraints.¹¹

Of the thirteen programs that added coverage for tobacco-dependence treatment since 1998, two added coverage for Zyban only; six, for both Zyban and at least one form of NRT; and five, for Zyban, NRT, and counseling. Of the three types of treatments, the largest coverage increase was for Zyban (thirteen programs added coverage). NRT coverage expanded over this same period, from twenty-three programs in 1998 to thirty-three in 2003, and coverage for counseling services increased from five to fourteen programs.

Comprehensive coverage. The number of programs offering comprehensive coverage increased from four programs in 1998 to thirteen programs in 2003 (Exhibit 1). In addition, the number of programs covering all six treatments increased from three in 1998 to six in 2003.

■ **Use of the 2000 PHS guideline.** One of the potential explanations for the increase in

EXHIBIT 1
State Tobacco-Dependence Treatments Provided, 1998 And 2003

State	Any coverage	NRT				Counseling		Comprehensive coverage ^a
		Gum	Patch	Spray/ inhaler	Zyban	Individual	Group	
AZ	98, 03				98, 03			
AR	03				03			
CA	98, 03	98, 03	98, 03	98, 03	98, 03	98, 03 ^b	98, 03 ^b	98, 03
CO	98, 03	98, 03	98, 03	98, 03	98, 03			
DE	98, 03	98, 03	98, 03	98, 03	98, 03			
FL	98, 03	98, 03	98, 03	98, 03	98, 03	98, 03 ^b	98, 03 ^b	98, 03
HI	03	03	03	03	03			
IL	03	03	03	03	03			
IN	03	03	03	03	03	03	03	03
KS	03		03		03	03	03	03
LA	98, 03	98, 03	98, 03	98, 03	98, 03			
ME	98, 03	98, 03	98, 03	98, 03	98, 03	03		03
MD	98, 03	98, 03 ^c	98, 03 ^c	98, 03	98, 03			
MI	98, 03	98, 03	98, 03		98, 03			
MN	98, 03	98, 03	98, 03	98, 03	98, 03	98, 03	98, 03	98, 03
MS	03	03	03	03	03			
MT	98, 03	98, 03 ^b	98, 03	03	98, 03			
NV	98, 03	98, 03	98, 03	98, 03	98, 03			
NH	98, 03	98, 03	98, 03	98, 03	98, 03			
NJ	98, 03	98, 03	98, 03	98, 03	98, 03	03	03	03
NM	98, 03	98, 03	98, 03	98, 03	98, 03			
NY	03	03	03	03	03		03	03
NC	98, 03	98, 03 ^c	98, 03 ^c	98, 03	98, 03			
ND	98, 03	98, 03	98, 03		98, 03	03		03
OH	98, 03	98, 03	98, 03	98, 03	98, 03			
OK	03	03	03	03	03			
OR	98, 03	98, 03	98, 03	98, 03	98, 03	98, 03	98, 03	98, 03
PA	03	03	03	03	03	03	03	03
RI	98, 03					98, 03 ^b	98, 03 ^b	
SD	03				03			
TX	98, 03	98, 03	98, 03	98, 03	98, 03			
UT	03	03	03		03			
VT	03	03	03	03	03			
VA	98, 03			98, 03 ^b	98, 03 ^b			
WV	03	03	03	03	03	03		03
WI	98, 03		98, 03 ^c	98, 03	98, 03	03		03
DC	98, 03	98, 03 ^c	98, 03 ^c	98, 03	98, 03			
1998	24 (47%)	20 (39%)	21 (41%)	18 (35%)	23 (45%)	5 (10%)	5 (10%)	4 (8%)
2003	37 (73%)	30 (59%)	32 (63%)	28 (55%)	36 (71%)	13 (25%)	10 (20%)	13 (25%)
Added since 1998	13	10	11	10	13	8	5	9

SOURCE: Center for Health and Public Policy Studies, State Medicaid Tobacco Dependence Treatment Survey, University of California, Berkeley (administered annually from 1998 to 2003).

NOTES: States were surveyed in 1998 and in subsequent years through 2003 regarding whether they covered tobacco-dependence treatments for the general Medicaid population. Any inconsistencies with previous publications are the result of further clarification since the 1998 survey.

^a Defined as coverage for (1) at least one nicotine replacement therapy (NRT), (2) Zyban, and (3) individual or group counseling.

^b This benefit was not reported as being covered in the 1998 survey; however, when respondents in subsequent surveys were asked for the first year this service was covered, the year reported was prior to 1998.

^c Maryland, North Carolina, Wisconsin, and Washington, D.C., cover nicotine replacement gum or the patch, or both, only if there is a prescription.

tobacco-dependence coverage in Medicaid is the publication of the 2000 Clinical Practice Guideline for Treating Tobacco Use and Dependence from the U.S. Public Health Service (PHS), which details the evidence on the treatments' medical effectiveness and recommends their inclusion in benefit packages.¹² In 2000, twenty Medicaid program representatives responded that they were aware of the guideline; by the end of 2003, thirty-two were. Nevertheless, few representatives said that they used the guideline to design benefits, administer programs, or train health care professionals. In 2000, four programs used the guideline for designing benefits, three used it to design their tobacco-dependence programs, and two used it to train health care professionals on tobacco-use cessation. By 2003, more programs reported use of the guideline for these purposes: Seven used the guideline for designing benefits, six for designing programs, and five for training professionals.

The seven programs that used the guideline for designing benefits are Indiana, Maine, Mississippi, New York, Oklahoma, Oregon, and West Virginia. On average, these programs have more comprehensive tobacco-dependence benefits than those states that have not used the guideline to design benefits.

■ **Targeting special populations.** The surveys also examined whether Medicaid programs target special populations for smoking cessation, specifically pregnant women and children (under age eighteen), who are part of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

Programs for pregnant women. In response to the risks of smoking during pregnancy, twenty Medicaid programs reported in 2003 that they had tobacco-use cessation programs or benefits specifically for pregnant women (Exhibit 2). Twelve of these did not cover counseling for the general Medicaid population but had a counseling benefit specifically for pregnant women enrolled in Medicaid. The remaining eight programs already covered counseling for the entire Medicaid population but had additional smoking cessation services targeting pregnant women.

Programs for children. The consequences of youth smoking include short-term health effects (reduced physical fitness and an increase in respiratory problems); an increased chance of becoming strongly addicted to nicotine; and long-term health risks (cancer and cardiovascular disease).¹³ Although the 2000 PHS guideline recommends the consideration of pharmacotherapy for adolescents in the treatment of tobacco dependence, neither Zyban nor NRTs are approved by the FDA for use in nonadults.

In 2003, thirty-two programs reported covering tobacco dependence treatments for children through their EPSDT programs. Coverage under EPSDT was highest for pharmacological therapies (twenty-five programs covered Zyban, twenty-three covered at least one form of NRT, and fifteen covered counseling). In addition, twenty EPSDT programs covered at least one tobacco-dependence treatment for parents who live in a household with EPSDT-covered children.

■ **Coordination with other state programs.** Many Medicaid programs reported that they coordinate with other state agencies to treat tobacco dependence (Exhibit 2). A recent trend in tobacco-use cessation is the establishment of state telephone quitlines that provide residents with advice, counseling, and guidance to resources for effective treatment. As of 2004, thirty-nine states operated a quitline (Exhibit 2). State quitlines appear to serve as complements to rather than substitutes for Medicaid coverage of tobacco-dependence counseling. Of the fourteen states where Medicaid covers individual or group counseling (or both) for the general Medicaid population, thirteen also operate a quitline.

Discussion

Overall, the increase of Medicaid coverage for tobacco-dependence treatments indicates a growing awareness of their importance for the health and well-being of Medicaid recipients, as well as for the health care costs associated with smoking-related illnesses. Similar increases in coverage have also been found among managed care plans, which suggests a broader movement toward recognizing the im-

**EXHIBIT 2
Tobacco-Dependence Treatments For Special Medicaid Populations And Program
Coordination**

States	Special populations		Coordination		
	Exclusive treatment for pregnant women	Treatment covered through EPSDT	Medicaid works with tobacco control division	Medicaid works with maternal and child health division	State operates a smoking quitline
AK		●			●
AZ	●	●	●	●	●
AR		●			●
CA		●	●	●	● ^a
CO	●	●			●
CT				●	● ^a
DE		●		●	●
FL		●			●
GA				●	●
HI		●			
IL		●		●	● ^a
IN		●		●	
IA	●		●		●
KS			●		●
KY	●	●		●	●
LA					●
ME		●	●	●	●
MD	●			●	
MA	●	●	●	●	●
MI		●		●	●
MN	●			●	●
MS	●	●	●	●	●
MO				●	
MT		●		●	
NE		●	●	●	●
NV	●	●	●		●
NH	●	●		●	●
NJ	●	●	●	●	●
NM		●		●	●
NY	●		●	●	●
NC				●	
ND		●		●	● ^b
OH		●		●	●
OK		●	●	●	●
OR	●		●	●	●
PA	●	●			●
RI	●	●			●
SC				●	● ^b
SD		●		●	●
TX				●	●
UT	●	●	●	●	●
VT		●			●
VA	●	●		●	
WA	●	●		●	●

portance of treating tobacco addiction as part of comprehensive health insurance.¹⁴

Although these findings are encouraging,

there is still room for improvement: Only 25 percent of Medicaid programs cover all three elements of recommended care, and fewer

**EXHIBIT 2
Tobacco-Dependence Treatments For Special Medicaid Populations And Program
Coordination (cont.)**

States	Special populations		Coordination		
	Exclusive treatment for pregnant women	Treatment covered through EPSDT	Medicaid works with tobacco control division	Medicaid works with maternal and child health division	State operates a smoking quitline
WV	●		●	●	●
WI	●		●	●	●
WY		●	●	●	● ^a
DC				●	
States	20 (39%)	32 (63%)	17 (33%)	37 (73%)	39 (76%)

SOURCE: Center for Health and Public Policy Studies, State Medicaid Tobacco Dependence Treatment Survey, University of California, Berkeley, 2003.

NOTES: State Medicaid agencies were asked (1) if they offer any tobacco dependence treatment exclusively for pregnant women; (2) if the state operates a telephone quitline for smokers; (3) if they cover any tobacco dependence treatments under their Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program; (4) if they work with their state's tobacco control division; and (5) if they work with their state's maternal and child health division. The quitline information provided in the survey was verified by the Center for Tobacco Cessation survey of states through September 2003.

^a Identified as a state with a quitline by the Center for Tobacco Cessation survey.

^b Although North Dakota and South Carolina did not report having a quitline in 2003, they were identified as states with quitlines through press releases announcing the launch of the quitlines in 2004.

than 10 percent cover all six first-line treatments. Despite the clinical evidence of medical efficacy presented in the 1996 and 2000 PHS guidelines on the effectiveness of counseling in treating tobacco dependence, it appears that this has not made a strong impression on state policymakers, who seem to favor coverage of pharmacotherapies. It thus appears that FDA approval of medications for treating tobacco dependence is much more likely than clinical guidelines to stimulate adoption of specific treatments.

It seems unlikely that all fifty states will offer Medicaid coverage for all of the recommended treatments in the near future. Neither are the inequities in coverage across state Medicaid programs likely to subside. It would make both good economic and public health sense for Congress to add coverage of effective tobacco-dependence treatment to the core package of Medicaid benefits defined at the federal level, rather than continuing to allow states to voluntarily add benefits incrementally. Recently, federal policy has acknowledged tobacco as the leading cause of preventable death, and the Centers for Medicare and

Medicaid Services (CMS) has taken the lead in adopting coverage for tobacco-dependence counseling for the Medicare population.¹⁵ In addition, the new Medicare Part D prescription drug benefit covers smoking cessation pharmacotherapy prescribed by a physician for eligible beneficiaries.

It is also essential, if these benefits are to be effective, for states to actively inform physicians and Medicaid recipients of the availability of tobacco-dependence treatment benefits and to encourage their use, lest they be underused.¹⁶ In addressing this problem, media campaigns, particularly if they are tied to quitlines, have proved effective in reaching out to smokers who want to quit: Calls to quitlines increase directly in response to mass-media campaigns.¹⁷ Quitlines can be a source not only for counseling services, but also for which treatments are covered and which are effective. Mass-media campaigns combined with other interventions have also been found to be effective in increasing smoking cessation.¹⁸

Another key element of a successful smoking cessation strategy is the documentation of smoking status in the medical records of

Medicaid enrollees.¹⁹ This not only increases documentation, but also increases the rates at which providers advise smokers to quit.²⁰ One of the biggest barriers to adopting smoking status as a vital sign is the lack of institutionalized systems, such as electronic medical records, for routinely screening for smoking status in most medical practices.²¹ Therefore, we recommend that the CMS and state Medicaid programs work toward inclusion of tobacco use as a vital sign in the medical records of all Medicaid and Medicare enrollees.

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NOTES

1. "Cigarette Smoking among Adults—United States, 2002," *Morbidity and Mortality Weekly Report* 53, no. 20 (2004): 427–431.
2. "Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses—United States, 1997–2001," *Morbidity and Mortality Weekly Report* 54, no. 25 (2005): 625–628.
3. CDC, *The Health Benefits of Smoking Cessation: A Report of the Surgeon General* (Atlanta: CDC, 1990); and CDC, *The Health Consequences of Smoking: A Report of the Surgeon General* (Atlanta: CDC, 2004).
4. "Cigarette Smoking among Adults."
5. See our analysis of the CDC's 2000 Behavioral Risk Factor Surveillance System (BRFSS) survey data, available at http://www.cdc.gov/brfss/technical_infodata/surveydata/2000.htm (accessed 18 May 2005).
6. M.C. Fiore et al., *Treating Tobacco Use and Dependence: Clinical Practice Guideline* (Rockville, Md.: Public Health Service, 2000).
7. In 1998, Virginia refused to participate, citing a state policy of not participating in surveys.
8. H.H. Schauffler, D.C. Barker, and C.T. Orleans, "Medicaid Coverage for Tobacco-Dependence Treatments," *Health Affairs* 20, no. 1 (2001): 298–303) reports twenty-five states covering these treatments in 1998. Subsequent analyses and clarifications have revealed that one state (Oklahoma) inaccurately reported coverage in 1998 and that two (Rhode Island and Virginia) were providing coverage but did not report it.
9. Fiore et al., *Treating Tobacco Use*.
10. Pre-1998 information is based on survey responses and supporting documents specifying which year coverage began for specific treatments.

11. T.A. Coughlin and S. Zuckerman, "Three Years of State Fiscal Struggles: How Did Medicaid and SCHIP Fare?" *Health Affairs* 24 (2005): w385–w398 (published online 16 August 2005; 10.1377/hlthaff.w5.385).
12. Fiore et al., *Treating Tobacco Use*.
13. CDC, *Preventing Tobacco Use among Young People: A Report of the Surgeon General* (Atlanta: CDC, 1994).
14. C. McPhillips-Tangum et al., "Addressing Tobacco in Managed Care: Results of the 2002 Survey," *Preventing Chronic Disease*, October 2004, http://www.cdc.gov/pcd/issues/2004/oct/04_0021.htm (accessed 18 May 2005).
15. CMS, "Medicare Adds Coverage of Smoking and Other Tobacco Use Cessation Services," Press Release, March 2005, <http://new.cms.hhs.gov/apps/media/press/release.asp?Counter=1395> (accessed 23 January 2006).
16. See, for example, V.E. Cokkinides et al., "Under-Use of Smoking-Cessation Treatments: Results from the National Health Interview Survey, 2000," *American Journal of Preventive Medicine* 28, no. 1 (2005): 119–122; and S.B. McMenamin et al., "Physician and Enrollee Knowledge of Medicaid Coverage for Tobacco Dependence Treatments," *American Journal of Preventive Medicine* 26, no. 2 (2004): 99–104.
17. K.M. Cummings et al., "Results of an Antismoking Media Campaign Utilizing the Cancer Information Service," *Journal of the National Cancer Institute Monographs* 14 (1993): 114–118.
18. *Ibid.*
19. Fiore et al., *Treating Tobacco Use*.
20. See, for example, M.D. Robinson, S.L. Laurent, and J.M. Little Jr., "Including Smoking Status as a New Vital Sign: It Works!" *Journal of Family Practice* 40, no. 6 (1995): 556–561.
21. See, for example, C.J. Bentz, N. Davis, and B. Bayley, "The Feasibility of Paper-based Tracking Codes and Electronic Medical Record Systems to Monitor Tobacco-Use Assessment and Intervention in an Individual Practice Association (IPA) Model Health Maintenance Organization," *Nicotine and Tobacco Research* 4, no. 1 Supp. (2002): S9–S17.