Engaging Health Plans and Employers in Purchasing Quitline Services
November 2017

Context
Currently state quitlines serve only 1 percent of tobacco users nationally. The Patient Protection and Affordable Care Act (ACA) requires that most insurance plans (fully and self-funded plans) offer access to all U.S. Public Health Service recommended tobacco cessation medications and counseling without cost-sharing or prior authorization. (1) This requirement was meant to ensure that more tobacco users have access to a comprehensive tobacco cessation benefit. In 2015, 90.9 percent of people were covered with some type of health insurance. (2)

Goal
To provide cessation treatment to six percent of tobacco users in each state annually through a combination of services from state quitlines and commercial quitlines (that are purchased by health plans, employers and insurers).

Importance of This Topic
The ACA aims to make cessation a regular part of healthcare. Without investments from the commercial sector, NAQC’s goals of investing $10.53 per smoker in quitlines and reaching six percent of tobacco users with treatment can not be achieved. Establishing cessation coverage among employers and health plans has the potential to expand utilization of evidence-based treatment significantly and allows states to focus their resources on the uninsured and other special populations.

Compared to state quitlines, commercial quitline contracts may have:
- More comprehensive and consistent services,
- More medications including full regimen of prescription drugs,
- Engagement strategies that include incentives, and
- Higher participation rates and alignment with existing wellness promotions.

Existing Data
Health insurance coverage in the United States: 2015 (2)
- In 2015, private health insurance coverage continued to be more prevalent than public coverage, at 67.2 percent and 37.1 percent, respectively. Of the subtypes of health insurance, employer-based insurance covered 55.7 percent of the population for some or all of the calendar year, followed by Medicaid (19.6 percent), Medicare (16.3 percent), direct-purchase (16.3 percent), and military coverage (4.7 percent).
- Nationally, 9.1 percent of residents are uninsured (range: 2.8 percent in MA to 17.1 percent in TX).

Closing the Gaps
- NJH and Optum have approximately 1,065 commercial contracts covering over 2 million lives. These two service providers and others are seeking commercial contracts for quitline services, so we expect the number of covered lives will increase.
Each year, state quitlines receive over 1.1 million calls and provide counseling and/or medications to about 350,000 tobacco users. About 20-25% of the calls are generated by the national Tips Campaign (which runs for 20 weeks).

Some health insurers and employers have begun to comply with the ACA requirements by offering cessation treatment during office visits and through commercial quitline services for their members. This increases the availability and utilization of evidence-based cessation services.

National Jewish Health and Optum conduct triage when possible between state quitlines and commercial contracts to ensure that a caller receives the most intensive treatment available.

In NY, Roswell Park has developed a triage protocol with Medicaid MCOs (discussed in the companion paper on Medicaid).

Over the past five years, nearly a dozen states have worked towards developing cost-sharing partnerships and over half of them now have some form of partnerships in place. Colorado, North Carolina, Kentucky and Utah have made some of the greatest strides in advancing cessation coverage among commercial insurers and employers.

While some insurers and employers offer cessation treatment benefits, many continue to take advantage of the free cessation treatment services offered by state quitlines.

Next Steps for NAQC to Consider

- Compile information on existing state legislation that requires fully and self-funded insurance plans, including Medicaid plans, to provide evidence-based treatment services. Specifically, work with partners to collect copies of states’ legislation and experiences to share with NAQC members and partners. If information is available, conduct phone interview to assess states’ experiences with implementation of legislation.

- Assess state interest and/or barriers and resources needed for limiting state quitline services to the uninsured or other special populations, and identify ways that NAQC, CDC and others can support and encourage such action.

- Develop “make the case” materials that present return-on-investment (ROI) and can be tailored for use by individual state quitlines. Include information on ACA requirements vis-à-vis cessation services.

- Develop a 1-2 page position paper, supported by other key stakeholders, on the importance of cessation treatment benefits and the ROI of quitline services for distribution to NAQC members, state insurance agencies, health plans and other entities. Include information on ACA requirements vis-à-vis cessation services.


  - This paper also can be used to provide models for triaging calls between state quitlines and commercial insurers/health plans and for monitoring the reach of public and private quitlines. The paper describes how some state quitlines serve as a triage hub to refer insured callers to their plans’ cessation services (Minnesota model, New York model with Medicaid, Colorado model). It also includes approaches for calculating reach more broadly, processes for supporting the private sector in sharing data with public health colleagues, and potential funding sources (i.e., organization match, percentage of commercial funding for uninsured, foundations, etc.).

- Retool the existing list of high quality and cost-effective quitline vendors on NAQC’s website to be used as a marketing piece for the commercial sector.

- Provide guidance for developing directories of cessation services offered by major insurers in each state (to help with monitoring state insurers and triaging calls). These directories may be a resource to health care providers, quitlines, state health departments and advocates.
• Collect information (data and stories) from insurers who are covering the cost of services for members/employees. If insurers are willing to share it, this information can be helpful in helping to make the case to others.

References and Resources