| MAKING THE CASE |

Public and Private Insurers Covering Costs of Quitline Services: Service Delivery Models and Payment Mechanisms

RECOMMENDED BEST PRACTICE

The U.S. Public Health Service Clinical Practice Guidelines recommends public-private cost sharing as a best practice for comprehensive tobacco control programs (Fiore MC, 2008):

"State action on tobacco use treatment should include the following elements:

- *Sustaining, expanding, and promoting the services available through population-based counseling and treatment programs, such as cessation quitlines;*
- *Covering treatment for tobacco use under both public and private insurance, including individual, group, and telephone counseling and all FDA-approved medications;*
- *Eliminating cost and other barriers to treatment for underserved populations, particularly the uninsured and populations disproportionately affected by tobacco use*
- *Making the health care system changes recommended by the PHS guideline."*

The 2014 CDC Best Practices for Comprehensive Tobacco Control Programs provides guidance to state tobacco control programs on their role in advancing comprehensive tobacco cessation coverage. (Centers for Disease Control and Prevention, 2014)

"State tobacco control programs can educate private and public health care systems, health insurers, and employers on the importance of assuming responsibility, and assuming the costs of, providing cessation services to their members and employees.

Furthermore, CDC produced a document promoting and specifying ways to establish such partnerships (Center for Disease Control and Prevention, 2006):

"State health departments and businesses are uniquely positioned to expand the provision of tobacco-dependence treatment through partnerships and purchasing strategies. Insurance coverage can be expanded for state employees and Medicaid recipients. Business partnerships can be developed to initiate or expand coverage for self-insured or indemnity populations. Comprehensive benefits must be appropriately promoted, and their use should be monitored."

SERVICE DELIVERY OPTIONS

1. **Health plan internal services model.** Health plans provide and promote their own cessation services to their members using their own telephone number or website. There is no relationship with the state-funded quitline. Insured individuals who call the state quitline as opposed to their plan's quitline may be served by the state or referred back to their plan for services.

   Pros: Health plan/employers use their own quitline, website, wellness program or clinician counseling. Reach of cessation services expanded with no cost to the state.

   Cons: No relationship with the state-funded quitline. Services may not be evidence-based. Reach, utilization and effectiveness not known.

2. **Triage and transfer model.** The state-funded quitline receives all incoming calls, identifies whether the caller is covered under a commercial contract or state partnership plan and diverts them from the state contract to the commercial contract or partnership plan. The state or the health plan may provide funding for the quitline vendor to conduct the triage and transfer; in some cases this may include verification of eligibility.

   Pros: Seamless for caller. Can expand access of treatment services with no or minimal cost to state.

   Cons: Services can vary between state and private payer leading to lower satisfaction and quit rates.

3. **Single Vendor Reimbursement model.** The state-funded quitline provides all services, and the public or private partner reimburses the quitline for some or all of the costs for its members or employees. Contracts are established between each payer and either the state or the quitline vendor.

   Pros: State can negotiate baseline package of services at state rate – minimizing variation of services provided to callers and maximizing caller satisfaction. No infrastructure cost to the payer. Payer gets the benefits of national and state media and outreach.

   Cons: State may or may not have access to data (see Contractual Agreements below).

4. **Cooperative fax referral models.** The state quitline and health insurance plans cooperate and share costs to implement a single state-wide fax referral program. The quitline services may be provided completely by the state quitline, or referrals may be transferred to separate quitline services operated by each health plan. Cooperative fax referral can be used alone or in conjunction with any of the three models described above.

   Pros: Streamlined process for health care providers. Provides opportunity to develop relationships with health plans to further advance cost-sharing partnerships.

   Cons: Services can vary between state and health plan services leading to lower caller satisfaction and quit rates.

CONTRACTUAL AGREEMENTS

The contractual agreements can vary greatly and can be held between different entities, as described below.

1. The state holds the contract with both the vendor and payers (health insurance plan, employer group) and serves as an administrator.

   Pros: Insurance plan/employer may benefit from state quitline services rate. State has access to data and can track utilization and quitline reach.

   Cons: Contracting processes and fiscal management of contracts is time consuming and requires dedicated staff to manage. Furthermore, state contracting systems do not lend themselves to entering into new contracts in a timely manner. Distribution of reports to individual payers may be responsibility of the state.

2. The quitline vendor contracts directly with the payer.

   Pros: Streamlines contracting and payment process. Vendor manages contracts, payments and report distribution.

   Cons: Services offered by plan/employer may vary by contract. Access to data limited. MOU between state and payer may be required to have data access.

3. The state contracts with an outside entity, such as a Foundation, to serve an administrator with payers.

   Pros: Foundation manages contracts and payments. State can establish baseline packages of quitline services to ensure the provision of evidence-based services. Contracts can be put into place in a timely fashion.

   Cons: Additional cost for Foundation services and time required by state staff to manage Foundation contract and possibly report distribution. MOU needed to have access to individual payer data.

PAYMENT MECHANISMS

Financial arrangements between quitlines and other payers primarily take three forms, although the details of these arrangements vary greatly and they are sometimes combined.

- **Reimbursement for actual costs.** This may cover all costs, intake costs only, partial counseling costs, all or part of NRT costs. In addition, some private payers reimburse quitlines or states for data reports.
- **Per registrant charge.** This involves a flat fee per individual registrant, regardless of utilization level.
- **Per member per month charges.** Health plans may pay the state quitline a small charge per insured member per month, regardless of how many members actually utilize quitline services.
- **Flat fee.** Private payers provide an annual flat fee to support specific quitline services, such as fax referral systems, triage and transfer systems, or utilization reports on covered callers.

Adapted from: *Florida Quitline Evaluation Ad Hoc Report: Quitline Cost Sharing Models.* Florida Department of Health Bureau of Tobacco Prevention Program. Prepared by Professional Data Analysts, Inc., Minneapolis, MN.

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