Medicaid Coverage For Tobacco-Dependence Treatments

Only half of the states cover even one smoking-cessation treatment for their Medicaid recipients.

By Helen Halpin Schauffler, Dianne C. Barker, and C. Tracy Orleans

Medicaid is the primary purchaser of health insurance for low-income persons, including children and their mothers, the elderly, persons with disabilities, and participants in federally assisted income-maintenance programs. In 1998 Medicaid provided health insurance coverage for nearly thirty-one million Americans, or approximately 11 percent of the U.S. population. The rates of smoking in the Medicaid population are higher than in the general public. For example, in a 1999 statewide survey of California adults (ages eighteen to sixty-four), smoking prevalence in the Medicaid population was 31 percent compared with 19 percent among all insured adults. In 1999 Medicaid covered an estimated five million or more adult smokers.

In April 1996 the Agency for Health Care Policy and Research (AHCPR) published a Clinical Practice Guideline on Smoking Cessation. An updated and revised guideline was released by the U.S. Public Health Service 27 June 2000. The guideline makes recommendations to help clinicians, health insurers, and purchasers identify tobacco users and support and deliver effective smoking-cessation treatments. The recommendations were based on a thorough review of the scientific evidence on the efficacy and effectiveness of smoking-cessation interventions. The AHCPR guideline recommends that purchasers of health insurance (employers, Medicaid, and Medicare) cover both nicotine replacement therapy (NRT) and counseling in their contracts with health plans.

- **Treatment costs.** One of the reasons that some state Medicaid programs are taking an interest in tobacco control is the high cost associated with treating tobacco-related disease. In 1993 the federal and state governments spent approximately $12.9 billion under Medicaid treating tobacco-related disease. Individual state Medicaid spending ranged from a low of $11 million in Wyoming (8.2 percent of expenditures) to a high of $1.9 billion in New York (10 percent of expenditures).

- **Litigation.** Four state attorneys general sued the tobacco industry in 1997 in part to recover the costs of treating tobacco-related disease for Medicaid recipients. Another forty-two states joined them in signing the Master Settlement Agreement (MSA) in November 1998. In addition, Minnesota, Mississippi, Texas, and Florida settled separate state lawsuits against the tobacco industry. The settlements have brought billions in discretionary dollars to the states.

- **Funding tobacco-control programs.** The MSA placed no restriction on how the funds are to be spent. Tobacco-control advocates have encouraged states to allocate fund-
ing to support comprehensive tobacco-control programs, including smoking cessation. The Centers for Disease Control and Prevention (CDC) published a “best practice” guideline for funding tobacco-control programs, which includes smoking cessation as one of nine components. The National Cancer Policy Board of the National Academy of Sciences has also prepared a report on how states can reduce tobacco use, which supports treatment programs for tobacco dependence. In addition, the Center for the Advancement of Health has published findings and recommendations for treating tobacco-related disease in the United States.

As of January 2000 only three states (Indiana, Maryland, and New Jersey) had proposed or enacted legislation to designate a share of the settlement specifically for smoking “cessation.” An additional nine states have earmarked a specific dollar amount or proportion of the settlement to fund “tobacco-control” programs, which may or may not include smoking cessation. Four states have enacted or proposed legislation to fund “prevention” programs, and two more states plan to fund “anti-smoking” programs. In all, more than 400 bills addressing the use of the MSA were introduced or carried over into the forty-four state legislatures that were in session in 2000.

Medicaid optional benefits. States have wide discretion in the selection of optional benefits they offer beyond a required core set. Who makes these decisions varies by state: In some states the legislature votes on adding or subtracting Medicaid benefits, while in others the state Medicaid agency has full authority. As such, state Medicaid programs may be described as offering fifty-one separate benefit packages that vary as a function of each state’s optional benefits. Tobacco-dependence treatment may be covered under Medicaid as a preventive service option (Social Security Act, Section 1905[a][13] and/or as part of prenatal care services (Section 9501, Consolidated Omnibus Budget Reconciliation Act, 1995). Details on the extent of this coverage have not previously been documented or made publicly available.

Study Methods

To better understand the extent to which state Medicaid programs cover tobacco-dependence treatment and are aware of and use the AHCPR clinical practice guideline, we surveyed all state Medicaid programs in 1998. A mail survey was sent to fifty-one Medicaid program directors by staff of the Health Policy Tracking Service of the National Conference of State Legislatures. Respondents included state Medicaid directors or directors of policy, planning, contracting, medical services, program support, or health care financing.

In the initial response to the survey, there was much missing data. Four states had not returned their questionnaires, and responses to important questions were missing from the other forty-six states plus the District of Columbia. A follow-up survey was conducted by the Center for Health and Public Policy Studies at the University of California (UC), Berkeley, during July 1999. A subset of forty questions from the original questionnaire was identified as providing the most important data on tobacco-dependence treatment benefits and programs.

The final response rate was 98 percent. Four states completed the survey by telephone. Only Virginia refused to participate in the research, responding in a letter that not participating in surveys is their state’s policy.

All surveys were cleaned for internal consistency, and the data were entered and checked using a double entry process by the UC Survey Research Center. Frequencies were calculated for all questions, and cross-tabulations were run to identify relationships that might explain variations in Medicaid coverage.

Study Findings

Based on the survey responses, we found that twenty-four states plus the District of Columbia covered one or more treatments for tobacco dependence in 1998, and twenty-five covered none (Exhibit 1). This translates into Medicaid coverage for one or more tobacco-dependence treatments for about half of Medicaid recipients nationwide. None of the
coverage offered differed by Medicaid beneficiary category or by coverage under traditional fee-for-service (FFS) Medicaid versus Medicaid managed care.

### Covered treatments

State Medicaid programs were most likely to cover pharmacotherapy for tobacco dependence, including bupropion (twenty-two states and D.C.), the nicotine patch (twenty-one states and D.C.), gum (nineteen states and D.C.), and nasal spray (sixteen states and D.C.). Montana and Wisconsin covered the nicotine patch but not the gum. Most states that covered the NRT patch or gum covered both over-the-counter (OTC) and prescription products. However, three states and the District of Columbia excluded coverage of an OTC patch and gum and covered only prescription NRT. Kansas and Arizona covered bupropion (Zyban) only. Ten states covered all forms of Food and Drug Administration (FDA)-approved pharmacotherapy.

### EXHIBIT 1

**State Medicaid Program Coverage Of Tobacco-Dependence Treatment, Among Those That Covered Any Treatment, 1998**

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<tr>
<th>State</th>
<th>OTC gum</th>
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**Percent of states**

- 30%
- 28%
- 40%
- 44%
- 34%
- 46%
- 12%
- 16%
- 8%

**SOURCE:** Authors' survey of fifty-one state Medicaid programs, 1998.

**NOTES:** Virginia did not respond to the survey. States that are not listed did not offer coverage for tobacco-dependence treatments in 1998. OTC is over-the-counter.
Only ten states covered any form of counseling for tobacco dependence. The most common package of benefits offered by eleven state Medicaid programs covered all forms of NRT and bupropion but no counseling, despite the evidence that quit rates associated with behavioral counseling interventions and pharmacotherapy are more than doubled when these treatments are combined.9

**Comprehensive benefits.** Six states (Delaware, Maine, Maryland, Minnesota, New Mexico, and Oregon) offered comprehensive Medicaid benefits for treating tobacco dependence (all forms of NRT, bupropion, and both group and individual counseling). Altogether, only 5.5 percent of Medicaid recipients had access to such comprehensive benefits in 1998.

**AHCPR guideline.** We found that among the Medicaid program directors we surveyed, the directors in twenty-eight states and the District of Columbia were aware of the AHCPR guideline. Among them, only four states (California, Nevada, Oregon, and Wisconsin) based their benefits on the guideline. In addition, nearly half of the programs whose directors were familiar with the guideline did not cover any tobacco-dependence treatments, and 38 percent did not use the guideline in defining their benefits.

The AHCPR guideline also recommends that providers (1) systematically identify all tobacco users at every visit, (2) document smoking in the medical record, (3) strongly advise all smokers to quit, (4) offer counseling, (5) arrange for follow-up support, and (6) encourage smoke-free environments.10 We found that only New York and Rhode Island requested that their Medicaid providers carry out all six support activities. Only nine states requested that their Medicaid providers carry out one or more of these activities. Indiana, New York, and Rhode Island were the only states that asked Medicaid providers to routinely ask patients about their smoking; however, none of these states covered any treatments for tobacco dependence. We also found that none of the four states that based their Medicaid benefits on the AHCPR guideline requested that their Medicaid providers conduct any of the recommended activities to support smoking cessation.

**Other treatment interventions.** Only four state Medicaid programs (Arizona, Maine, Rhode Island, and Wyoming) reported offering any special programs designed to assist women who are pregnant or breastfeeding to quit smoking, despite the strong evidence base that quitting during pregnancy reduces the incidence of low birthweight.11

Only eight states reported conducting any outreach activities to identify Medicaid smokers and help them to quit. Only four (California, Ohio, Oklahoma, and Wisconsin) routinely measured and collected data on the proportion of smokers who have received advice to quit from their provider.

**Factors associated with treatment coverage. Smoking prevalence.** The fourteen states with the highest rates of smoking (at least 25 percent of the adult population smokes) were Alaska, Arkansas, Indiana, Kentucky, Louisiana, Michigan, Missouri, North Carolina, Nevada, Ohio, South Carolina, South Dakota, Tennessee, and West Virginia. One-third or fewer of these covered bupropion (4); NRT spray or inhaler (2); or group (0), individual (0), or telephone counseling (0). These high-prevalence states were also less likely to cover the NRT gum or patch. However, these states were more likely than the low-prevalence states were to report that they conducted outreach activities to encourage Medicaid recipients to quit smoking (29 percent versus 12 percent).

**Tobacco-growing states.** States that are the major growers of tobacco (Georgia, Kentucky, North Carolina, South Carolina, Tennessee, and Virginia) were less likely to provide

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“States that are the major growers of tobacco were less likely to provide Medicaid coverage for tobacco-dependence treatment.”
Medicaid coverage for tobacco-dependence treatment. North Carolina’s Medicaid program was the only one that covered any pharmacotherapy (NRT and bupropion), and none covered any counseling.

Use of MSA funds. Of the eighteen states that planned to use part of their MSA funds to control or prevent tobacco use, twelve (67 percent) covered tobacco-dependence treatments under Medicaid. However, among the twenty-four state Medicaid programs that covered these treatments, fewer than half planned to use any of their MSA funds for tobacco control.

Discussion

Although tobacco use is the single most preventable cause of disease and is most prevalent among low-income populations, only half of all Medicaid recipients were covered for any tobacco-dependence treatments in 1998. This is true despite the overwhelming evidence on the health benefits of quitting, the availability of effective treatments, the relative cost-effectiveness of these treatments, and the availability of an evidence-based, clinical practice guideline. Lack of health insurance coverage for preventive services is a major barrier to their use.12 Fewer than 6 percent of Medicaid recipients had coverage for comprehensive tobacco-dependence treatments in 1998.

■ Barriers to coverage and use. One of the reasons for noncoverage may be that respondents in twenty-one states were not familiar with the AHCPR guideline two years after its initial release. However, we do not know if this represents the awareness level of all Medicaid program staff in a state. Only four of the twenty-eight state Medicaid directors who were aware of the guideline reported using it as the basis for defining coverage or programs. State Medicaid agencies could benefit greatly from training on how to translate the guideline into benefits and programs that are most effective in increasing quit attempts and quit rates among Medicaid smokers.

Another barrier to coverage may be cost. In 1999 in California the average cost for an eight-week course of treatment for the nicotine patch was $180; for an eight-week course of nicotine gum, $350. Despite the relative cost-effectiveness of these treatments and their potential for short-term cost savings, Medicaid will certainly incur additional costs in offering these new benefits. The most obvious source of revenue to finance coverage is funding from the MSA, which was based, in part, on estimates of the costs of treating tobacco-related disease under Medicaid. In addition, states are unlikely to realize the full benefits of smoking cessation given the turnover in the Medicaid population. However, the benefits can be realized within nine months or fewer among pregnant women and their infants and within one year after quitting smoking among those at risk for heart disease.

Finally, there has been little political demand for covering these treatments from smokers, medical professionals, employers, or the tobacco-control community. Also, the influence of the tobacco industry on health policy in many states may explain this lack of coverage.

Even in those states where Medicaid does cover treatments for tobacco dependence, barriers to their use may remain. For example, we found that very little effort was being made by state Medicaid programs to inform smokers of the availability of these benefits or how to access and use them.

■ Broad choice of treatments. We were encouraged to find that the majority of state Medicaid programs that covered NRT covered both OTC and prescription products. In addition, nearly half of the states have moved quickly to add Medicaid coverage for bupropion, which has been demonstrated to be effective in reducing smoking and has been approved by the FDA for treating tobacco dependence.13

■ Defining benefits. Among the state Medicaid programs that covered tobacco-dependence treatments, we found considerable variation in which treatments were covered. The most important component of any health insurance benefit for tobacco-
dependence treatment includes coverage of both counseling and all FDA-approved pharmacotherapy.  

Our findings suggest that coverage and reimbursement policies in state Medicaid programs have not kept pace with the growing evidence base for tobacco-dependence treatments, and most are failing to cover services that are effective in a population that most needs them. It is in the interest of the public’s health and the efficient use of government resources for state Medicaid programs to use the existing evidence base for defining coverage for treating tobacco dependence; most do not.

The authors express their appreciation to the Health Policy Tracking Service of the National Conference of State Legislatures for conducting the initial mail survey. Funding support for this project was provided by the Robert Wood Johnson Foundation.

NOTES

10. Ibid.