

# The Role of Reimbursement and Third Party Financial Support in Sustaining Quitlines

## Introduction

The North American Quitline Consortium (NAQC) is a non-profit organization that seeks to unite quitline stakeholders—funders, service providers, researchers and national organizations—in the U.S. and Canada to improve access to and quality of quitline services. Efforts strive to decrease the toll of tobacco related diseases and deaths in North America. NAQC's mission is to serve as a learning organization to:

- Maximize the access, use, and effectiveness of quitlines in North America;
- Offer a forum to link those interested in quitline operations; and
- Provide leadership and a unified voice to promote quitlines.

Currently, NAQC is comprised of over 300 members, including representatives from quitlines across North America. Quitlines have grown significantly over the last two decades. Within North America quitlines exist in all U.S. states, D.C. and five territories; in each Canadian province; and, most recently, in Mexico. The evidence-base for quitline services was established through clinical trials and recommended to health care practitioners through the *U.S. Public Health Services Clinical Practice Guideline: Treating Tobacco Use and Dependence*.<sup>1</sup> In addition to treating tobacco users, some quitlines also provide services to friends and relatives of tobacco users and health care professionals.

While there are many important issues for the quitlines, one emerging issue related to quitline sustainability is third-party reimbursement for quitline services. As part of a grant from the Robert Wood Johnson Foundation (RWJF), NAQC developed this white paper on third-party reimbursement of quitlines to serve as a resource to NAQC members and tobacco control partners. Due to differences in health care financing in the U.S. and Canada, this project focuses solely on U.S. quitlines.

This paper assesses the current practices of quitlines with regard to third-party reimbursement and other forms of financial support, provides an overview of the opportunities for obtaining third party support and sets next steps for garnering third-party financial support for quitlines.

## Background – About Quitlines

Quitlines are telephone-based services that offer counseling and information to help smokers quit. In 1992, after research demonstrated telephone-based counseling for tobacco cessation an effective treatment, the California Department of Health launched the first statewide telephone counseling service to help smokers quit. Since then the number of states and provinces in North America offering quitline services for smokers and other tobacco-users has increased dramatically. There are a wide variety of quitline service provider types, including commercial companies, charities/endowments, voluntary organizations, university and medical centers, governments and private non-profits.

## Provider of Critical Services

Quitlines serve as an important cessation resource in most communities. Together with face-to-face counseling services provided by physicians and others, quitlines form the core of evidence-based cessation services in the U.S. and Canada. The 2008 Public Health Service Tobacco Use and Dependence Guideline Panel identified

quitline effectiveness as a topic deserving focused meta-analysis, resulting in the statement “Telephone quitline counseling is effective with diverse populations and has broad reach. Therefore, clinicians and health care delivery systems should both ensure patient access to quitlines and promote quitlines.”<sup>1</sup>

Many healthcare providers and community-based organizations refer smokers to quitlines. In the U.S., quitlines reach about 1% of the country’s 46 million smokers each year.<sup>2</sup> Researchers have estimated with adequate funding and promotional activities, quitlines could reach 16% of the smokers each year.<sup>3</sup>

### **Current Status of U.S. Quitlines**

In the U.S., most states fail to fund tobacco prevention programs at minimum levels recommended by the U.S. Centers for Disease Control and Prevention (CDC). Altogether, states provide funding at levels of less than half what the CDC recommends. The combined amount states allocated for tobacco prevention in Fiscal 2008—\$717.2 million—is an increase of 20% from the \$597.5 million allocated in Fiscal 2007, but is still just 45% of the \$1.6 billion minimum CDC recommends. States this year will collect a record \$24.9 billion from the tobacco settlement and tobacco taxes. Just 6.4% of these dollars can fund tobacco prevention and cessation programs in every state at the minimum levels recommended by the CDC. However, states are spending less than 3% of their tobacco revenue on tobacco prevention and cessation.<sup>4</sup>

Based on information gathered in NAQC’s 2006 annual survey of quitlines, 21 U.S. state quitlines received funding from state general revenues, 11 from state tobacco taxes, 23 from the Master Settlement Agreement (MSA) and 34 from the federal government. The sum of quitline budgets for FY2006 was \$70.7 million with a median of \$775,000 (48 quitlines reporting). The sum of quitline budgets just for services (excluding promotions) was \$43.5 million with a median of \$515,000 (49 quitlines reporting).<sup>5</sup>

The role of the private sector in supporting quitline services has not been well explored, although a positive return on investment can be demonstrated for telephone counseling as well as nicotine replacement therapy (NRT). Many health plans and employers expend resources to cover evidence-based tobacco cessation medications, but their approach to covering evidence-based behavioral treatments appears more variable. Few state-run quitlines receive any support from the private sector. However, some commercial quitline operators, which may be more accustomed than public health officials to making the business case for tobacco cessation, have shown it is possible to market quitline services to corporations and health plans. This has resulted in the development of some private sector quitlines for select employers and health plans.

### **Future of Tobacco Control Funding**

The continuing reallocation of MSA funds and tobacco tax revenue to non-tobacco control areas in addition to declining tobacco tax revenue may further jeopardize tobacco control funding, and specifically quitline budgets. Cost sharing or other financial arrangements between the public and private sectors may be a practical and equitable way to maintain or increase quitline funding.<sup>6</sup>

### **Opportunity for Rembursement**

Prevention and chronic disease management services are typically provided by healthcare providers and reimbursed by third party payers, through private health insurance or government programs including Medicare, Medicaid, and the State Children’s Health Insurance Program (SCHIP). Although tobacco cessation falls under the category of prevention and chronic disease management, the public health system rather than private or government payers often provide it without reimbursement.

While, in recent years, several states have made great strides in generating health plan awareness of quitlines and physician referrals to state quitlines, very few have taken the important step of securing private insurance financial support or reimbursement for quitline counseling services and provision of NRT—a part of most quitline protocols. As NAQC considers program activities to support third party reimbursement for quitlines, it is important to understand the structure of the health insurance market in the U.S., employers’ role and how

this structure will impact quitline reimbursement strategies. What follows is a very brief overview of the health insurance market, the primary players and leverage points for change among them. Other aspects of health insurance that might influence reimbursement or other financial support for quitlines and tobacco cessation are: 1) industry cost pressures, 2) coverage of preventive services and 3) the role of disease management. An overview of each of these areas is provided.

It is important to note the very complexity of the health insurance industry and differences in terms, acronyms and ways of doing business have served as obstacles for many quitlines approaching this sector for financial support. This paper provides the following categories of recommendations, which will be explored in greater detail later on, as ways to overcome such obstacles. These recommendations are primarily based on survey results and interviews conducted as part of this paper's development.

#### *Spectrum of Options*

For every state, the variety of public and private entities impacting access to quitline services is diverse as are the roles and relationships between these entities. These dynamics influence the options a quitline might pursue to promote broader support for quitline services. NAQC should work to define the role and relationship of all of these agencies and identify a spectrum of options that ensure all tobacco users access to quitline services.

#### *Circumstance-Specific Feasibility*

To support states in considering appropriate options to expand funding and access, NAQC should identify circumstances under which the different options are more or less feasible to implement and support.

#### *Leverage Points for Expanding Access to and Use of Quitlines*

To allow states to develop appropriate strategies, NAQC should identify leverage points for expanding access to and use of quitline(s) by different constituents and frame the appropriate message for each lever point (e.g. messages for large self-insured employers versus health plans versus disease managements (DM) vendors).

#### *National Support and Leverage*

Where feasible, NAQC should take advantage of leverage points at a national level to expand support for and use of quitlines (e.g. health plans, employers and DM vendors).

#### *State and Local Tools*

NAQC should develop tools to support local efforts to expand access into new market segments.

### **Understanding the Health Insurance Market**

The most tangible way health plans manifest support for any given type of service, including tobacco cessation, is by providing benefit coverage and reimbursing for services. Health plans generally decide to provide coverage and reimbursement based on pressure from purchasers—the people or organizations buying health plan coverage for their employees. Coverage decisions stemming from purchaser pressure can be voluntary or mandated by law.

There are three primary types of purchasers:

1. Fully insured employers
2. Self-insured employers
3. Government

**Figure 1**

*Extrapolated from multiple sources including Kaiser Family Foundation and Employee Benefit Research Institute Issue Brief October 2007.*

*Fully Insured*

Fully insured employers cover about one-quarter of the population. These employers pay a premium to provide agreed upon benefits to eligible employees and dependents. The insurance company bears all the risk, meaning it is responsible for all service costs. If total services for the group cost less than total premium collected in any given year, the insurance company keeps the difference; if services cost more, the insurance company must bear the cost. While there may be negotiations about the benefits to be covered, once the contract between the employer and the insurance company is signed, the insurance company determines reimbursements. Fully insured employers can exert pressure for quitline services when negotiating benefits.

Fully insured companies are regulated at the state level, as a result of legislation passed in 1945 called the McCarran-Ferguson Act. This Act allows state law to regulate the business of insurance without Federal government interference.

State mandates for coverage apply only to the fully insured sector, another potential point of leverage for insurance company support. However, it is important to note that because fully insured business represents only about a quarter of the population, a mandate has limited impact (*See “Mandates” section below*).

*Self-Insured*

Self-insured companies represent another quarter of the population. Self-insured employers, rather than the health plans, pay for the services used by their employees. Although a self-insured company incurs administrative costs, it pays only for the services used by its employees. The self-insured avoid paying costs that are included for fully insured groups, such as premium taxes and the insurance company’s profit margin. Generally, companies with at least 250 employees are in a position to consider self-insuring. Self-insuring with a small number of employees does not provide a large enough base to distribute the odds of incurring a high claim; small self-insured employers can suffer huge financial consequences of one very high claim from an unanticipated health issue. As a consequence, most small companies cannot afford the risk of self-insuring.

Self-insured companies are exempt from state insurance regulation but are subject to provisions of the Employee Retirement Income Act of 1974 (ERISA). Because they are exempt from state mandates (*See “Mandates” section below*), self-insured purchasers must be convinced of the merits of tobacco cessation. Tobacco cessation is demonstrated to be cost-effective for employers in a very short time frame<sup>7</sup>. It is also cost-effective for health plans, but can take two to three years before the cost benefit is realized. Therefore, self-insured employers are a logical target for education efforts around coverage benefits.

Self-insured employers generally contract with a third-party administrator (TPA) to help them administer their benefits. The TPA helps identify if an employee is eligible for coverage, arranges for payment for services, often conducts utilization review, provides access to preferred provider networks and generally provides data analysis and reports to the employer. Many insurance companies also serve as TPAs, taking advantage of the economies of scale they can generate with their networks of physicians and their claims processing capabilities. As a result, it is often very difficult to discern if an employer is insured or self-insured.

Self-insured companies can exert pressure for insurance company support for quitlines as a component of the coverage they want to provide their employees. Often large self-insured companies pave the way for more widespread coverage by providing services and thereby demonstrating feasibility. Once feasibility has been established, insurance companies and TPAs are more willing to extend similar benefits to smaller companies and their fully insured clients.

### *The Government*

The government generally wears two very different hats with respect to health plan interactions. The government can exert pressure for insurance company support for benefits as a purchaser and a regulator. The Federal government is one of the largest national purchasers of health care benefits and contracts with many different insurance companies around the country to provide benefits to federal employees. In many states, the state employee group is among the largest in the state. States also determine Medicaid benefits and reimbursement rates. Deciding to fiscally support quitlines through either its state employee purchasing power or its Medicaid purchasing power can create momentum for other purchasers to follow suit.

From a regulatory perspective, the state government can exert pressure for insurance company support for quitlines by mandating coverage benefits through legislation. However, as noted below, this can present significant challenges. Government health programs like Medicaid are not subject to state health insurance mandates, but states may legislate specific benefit coverage for Medicaid or its state employee benefit programs.

### *Mandates*

A health insurance mandate is a requirement that an insurance company or health plan cover specific healthcare providers, benefits or patient populations, including services like mammograms, well child care or tobacco cessation counseling. For almost every healthcare product or service, there is someone who wants insurance to cover it. Often advocacy groups promote mandated benefits to make health insurance more comprehensive, but mandates also make insurance more expensive. The Council for Affordable Health Insurance estimated mandates increase the cost of basic health coverage from 20% to 50%.<sup>8</sup>

Because insurance is regulated by the states, benefit mandates pertain only at this level. Proposing state mandates for coverage of quitlines and other tobacco cessation treatments represent a point of leverage for insurance company support. However, because of the upward impact on premium cost, this strategy is not likely to garner support from either the purchaser or provider community and will not engender collaboration from health plans.

Purchasers oppose mandates because they generally increase the cost of coverage and apply to a relatively small portion of the population with health benefits coverage. Mandated benefits apply only to fully insured groups, generally small employers. Self-insured employers are not regulated by state insurance laws and are exempt from all state benefit mandates. Likewise, public sector purchasers, including governments and the military, are also exempt from mandates. As such, a mandate may impact as little as a quarter of the insured population and an even smaller percent of the total population.

Health care providers generally oppose mandates because cost increases ultimately reduce access to coverage. Furthermore, the long-term benefits of mandated coverage rarely accrue to individual purchasers, health plans

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### **Pressure on Costs**

The cost of health care has far outstripped the cost of other goods and services. This creates tremendous pressure on insurance companies to find ways to control the rate of increase. The increases also require self-insured companies to identify ways to reduce the cost of administration and actual services.

Insurance companies generally seek ways to reduce short-term health costs. There are three reasons for such an approach:

1. Most employers purchase on the basis of cost.
2. In the U.S., people stay with the same insurance company for an average of 2-3 years, thus creating limited opportunity for an insurance company to reap the benefits of an investment in long-term health.
3. A trend toward consolidation and a shift to publicly traded for-profit status in the insurance industry has heightened focus on quarter-to-quarter financial results.

It should be noted that many of the insurance companies with longer retention rates and less investor pressure are the ones that make the greatest investment in medium and long-term cost reduction strategies, including prevention and wellness.

Self-insured employers face many of the same pressures. However, larger employers are increasingly aware of pending labor shortages and the longer-term impact of poor health on health care costs and productivity. This has created growing support for chronic care management, prevention and wellness activities and an interest in return on investment calculations for a host of health care interventions and services. As noted previously, tobacco cessation is demonstrated to be cost-effective for employers in a very short time frame.<sup>7</sup> It is also cost-effective for health plans, but can take two to three years before realizing such as cost benefit.

### **Coverage of Preventive Services**

A great deal of social pressure for coverage of preventive services exists. Tobacco cessation is an important action to prevent many diseases as well as a key component to treating many conditions exacerbated by tobacco (e.g. COPD). Good evidence-based data exists on cost-effective preventive services and length of time to generate a positive return—both of which are particularly strong for tobacco cessation. However, a common failure of efforts to measure return on investment for prevention is the lack of distinction between private and social costs. Social costs and benefits are those that accrue without regard to the identity of the individual or firm bearing the cost. Private costs and benefits are those tied to a specific entity. While it is clear many preventive services generate a social benefit, many health plans and employers do not believe they receive a positive bottom line benefit that outweighs implementation costs of preventive services.

Coverage of preventive services is not always based on cost-effectiveness. Often coverage is provided for services that are politically attractive or have a strong lobbying or constituent base, but may not necessarily have the strongest cost effectiveness analysis. Tobacco is a clear illustration of this scenario. While it is very cost-effective to offer cessation services, such services are covered to a much lesser extent than other, less cost-effective preventive services.

### **Disease Management (DM)**

Disease management (DM) is the concept of reducing health care costs and/or improving quality of life for individuals with chronic disease conditions by preventing or minimizing the effects of the disease. The general focus is to ease the disease path, not cure the disease. In the U.S., DM is a large, multi-vendor industry. Approximately 50% of employers offer some level of DM. The number is expected to grow as employers shift to focusing on employee health. Most DM vendors offer a return on investment calculation (ROI) for their

NAQC Issue Paper: *The Role of Reimbursement and Third Party Financial Support in Sustaining Quitlines* programs. However, over the years there have been dozens of ways to measure ROI.

Tobacco cessation is an important aspect of DM because of its major role as a contributor to comorbidities in most of the major chronic conditions (e.g. cardiovascular disease, diabetes, asthma, chronic obstructive pulmonary disease). Virtually all of the credible DM vendors assess tobacco use of their clients as part of an initial assessment, allowing them to suggest behavioral and other self-management strategies to improve health status. However, most DM vendors outsource their tobacco cessation programs. The notable exception to this is Healthways, one of the dominant DM companies, which owns its own tobacco cessation subsidiary QuitNet (QuitNet does not include telephonic support). According to the Disease Management Purchasing Consortium, Free & Clear is the most frequently used quitline vendor by DM companies.

Preliminary research would appear to indicate that many DM vendors do not actively promote or support tobacco cessation interventions, including telephonic support via a quitline. Preliminary research also indicates many purchasers assume DM vendors offer more than simply asking about tobacco use. As such, with an investment in purchaser education, this is an area of potential leverage for additional referrals to quitlines. Health plans or employers can leverage their purchasing power to pressure DM vendors for more proactive tobacco cessation interventions, including explicit use of quitlines.

**Table 1: Summary of Market Sectors and Leverage Points to Promote Insurer Support of Quitlines**

Market Sector	Leverage Point	Counter Response from Health Insurer
Fully insured employers*	Sales and benefit negotiations with health insurers: <ul style="list-style-type: none"> <li>• Provide quitline benefit.</li> <li>• Require Plan’s DM vendor to include quitline benefit.</li> </ul>	If insurer or DM vendor is not convinced of tobacco ROI, may raise cost of coverage to add a quitline benefit or service.
Self-insured employers* (including Federal and state government)	Serve as a gauge of market interest and push insurers and DM vendors to recognize groundswell of support – lessons applied in self-insured market can be applied to fully insured market.	Not perceived negatively by insurer or TPA other than need to create administrative infrastructure. Self-insured employer can dictate coverage options.
State government - regulator	Mandated coverage.	Opposed by health insurers, employers and providers due to impact on cost of coverage.
Advocacy groups	Mandated coverage.	If ROI not established firmly, will raise price of coverage for insured employers (no impact on self-insured).

\*May include Federal or state government in their capacity as purchasers on behalf of public employees.

### **Current Practices Among State Quitlines with Regard to 3<sup>rd</sup> Party Reimbursement**

Previous surveys, discussion and literature were compiled to identify state quitlines with initiatives or unique models for funding and/or delivery of services incorporating health plans or employers. These early initiatives were not limited to reimbursement by third party payers and include all discussions of funding and cost-sharing arrangements between state tobacco control programs, their quitline vendors and third parties. Notes on past reimbursement efforts are summarized in the following table:

**Table 2: Notes on Past Reimbursement Efforts**

State	Description of Health Plan/Employer Support	Source
CO	“Developing an action plan to increase health plan coverage for tobacco cessation and support of the Quitline.”	NAQC Listserv (June 2008).
ME	Receive financial support from insurance company.  “Largest insurers in state subsidize quitline (by paying a lump sum annually).”	2006 NAQC Survey.  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 Preliminary Report on Resolve, Regarding Tobacco Cessation and Treatment (January 15, 2008).
MI	Receive financial support from insurance company  “The state has five Medicaid Managed Care Plans that cost-share with the Quitline. The Medicaid Managed Care Plan Partners contribute \$25 towards the cost of counseling for each of their members who enroll.”	2006 NAQC Survey.  State of Maine Preliminary Report on Resolve, Regarding Tobacco Cessation and Treatment (January 15, 2008).
MN	If an insured caller’s health plan offers telephone counseling, the caller is transferred directly to that plan’s tobacco quitline. The Helpline works in partnership with seven state health plans to facilitate this triage system.	Health Plan Benefits and Provider Reimbursement for the Treatment of Tobacco Dependence (April 2003, Pacific Center on Health and Tobacco).
NC	Receive financial support from insurance company	2006 NAQC Survey.
OH	Receive financial support from insurance company  “The state’s quitline has over 80 corporate, business, medical center, school and pension plan partners as well as eight health plans throughout Ohio. These partners contribute up to \$46 of the \$92 of actual costs of nicotine replacement patches for each member who participates in the Ohio Tobacco Quitline counseling program.”	2006 NAQC Survey.  State of Maine Preliminary Report on Resolve, Regarding Tobacco Cessation and Treatment (January 15, 2008).
OR	“In addition to providing initial telephonic cessation assistance, the Quit Line can identify the insurance benefits available to callers through their health plans and helps link them to these services.”	Health Plan Benefits and Provider Reimbursement for the Treatment of Tobacco Dependence (April 2003, Pacific Center on Health and Tobacco).



<b>UT</b>	<p>Receive financial support from insurance company</p> <p>“The state has a partnership with the Public Employee’s Health Program (PEHP). PEHP contracts with the tobacco program to provide Utah Quitline services (counseling, and NRT as appropriate) for their members. The contract budget is \$35,000.”</p>	<p>2006 NAQC Survey.</p> <p>State of Maine Preliminary Report on Resolve, Regarding Tobacco Cessation and Treatment (January 15, 2008).</p>
<b>WI</b>	<p>“Each Quit Line Specialist can reference the database of Wisconsin health plans and provide each caller with information regarding cessation coverage and benefits.”</p>	<p>Linking a Network: Integrate Quitlines with Health Care Systems.(July 2003, Pacific Center on Health and Tobacco).</p>

To confirm these programs are still in place and learn about additional models, a survey was fielded on August 13, 2008 (see Appendix III). The survey helped identify states that have worked with or are considering working with private employers and/or health plans to support the state quitline. An e-mail introduction and link to the survey went to all U.S. state quitline funders.

Questions were also asked about Medicaid support for the quitline and the data and information quitlines collect to track insurance status. The survey was intentionally kept short, with the goal of using it to identify those states with which follow up interviews should be scheduled.

Twenty-four states and Puerto Rico responded to the survey. Eight states were identified for follow-up.

The primary considerations prompting a follow up were affirmative responses to the following questions:

- Which free or subsidized services are provided with health plan, employer, Medicaid or other funding through cost sharing, contracts, triaging or other financial arrangements?
- Does your state’s quitline have any financial arrangements such as cost-sharing, contracts, triaging or others with insurers, institutions or employers to deliver:
  - Promotion of quitline services
  - Fax referral services
  - Services directed at priority populations
  - Help with implementing smoke free policies

States that answered affirmative to the following questions were considered, but not automatically included for additional follow-up in the following areas:

- Does the quitline share individual or aggregate data with insurers or employers?
- Have you or do you have plans to approach any potential funders in your state outside the tobacco control program for quitline funding or other financial arrangements?
- Additional comments provided at the end of the survey.

Of the eight selected states, the following seven agreed to participate in phone interviews or email dialogues:

- |              |                |             |
|--------------|----------------|-------------|
| 1. Alabama   | 2. Colorado    | 3. Kentucky |
| 4. Minnesota | 5. Mississippi | 6. Ohio     |
|              |                | 7. Vermont  |

The follow up discussions (see Appendix I) probed more substantively into what states are doing in terms of activities to engage health plans and/or employers in supporting the quitline. Interviews included questions regarding success factors and barriers and solicited recommendations regarding how NAQC can be most effective in assisting states in these outreach efforts.

### **Survey Results**

The twenty-four survey responses received by NAQC illustrated the following trends related to third party reimbursement.

Populations served by state funded quitlines:

- The most common services provided using state and/or federal funding are quitline counseling for uninsured (19/21), Medicaid (18/21) and privately insured (17/21) citizens.
- State funded pharmacotherapy is provided to the uninsured by 13 (of 21) states.
- State funded pharmacotherapy is provided to Medicaid participants in 10 (of 21) states.
- State funded pharmacotherapy is provided to insured citizens in 9 (of 21) states

Data sharing with insurers and employers:

- All but one responding quitline collects insurance status or employer information from callers.
- Eight respondents share individual or aggregate data with insurers, three with employers and only one with both.

Financial relationships with insurers, employers or other institutions:

- Five states have ventured into financial arrangements with insurers, institutions or employers to provide services such as help implementing smoke free policies, promotion of fax referral services or services for priority populations.
- Seven state quitlines provide some level of free or subsidized services with health plan, employer, Medicaid or other funding.

Mandated benefits:

- Only two states reported mandated benefits for tobacco cessation. Because the survey did not ask for details regarding mandated benefits, the scope of the mandate is not known.

### **Interview Results**

Notes from the seven follow up discussions are included in Appendix I. States shared their experiences, successes, barriers and suggestions for how NAQC can support them in working with employers and insurers on the issue of reimbursement. For example, Alabama approached insurers about contributing to quitline funding, but was not successful. Colorado has had success in working with plans on fax referrals and a new pay-for-performance program through Anthem Blue Cross and Blue Shield, but the quitline receives no direct reimbursement. Minnesota, Ohio and Vermont have relationships with health plans to support NRT. Minnesota health plans offer their own quitline services for insured members and collaborate on triaging and transferring members to the appropriate resource.

Barriers cited by four of the states were related to costs and budgets. In Colorado, the history of providing counseling and NRT to all citizens at no cost is now creating a barrier to asking for private health plan contributions. Minnesota's program experienced challenges with its triage system when the state Helpline offered NRT at no cost but health plan quitlines did not. Ohio's budget cuts have required it to stop contributing toward the cost of NRT for insured residents, but insurers are still agreeing to participate by maintaining unique contractual relationships with the quitline.

Representatives from Alabama, Colorado, Ohio and Vermont said NAQC could help them articulate return on investment and other compelling arguments for use when asking insurers and employers for support. The request for these arguments or talking points could be used with local and national entities, since coverage decisions are made at both levels depending on the employer and/or the insurer. Quitline and state public health employees also find the organization, decision-making and terminology at health plans to be different than the environment in which they typically work. As a result, they report difficult conversations given a lack of common language and analytical tools. Assistance in understanding the dynamics of health plan operations and decision-making was a common request. Minnesota’s quitline would like specific assistance on Medicaid coverage for quitline counseling.

**Recommendations**

Based on the survey results and interviews, recommendations to NAQC fall into five general categories listed below with details provided for each recommendation.

*Spectrum of Options*

Although very few states have moved beyond the contemplation stage in terms of tapping health plan or employer resources to support quitlines, it is clear there are several feasible approaches for public-private collaboration. If the ultimate goal is to provide all citizens with access to quitline services of some sort, then NAQC could take the lead in articulating the value of valid options. Options and possible variations include:

**Table 3: Possible Options & Variations**

Option	Funding Variations	Examples (Appendix I)
Single state quitline	a. All funding from state and/or federal sources, b. Funding contributed by health plans or employers, c. Independent contracts encouraged between state endorsed quitline and private employers or health plans.	<ul style="list-style-type: none"> <li>▪ Ohio</li> <li>▪ Mississippi</li> </ul>
Single state funded quitline operating alongside others, but not coordinating services	There is a high probability there are private quitlines in operation in most states not currently coordinated with state efforts. These include but are not limited to health insurance carrier quitlines and DM vendors.	<ul style="list-style-type: none"> <li>▪ Colorado</li> <li>▪ Massachusetts</li> </ul>
Multiple coordinated state quitlines	State run quitline(s) to support uninsured and/or other distinct populations with multiple quitlines supported by health plans and/or employers.	<ul style="list-style-type: none"> <li>▪ Vermont</li> <li>▪ Minnesota</li> </ul>

*Note: The role of NRT cost sharing/financial arrangements and quitline counseling transcends each of the options noted above.*

Many factors influence the options a state might consider, including the nature of and the relationships between the public agencies supporting the state’s quitline, the contracted quitline vendor, health plans which may also have contracted quitline vendors, the employer community and DM vendors. Understanding how these players’ roles are defined and their interactions will help clarify how best to make the case and direct efforts to:

- Expand access;
- Promote benefit coverage and reimbursement to different sectors;

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- Include quitline reimbursement in coverage and reimbursement decisions; and
- Enter into cost-sharing or other financial partnerships for quitline services.

Each option has value based on the state and circumstances in which it operates. Thus, it is not to NAQC's advantage to endorse or advocate for one definitive approach, but rather to identify the drivers shaping each option.

### *Circumstance-Specific Feasibility*

Each state's quitline model grew up out of specific circumstances including the local health insurance market, size and influence of local employers, presence of a strong or dominant health care or hospital system, etc. As states identify an operational model that could expand funding and access to quitline services, they need to acknowledge, identify and understand these circumstances and determine which are changeable and which are not. Factors that cannot be changed will limit the potential options, but states will be able to determine which leverage points may yield the most support.

To support states in considering appropriate options to expand funding and access, NAQC should identify circumstances under which different models are more or less feasible to implement and support. . For example, Colorado's history of one state-promoted quitline and universal access to subsidized NRT places it on the spectrum of options such that movement toward a Minnesota-like model of health plan reimbursement for NRT would be very difficult.

Assistance in understanding ways to maneuver within its own environment will allow any state to maximize its own opportunities. To provide appropriate options for states, NAQC should identify circumstances under which different models are more or less feasible to implement and support and identify the barriers to change that transcend any given model (e.g. external factors such as the political climate and the health insurance market).

### *Leverage Points for Expanding Access to and Use of Quitlines*

Leverage points in the development of each state's strategy include private employers, health plans, Medicaid, DM vendors and private quitline vendors. Each of these entities has a different reason for not engaging fully with state-run quitlines in the past as well as for potentially supporting quitlines in the future. NAQC can build upon the research and information presented in this paper to research and develop clear "value" messages for the different potential audiences.

Focus groups with employers and health plans, thought-leader sessions and return on investment calculations are all tools NAQC could explore to develop primary messages for each constituent group to promote quitline services. These messages may need to be adapted somewhat to local circumstances, but formulating the core message would be more efficient if done by NAQC on behalf of its members.

### *National Support and Leverage*

A representative of the Ohio quitline framed this recommendation most succinctly in stating "This is a top-down issue, so NAQC could help identify who is the highest person in the political food chain who can speak to the highest person in the health plan food chain." States indicated they sometimes have difficulty identifying with whom to speak, particularly since so many employers and health plans are national players. In addition, raising the profile of quitlines with organizations such as JCAHO or the National Governors Association is a way for NAQC to provide leverage that can help states in their regional efforts. The work of the CDC, Centers for Medicare and Medicaid Services (CMS) and the 13-State Collaborative that has come together to promote health systems change are other examples of ways NAQC can participate at a national level to help quitlines acquire more national support and leverage.

### *State and Local Tools*

State public health agencies expressed a need for tools to help them navigate the health plan and employer

NAQC Issue Paper: *The Role of Reimbursement and Third Party Financial Support in Sustaining Quitlines* environments. Without the proper vocabulary and a baseline understanding of health plan and employer purchasing dynamics, public health professionals are not as likely to succeed. Training, education and awareness-building material should provide public health professionals with sufficient knowledge to identify and understand market dynamics and work comfortably in the private sector purchasing world.

### **Next Steps**

Based on concerns regarding deteriorating state support for quitline services, NAQC should create consensus around a strategy to preserve public health quitline infrastructure for uninsured, underinsured and publicly insured populations. At the same time, NAQC should work with state public health agencies to determine the most effective mechanism for providing services to the privately insured population.

Assuming this strategy is acceptable to NAQC and its members, three interdependent tasks should be undertaken simultaneously:

#### *1. Develop Value Messages for Key Constituents*

Building on existing data, NAQC should frame the message(s) about the business case and ROI for quitline services, in addition to the evidence-base in support of quitline benefits. Recognizing these messages will differ by constituent, different components will need to be developed for:

- Employers
- Health plans
- DM vendors
- Medicaid

#### *2. National Convener and Clearinghouse*

Convene meetings with quitline vendors, disease management vendors, health plans, national employers and employer coalitions to build relationships and create consensus about the need to work together to provide services to the privately insured population. As a precursor to these meetings, expand upon the preliminary research presented here regarding current practices with respect to cessation coverage by DM vendors, attitudes of national employers and coalitions and coverage policies set by corporate headquarters of national health plans. Meetings will include defining the need with employers and coalitions, solutions quitlines can offer and ways to work more closely with health plan or DM vendors.

#### *3. Toolkit*

While pursuing these strategic paths, NAQC can also support a tactical course of action by building a “toolkit” for states to use to assess their health care marketplace and current quitline reimbursement model, identify the state’s goals and next best steps based on current circumstances. Specific tools should include:

- “Health Plan 101” or “Value Benefits Purchasing” curriculum to support public health professionals’ work in a new environment.
- Understanding the local health care marketplace and where it falls on the spectrum of coverage mandates, employer/health plan collaboration etc.
- Assistance to help states apply the national value messages described in “Leverage Points for Expanding Assess to and Use of Quitlines,” Recommendation 3 above.

This paper assessed the current practices of quitlines with regard to third-party reimbursement and other forms of financial support, provided an overview of the opportunities for obtaining third-party support and described next steps for garnering third-party financial support for quitlines. An open dialogue along with movement

NAQC Issue Paper: *The Role of Reimbursement and Third Party Financial Support in Sustaining Quitlines* forward on the recommendations in this *NAQC Issue Paper* will help ensure continued sustainability and access to quitlines for all tobacco users.

The following documents serve to provide additional information and support for this paper:

**Appendix 1: State Initiatives/Interview Notes**

**Appendix II: Survey Instrument**

**Appendix III: Survey Results**

*Learn more about NAQC: [www.naquitline.org](http://www.naquitline.org)  
3030 N. Central Avenue, Suite 602, Phoenix, AZ 85012-2713  
Ph: 602.279.2719. Fax: 602.279.2740. Email: [naqc@naquitline.org](mailto:naqc@naquitline.org).*  
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**Appendix 1: State Initiatives/Interview Notes**

<b>State:</b> AL	<b>Contact:</b> Julie Hare, Quitline Coordinator, Alabama Department of Public Health
<p><b>Efforts to work with health plans:</b></p> <p>Collects insurance status and reports in aggregate (BCBS, Medicare, Medicaid).</p> <p>Roughly two years ago Department staff went to large insurers to ask if they were willing to make a financial contribution to Quitline, but they were not.</p>	
<p><b>Other initiatives related to funding:</b></p> <p>Meeting with Medicaid and Pfizer (at Pfizer’s request).</p>	
<p><b>How NAQC can help:</b></p> <p>Articulating ROI and other arguments to take to insurers. Give states guidance on how to get their attention.</p>	
<b>State:</b> CO	<b>Contact:</b> Debbie Montgomery, MPH, RD, Adult Tobacco Cessation Director, Colorado Dept of Public Health and Environment - State Tobacco Education & Prevention Partnership
<p><b>Efforts to work with health plans:</b></p> <p>Colorado is developing strategies to actively encourage health plans, Medicaid and employer groups to provide cessation services and pharmacotherapy.</p>	
<p><b>Successes:</b> Kaiser is an active supporter of the QuitLine and is the single most dominant source of fax referrals. Anthem has incorporated some tobacco cessation measures (physician education) into its pay for performance program.</p>	<p><b>Barriers:</b> One major health plan player, Cigna, has an internal contracted quitline. Others indicate that their tobacco cessation services are available as buy-up options with little traction in the market. The major barrier for both health plan and employer support of the quitline is that its services (counseling and NRT) are currently available to all citizens at no cost.</p>
<p><b>Efforts to work with employers:</b></p> <p>Colorado has made “train the trainer” services (describe) available to Colorado employers but with little uptake. In the last year, Colorado has focused on learning more about what drives employers and health plans with respect to supporting tobacco cessation.</p>	

<p><b>Successes:</b> The Colorado Department of Public Health &amp; Environment has moved rapidly up the learning curve with respect to employer issues and has embraced the importance of developing and implementing strategies that target employer and health plan involvement.</p>	<p><b>Barriers:</b> Employers have not focused on the impact of tobacco and do not understand the rapid ROI that can be gained by proactively supporting tobacco cessation. A barrier for the state has been knowing how to approach employers and understand the issues associated with insurance, ERISA, mandated benefits etc.</p>
<p><b>How NAQC can help:</b> Colorado believes that many states are struggling with how to reach out to employers and health plans and many have the same lack of familiarity with this sector as the Colorado public health team. NAQC could provide assistance to all states by helping to frame the essential message regarding quitline value for employers, health plans and Medicaid. Each state could then adapt the central message to its own unique circumstances. Colorado also recommended development of a Private Market 101 class, including basics training, education and awareness-building material to provide public health professionals with sufficient knowledge to identify and understand market dynamics and work comfortably in the private sector purchasing world.</p>	

<p><b>State:</b> KY</p>	<p><b>Contact:</b> Irene Centers, Program Manager, Tobacco Prevention and Cessation, Department for Public Health</p>
<p><b>Efforts to work with health plans:</b> KY had worked with a state health insurer to implement a voucher system for their members. If the member participated in group cessation (specifically The Cooper/Clayton Method to Stop Smoking), he/she would receive a signed voucher for a two-week supply of NRT from their local pharmacy. The pharmacy treated the voucher like an Rx in their system.</p>	
<p><b>Efforts to work with employers:</b> The Executive Director of the Office of Health Policy asked for support developing a mechanism to cover nicotine replacement therapy for the State Employee Benefit Plan (SEBP). They based the state plan on that voucher system using both the C/C Method and Kentucky’s Tobacco Quit Line to verify participation.</p>	
<p><b>Successes:</b> The SEBP is self-funded and has more flexibility than most plans.</p>	

<p><b>State:</b> MN</p>	<p><b>Contact:</b> Ann Wendling, MD, MPH, Director of Cessation Programs, ClearWay Minnesota Jennifer Cash, MPH, Cessation Program Manager, ClearWay Minnesota</p>
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**Efforts to work with health plans:**

ClearWay Minnesota<sup>SM</sup>, an independent non profit organization, works in partnership with seven state health plans (covering 95% of Minnesota residents) to facilitate triage system, where first time callers are asked about insurance coverage and transferred directly to their plan's tobacco quitline. The ClearWay Minnesota funded QUITPLAN<sup>®</sup> Helpline offers uninsured callers and those who do not have access to telephone counseling through their health plan the opportunity to speak to a specialist and enroll in a five-call proactive counseling program.

ClearWay staff members meet quarterly with representatives of participating health plans to review enrollment data and evaluation results and to talk about services.

**Successes:**

Since the launch of the Helpline, ClearWay has been successful in collaborating with several plans to provide NRT through their help lines for their members and either eliminate their copays or collect the copays via the phone.

BCBS currently pays for helpline counseling services for its members without NRT coverage served through the ClearWay Minnesota QUITPLAN Helpline and has been working with self-insured employers to provide NRT to their employees and dependents that use the BCBS helpline.

**Barriers:**

When the Helpline began providing medications, the number of callers transferred to their health plans declined. ClearWay is working collaboratively with the health plans to improve the triage and service delivery systems to help increase transfers again in order to conserve ClearWay Minnesota resources for the uninsured and those without cessation coverage.

**Efforts to work with employers:**

Through a CDC-funded Minnesota Cancer Plan initiative, Ann chaired a group to look at reimbursement and coverage, starting with a survey to employers, chambers of commerce and coalitions. The next step will be to recommend minimum coverage and benefits, which will include quitline services.

**How NAQC can help:**

Working with Medicaid programs to pay for quitline counseling.

**State:** MS

**Contact:** Dena Pope,  
Special Projects Officer IV- Cessation Interventions, Mississippi State Department of Health, Office of Tobacco Control

<p><b>Efforts to work with health plans:</b></p> <p>Last year, Mississippi provided counseling and six weeks of NRT to all citizens. This year it was increased to eight weeks. Mississippi contracts with Information and Quality Health Care (IQHC) for quitline services. The contract explicitly encourages the vendor to develop relationships with employers and health plans to provide cessation services over and above what the state provides. IQHC has several contracts in place with health insurers and employers to provide additional services. These contracts are between the vendor and the health insurers or employers with no direct financial benefit accruing to the state.</p>	
<p><b>Successes:</b></p> <p>IQHC’s success in negotiating private contracts for additional services stems in part from its credibility and 10-year track record in Mississippi and in part due to the encouragement from the state.</p>	<p><b>Barriers:</b></p> <p>Cost is always a barrier.</p>
<p><b>How NAQC can help:</b> State appreciates the constant communications from NAQC, the Listserv and access to assistance and input.</p>	

<p><b>State:</b> OH</p>	<p><b>Contact:</b> Melanie W. Tidwel, MPH, Manager, Tobacco Cessation Program., Ohio Department of Health</p> <p>Amanda McCartney</p> <p>Previously, Communications Specialist. Ohio Tobacco Prevention Foundation</p>
<p><b>Efforts to work with health plans:</b></p> <p>In 2005, Ohio started partnering with health plans to offer free NRT to health plan members and employees. At the time, the Ohio Quitline did not provide free NRT. Later, Ohio started offering a two-week supply to any resident of Ohio. Under the employer and health plan program, members of participating health plans or employers were eligible for a four-week supply of NRT and one additional refill if they continued to participate in the Quitline’s telephonic counseling program. The Quitline split the cost of the NRT with the employers, but paid for the counseling and other services. Effective October 1 2008, the partnership program between the state and private health plans and employers will end. Ohio has negotiated a state rate for NRT and is encouraging plans and employers to pick up 100% of the cost. The state will continue to provide a 2-week supply of NRT to uninsured residents.</p> <p>The state is also encouraging private health plans and its quitline service provider to negotiate direct contracts for quitline services.</p>	

<p><b>Successes:</b> Eight insurers participate in the program. The first, Medical Mutual of Ohio, sent over 25,000 members through the program over the course of three years.</p> <p>Major success factors were:</p> <ul style="list-style-type: none"> <li>▪ High quit rates (~40% with NRT).</li> <li>▪ Low cost (NRT at less than half retail).</li> <li>▪ Ease of use.</li> </ul>	<p><b>Barriers:</b> When the program started Ohio provided no free NRT. When it started providing a two-week supply, there was some hesitation. That said, the four-week supply, with an additional refill served as a good incentive.</p> <p>In 2008 the budget was cut from \$10 M to \$2M and is likely to be reduced farther if the legislature doesn't provide funding, at least for the quitline.</p>
<p><b>Efforts to work with employers:</b></p> <p>After initial success with health plans, Ohio extended its program to employers. As with the health plan program, the employer program was very successful.</p>	
<p><b>How NAQC can help:</b> Maintain national focus on quitline, further knowledge of overall effectiveness of quitline in general – better to look at ROI and quality etc. at a national level. States need help understanding the language of health plans and employers. Also, tough getting to the right person. Maybe NAQC could help open national doors, which would pave the way for local people knowing who to speak with. “This is a top-down issue so who is the highest person in the political food chain who can speak to the highest person in the health plan food chain” (e.g. NAQC speak to JCAHO or NGA). Very appreciative of NAQC’s efforts.</p>	

<p><b>State:</b> VT</p>	<p><b>Contact:</b> Todd Hill, Public Health Specialist (Cessation), Department of Health</p>
<p><b>Efforts to work with health plans:</b></p> <p>Vermont has two tobacco programs funded by its health department: Quit in Person (QIP) and the Quit Line (QL). The QIP program provides hospital patients with access to NRT. Supplies are shipped by GSK directly to the patient’s home. GSK bills the state for the NRT, which in turn bills the health plan for its members. Vermont has plans to implement something similar with its Quit Line, but isn’t there yet.</p>	

<p><b>Successes:</b> The critical success factor for this program was the state’s ability to pass along wholesale rates for NRT to the health plans. Previously, the health plans were paying the full cost, at the retail pharmacy level. The ability to directly ship to a person’s home through GSK also removed a barrier of the smoker having to redeem a coupon at a participating pharmacy. Also, because QIP used the hospitals’ staffing resources, they knew how to work with insurers. Without this “bridge” it is unlikely that health plans would be engaged.</p>	<p><b>Barriers:</b> The health plans agreed to provide NRT through the QIP program for its insured but not self-insured members. Recently BCBS decided to cover all people. Of the other two major health plans, one accepts a list of all members who received NRT and screens out the self-insured on behalf of QIP. The other, Cigna, no longer participates because it has its own QL program.</p>
<p><b>Efforts to work with employers:</b> QIP provides worksite classes and programs.</p> <p><b>Successes:</b> Worksite programs are well received but there is very little tie in to the QL.</p>	<p><b>Barriers:</b> Despite a common funding source, QIP and QL view each other somewhat competitively.</p>
<p><b>Other initiatives related to funding:</b> Trying to get Medicaid to pay a flat \$100K a year to cover Medicaid NRT. Hard to get Medicaid’s attention right now.</p>	
<p><b>How NAQC can help:</b></p> <ol style="list-style-type: none"> <li>1. NAQC is in a better position than any single state to push CMS to reimburse for QL services. If history is any guide, CMS reimbursement will cause private plans and employers to revisit reimbursement for QL.</li> <li>2. It is very difficult for health department type people to understand how to frame a “value message” for QL in health plan or employer relevant terms. Help on this level would be great and would be applicable to all quit lines.</li> </ol>	

**North American Quitline Consortium**  
**Reimbursement Survey of State Funders**  
**August 13, 2008**

**Identifying information:**

Name

Position

Organization

State

E-mail

Phone number

**Health Insurer Information**

**1. Does your state quitline collect insurance status and/or employer from callers?**

Yes\*       No

\*If yes:

a. Would you be willing to share the intake script/question(s) about insurance and employer?

Yes       No       Not applicable

b. Does the quitline create reports and analyses based on *individual client* insurance status/coverage/company so that the insurer can specifically see which members were served?  Yes  No

c. Does the quitline create reports and analyses based on *aggregate* insurance status/coverage/company to report in general about the population served?

Yes  No

d. Does the quitline share individual or aggregate data with insurers?  Yes  No  Not applicable

e. Does the quitline share individual or aggregate data with employers?  Yes  No  Not applicable

f. Is your quitline willing to share a blinded copy of individual and/or aggregate insurance or employer report(s) with NAQC?

Yes  No  Not applicable

**Fax Referrals**

**2. Does the state quitline collect the insurance status and/or employer on fax referrals?**

Yes       No       Not applicable

**3. If yes, would you be willing to share a copy of the fax referral form with NAQC?**

Yes       No       Not applicable

**Services funded under state tobacco control program**

**4. Which free or subsidized services are provided with state and/or federal (i.e. CDC) tobacco control funding for the following groups?**

	<b>Quitline Counseling</b>	<b>Pharmacotherapy</b>
<b>Privately insured clients</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe
<b>Medicaid</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe
<b>Uninsured clients</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe

**Services funded by a payer other than the tobacco control program**

**5. Which free or subsidized services are provided with health plan, employer, Medicaid or other funding through cost-sharing, contracts, triaging or other financial arrangements for the following groups?**

	<b>Quitline Counseling</b>	<b>Pharmacotherapy</b>
<b>Health plan funded</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe
<b>Employer funded</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe
<b>Medicaid funded</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe
<b>Other</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe

**Funding Opportunities**

**6. Does your state’s quitline have any financial arrangements such as cost-sharing, contracts, triaging or others with insurers, institutions (e.g. hospitals or clinics) or employers to deliver:**

- a. Promotion of quitline services?  Yes  No
- b. Fax referral services?  Yes  No
- c. Services directed at priority populations?  Yes  No
- d. Help with implementing smoke free policies?  Yes  No
- e. Other?  Yes  No

**7. Have you approached, or do you have plans to approach any potential funders in your state outside the tobacco control program, such as insurers, institutions, or employers for quitline funding or other financial arrangements?**

Yes  No  Don’t know

**8. Do employers, insurers, or other institutions (e.g. hospitals or clinics) offer quitline services through their own contracts with service providers, resulting in multiple quitlines in your state?**

Yes  No  Don’t know

**9. Does your state have mandated benefits related to tobacco cessation?**

Yes  No  Don’t know

**10. Does your state's Medicaid benefit pay for (check all that apply):**

Tobacco counseling

Quitline counseling

Pharmacotherapies

Pharmacotherapies only if the patient is in counseling (**including** quitline)

Pharmacotherapies only if the patient is in counseling (**excluding** quitline)

**11. Do you have additional comments to share about quitline funding arrangements and/or reimbursement models?**

**12. May we contact you for additional information?**

Yes

No

Thank you for your time. To provide additional feedback or comments, please e-mail Michele Patarino at [MLPatarino@msn.com](mailto:MLPatarino@msn.com).

**Appendix III: Survey Results**







*Learn more about NAQC: [www.naquitline.org](http://www.naquitline.org)  
3030 N. Central Avenue, Suite 602, Phoenix, AZ 85012-2713  
Ph: 602.279.2719. Fax: 602.279.2740. Email: [naqc@naquitline.org](mailto:naqc@naquitline.org).*

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