

# Florida Quitline Evaluation

## Ad Hoc Report:

### *Quitline Cost sharing Models*

February 15, 2012

*Prepared for:*

**Florida Department of Health**  
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**Acknowledgements.** PDA would like to thank the many state quitline managers, service providers, and others who shared their experiences and recommendations about quitline partnerships with us. We extend a special thanks to those who agreed to allow their experience to be profiled in this report: ClearWay Minnesota, the Hawaii Tobacco Prevention and Control Trust Fund, the Ohio Department of Health and Segue Consulting, Deb Osborne (formerly of the Colorado Department of Public Health & Environment), and Alere Wellbeing, Inc.

## **Report Purpose and Background**

The Florida Bureau of Tobacco Prevention Program's (BTTP) Tobacco Quitline has been in operation since 2001, and has experienced significant growth since funding for the tobacco control program was restored in 2007. Evaluation of the Quitline has demonstrated that the Quitline is both effective in helping Floridians to quit tobacco, and cost-effective. In order to produce the greatest possible impact on tobacco use prevalence, the BTTP is now focusing on ways to increase the reach of this high-quality program among Florida tobacco users.

Public-private cost sharing partnerships provide a way to increase reach without increasing the state's financial costs to operate the Quitline. Such partnerships also equitably distribute costs between the BTTP, which is funded with a portion of Florida's tobacco settlement dollars, and private payers such as health insurance companies, employer groups, and unions. Private payers reap the benefits when their members or employees quit tobacco; benefits come in the form of lower insurance premiums, fewer days absent from work, and lower healthcare costs. Sharing costs of cessation services for insured and employed tobacco serves the public good.

This report is the first in a series of ad hoc reports produced for the Florida Department of Health, Bureau of Tobacco Prevention Program (BTTP). The report presents the case for public-private cost sharing as a means to increase the reach of cessation services among tobacco users and ensure that tobacco users have access to evidence-based cessation treatments. The report describes selected cost sharing models used by other U.S. quitlines, presents case studies of models implemented in other states and explores the fit of these existing models for the state of Florida.

The primary audience for this report is the Department of Health, Bureau of Tobacco Prevention Programs. The report is intended to inform Quitline administrators about the potential benefits of public-private partnerships, and the most feasible strategies for establishing cost sharing agreements in Florida.

### **Background**

The Florida Bureau of Tobacco Prevention Programs (BTTP) administers a comprehensive tobacco control effort mandated by the Florida Legislature and funded with tobacco trust fund dollars. The Quitline is one component of this comprehensive program. In addition to the Quitline, the Florida Bureau of Tobacco Prevention Programs includes a statewide tobacco prevention media campaign, tobacco control programs serving youth and adults, and evaluation services. Additionally, the Florida Area Health Education Centers Network (AHEC Network) is funded to provide face-to-face cessation services throughout Florida and to provide training for health professional students and practitioners. The BTTP is advised by a 23 person Tobacco Education and Use Prevention Advisory Council, consisting of state and national tobacco prevention and control experts.

### **About the Quitline**

The Quitline provides toll-free telephone-based and web-based tobacco use cessation services; both services offer a supply of nicotine replacement therapy at no cost to participants. Any person living in Florida who

wants to try to quit smoking can use these services free of charge<sup>1</sup>. The services are currently provided under a contract with Alere Wellbeing, Inc.

## Methodology

PDA conducted a series of interviews with seven state quitline administrators and funders and two quitline service providers in the U.S.<sup>2</sup> These semi-structured interviews were approximately one hour in length and provided information about quitline funding and demand, the type of cost sharing models in place, how partnership agreements were established, the amount of costs offset by the partnerships, and successes and challenges experienced. In addition, we reviewed published articles and conference presentations on cost sharing and consulted with experts at NAQC and private consulting firms who have worked with state quitlines. We drew upon all the information gathered to develop a typology of cost sharing models currently used by U.S. quitlines. This typology is not intended to be exhaustive of all possible models, but represents leading examples of current and recent models in practice in the U.S. We then documented several factors which could impact the feasibility of quitline cost sharing, such as (1) the number and size of health plans operating in the state, (2) the percent of residents with public, private, or no health insurance, (3) state mandates for cessation coverage, and (4) current quitline funding amounts. Finally, we used these factors to consider the feasibility of different quitline cost sharing models for Florida.

## What is Cost Sharing?

For the purposes of this report, cost sharing is defined as the sharing of the financial burden of providing tobacco cessation quitline services between a state agency and other entities which have a vested interest in the provision of cessation services.

## Potential partners

State-funded tobacco cessation program cost sharing relationships can exist between quitline funders and a variety of types of organizations such as employers, unions, private health insurance plans and public plans including Medicaid, Medicare and federal and state employee and military health insurance plans. Approximately half of callers to the Quitline have some type of health insurance. An absence of any type of cost sharing agreement with health insurance providers or large employer groups represents lost opportunities to offset quitline costs.

## Service delivery options

PDA's exploration identified four main quitline service delivery models among states with cost sharing relationships in place.

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

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<sup>1</sup> Telephonic counseling services are offered to Floridians age 11 and older; internet services are offered to those age 13 and older; nicotine replacement therapies are offered only to adults.

<sup>2</sup> Some interviews were conducted jointly with a consultant for the North American Quitline Consortium, as part of a separate project to draft recommendations to the NAQC council regarding strategies for increasing quitline capacity; others were conducted independently by PDA.

with the state-funded quitline. Insured individuals who call the state quitline as opposed to their plan's quitline will still be served by the state.

2. **Triage and transfer model.** The state-funded quitline receives all incoming calls, identifies whether the caller is covered under a partnership agreement, and then transfers the caller to a service provided by the paying partner. The state may provide funding for the quitline vendor to conduct the triage and transfer; in some cases this may include verification of eligibility. The Hawaii and Minnesota cases provide an example of this type of service delivery model.
  - **Independent contract model.** This is a variation on the triage and transfer model. Quitline vendors may initiate commercial contracts directly with employer groups, and in some cases, health plans. Vendors identify callers eligible under commercial contracts and divert them from the state contract to the commercial contract. These agreements exist independently of any involvement from the state, yet the end result is the same as that of a direct cost sharing agreement: costs for cessation services are borne by private payers. Alere Wellbeing Inc., the current vendor for the Florida Quitline, uses this model in Florida.
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. The Colorado and Ohio cases provide two different examples of this type of model.
4. **Cooperative fax referral models.** The state quitline and major 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.

## 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.

## Contractual Agreements

The contractual agreements between partners also greatly differ. Some states contract with both the vendor and payer (health insurance plan, employer group) and serve as an administrator. In other cases, the quitline vendor contracts directly with the payer.

## Making the case for cost sharing

### 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.”*

Furthermore, the CDC produced a guidance 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.”*

### Need for Services

Tobacco use is the leading cause of preventable death and disease. In 2010, 17.1% of Florida adults were current cigarette smokers (Centers for Disease Control and Prevention, 2010). However, smoking prevalence is much higher among certain demographic groups. Nationally, prevalence among the Medicaid-enrolled population is estimated to be 60% higher than that of the general population<sup>3</sup>. In Florida, a significantly higher percentage of the uninsured population smokes (32.0%) compared with the insured population (13.6%) (RTI International, 2009). Smoking also differs greatly by income level: according to 2010 BRFSS data, 31.8% of adults earning less than \$15,000 smoke, as compared to just 11.7% of those earning \$50,000 or more. Expanding effective quitline services through cost sharing will allow needed services to reach greater numbers of tobacco users in the state.

### Return on Investment for Tobacco Cessation

The return on investment (ROI) for reducing tobacco use is high. Cessation reduces health care costs, increases productivity, and increases both quality and years of life. Tobacco cessation is one of the most cost effective clinical prevention efforts, demonstrated to be equivalent to childhood immunizations and aspirin therapy for heart disease. This placed it ahead of commonly covered services such as colorectal cancer screening and influenza vaccinations in terms of return on investment (Maciosek, 2006). Within Florida, a

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<sup>3</sup> Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey, 2008. Analysis by the American Lung Association, Research and Program Services Division using SPSS software.

recent evaluation demonstrated that Florida's quitline program provides cost effective cessation treatment. The Quitline's cost per quit is lower than that of comparison quitlines, and the cost per quality life year saved is lower than that of other prevention efforts (Professional Data Analysts, Inc., 2011).

In 2010, the American Lung Association and Penn State University conducted a cost-benefit analysis of smoking cessation treatment for each state. After accounting for workplace productivity losses, premature death, and direct medical expenditures, tobacco use costs the state of Florida more than \$19.6 billion dollars a year (Rumberger, 2010). They also calculated that for every dollar spent on providing tobacco cessation treatment in Florida, the ROI is \$1.24, which would result in a total potential annual savings of over \$44 million a year.

Health plans and employer groups reap the benefits of reduced tobacco use in the form of lower health care costs, lower insurance premiums, and reduced employee absenteeism. Therefore, it is important that they also bear their share of the costs for cessation programs and not rely on the state to cover all costs.

### **Available funding vs. demand**

According to 2010 Florida BRFSS data, 46% of current smokers have made a quit attempt in the past year. Demand for Quitline service has grown since its inception in 2001. Since 2007, a statewide media effort has greatly raised awareness of the Quitline among Floridians. In FY 2011, the Quitline served over 59,000 tobacco users through its telephone and online cessation programs, reaching 2.14% of all tobacco users in the state. Even though funding for the Florida Quitline has increased over the years, the Quitline has operated at or above capacity since 2008 and the demand for services continues to grow. And although the Quitline is reaching a significant percentage of the state's smokers, the CDC recommends funding helplines at a level sufficient enough to reach 6% of tobacco users a year in order to produce a meaningful impact on prevalence. In an effort to further increase reach, the BTPP has modified the Quitline service package by reducing the amount of free NRT offered per person and reducing the standard number of proactive counseling calls from five to four in order to have the resources to serve a greater number of people. In addition, the BTPP launched a web-based cessation program which offers free NRT and information and support for quitting. The web-based program offers less intensive services than the Quitline, but also operates at a lower cost. Together, these system changes reduced the per person costs of services and expanded the Quitline's capacity to serve a greater number of people. Still, the ability to increase reach is limited by the amount of funding available. In the next year, there is potential for additional increased demand for services with the advent of a national anti-tobacco campaign beginning in March 2012 and with the FDA cigarette pack warning labels originally slated to appear in the fall of 2012. The labels will include the national quitline telephone number, 1-800-QUIT-NOW, which connects Florida callers to the Florida Quitline. Cost sharing agreements offer a way to continue to increase Quitline reach without increasing the state's share of financial support.

### **Insurance coverage among Quitline callers**

One opportunity to increase the capacity of the Quitline is to recoup costs for commercially insured callers. As it exists now, Florida is effectively serving a large percentage of callers with no health insurance. In calendar year 2011, about 48% of the Quitline callers were uninsured.<sup>4</sup> This is more than twice the percentage of overall uninsured tobacco users in the state of Florida (Florida Department of Health, 2011).

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<sup>4</sup> Florida Quitline caller data, provided by Alere Wellbeing, Inc.; callers enrolled July 1, 2010 through June 30, 2011.

Conversely, over half of Quitline callers *do* have some type of health insurance which may (though not always) offer some tobacco cessation benefit. Specifically, 25% of callers have private insurance, 17% have Medicaid, and 11% Medicare. These public and private payers are potential sources of cost sharing revenue. If Florida were to realize the full amount of these offsets, the state quitline could more than 20,000 additional callers per year. (Appendix 1 presents a breakdown of insurance coverage for Quitline callers and Florida tobacco users.)

There are a large number of health plans operating within the state of Florida, which suggests that efforts to establish cost sharing agreements should focus on the larger carriers. Although there are more than 40 carriers represented among Quitline callers during FY11, more than two-thirds had coverage from just five health plans: Blue Cross and Blue Shield,<sup>5</sup> United Health Care, Aetna Health, Cigna Healthcare, and Humana Health. (See Appendix 2 for a full list of health plans whose members currently utilize the Florida Quitline.)

## **Cost sharing in Florida: An Assessment of Resources and Challenges**

The potential for cost sharing is determined by many factors including political will, the willingness of private and public payers to participate, and the availability of state staff time and knowledge that can be dedicated to such an intensive effort. The following section details some of the resources and challenges of the Florida healthcare landscape to consider when pursuing cost sharing arrangements.

### **Resources**

Florida is fortunate in having a number of resources, both within the state and from national sources, to assist in implementing quitline cost sharing models.

#### **BTTP and Tobacco Education and Use Prevention Advisory Council (TAC)**

The BTTP and TAC have recognized cost sharing as a means to increase the reach of the Quitline and to ensure that private payers contribute their share of the costs of reducing tobacco use in the state. Health plans and employer groups reap the benefits of reduced tobacco use in the form of lower health care costs, lower insurance premiums, and reduced employee absenteeism. Therefore, it is important that they also bear their share of the costs for cessation programs and not rely on the state to cover all costs. As stewards of the tobacco control funds, the interest, support, and advocacy of the BTTP and TAC is a critical component.

#### **Florida Tobacco Cessation Alliance**

In 2010, Florida was one of seven states to receive funding from the through the ActionToQuit State Grant Program, implemented by Partnership for Prevention and funded by the Pfizer Foundation and Pfizer Inc. The goal of the grant program is to increase access to and use of proven tobacco cessation treatments. The grant led to the establishment of The Florida Tobacco Cessation Alliance which is directed by the American Lung Association in Florida. The Alliance is comprised of partner organizations including the Florida

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<sup>5</sup> Due to limitations in the Quitline dataset, we are unable to differentiate between callers insured by Blue Cross Blue Shield of Florida and BCBS plans headquartered in other states.

Department of Health, Florida Academy of Family Physicians, the American Cancer Society, the American Heart Association, the March of Dimes Foundation, the Florida Association of Health Plans, businesses, and other stakeholders. The mission of the Alliance is to “work together to raise awareness that tobacco dependency is a chronic, relapsing medical condition, not just a habit or personal choice, and to advocate for the adoption of comprehensive treatment resources for all tobacco users.” (Florida Tobacco Cessation Alliance)

To date the Alliance has convened a tobacco cessation summit, and developed an action plan with recommended strategies to improve access to and sustainability of cessation treatment. The Alliance is an excellent potential springboard for cost sharing efforts and relationship building, as it already consists of many major stakeholders and policy influencers. Additionally, the groups in attendance are participating specifically because they support cessation services, so they will ideally be positive influencers both publicly in the media and amongst the decision-makers of health plans and employers.

### **Community Grants Program**

DOH has awarded community grants to advocate for tobacco cessation and prevention policies with local governments and businesses. Although the grants are designed to address a wide range of tobacco policies (e.g. smoke free ordinances, point of purchase advertising, etc.) some grants work specifically to establish business and employer policies to cover tobacco cessation treatment for employees. Given that DOH representatives and grantees are already working directly with employers, this is an opportunity for further relationship-building and discussions about potential cost sharing arrangements with the larger private employers.

### **NAQC Technical Assistance**

Florida is fortunate to have been selected by the North American Quitline Consortium (NAQC) to receive technical assistance on establishing cost sharing during FY13. The technical assistance will be delivered by Deb Osborne, MPH, NAQC's Manager of Public-Private Partnerships and will be focused on achieving cost savings for the Florida Quitline, including guidance on pursuing cost sharing from various possible sources. Ms. Osborne is conducting four presentations to eight selected states to provide a foundation for the work as well as providing resources and worksheets. She is also facilitating monthly information-sharing calls with Florida and eight other states that were selected to receive the technical assistance and is available for individual consultation as needed.

## **Challenges**

### **Large number of private health plans**

There are numerous health insurance plans operating in the state of Florida. Other states which have successfully implemented private payer cost sharing systems have enjoyed the benefit of working with fewer than ten health plans. Each additional health plan that DOH must reach out to requires significant staff time to build a relationship with and to make the case for cost sharing. Establishing contractual, financial and

logistical arrangements separately with each health plan would be time intensive for DOH. That said, as presented above, about two-third of insured quitline callers could be covered by establishing agreements with five plans.

### **High rate of uninsured residents**

Both the 2010 BRFSS and 2011 FLATS report that nearly 22% of Florida tobacco users have no health insurance coverage. Florida is ranked 41st among U.S. states and territories on the percentage of insured residents. This indicates that the ability to offset costs through public-private partnerships is somewhat limited; even with substantial cost sharing agreements in place, there will still be a relatively large number of uninsured tobacco users to be served by the Florida Quitline.

### **State employee benefits are limited**

Currently, the state of Florida does not offer comprehensive tobacco cessation benefits to all of its employees. State employees have the option of choosing between one Preferred Provider Organization (PPO) plan and six Health Maintenance Organization (HMO) plans for their health insurance. All of them offer different tobacco cessation benefits, and two of the health plans refer their members directly to the Florida Quitline (The Official Portal of the State of Florida). The lack of a comprehensive cessation benefit for state employees may prove to be a barrier should the state approach private payers with a request to provide that benefit for their members.

### **Staff time**

The states which have pursued cost sharing arrangements have emphasized the significant amount of staff time required to be thorough in the planning and stakeholder building process. Additionally, staff that are responsible for the effort should be knowledgeable about healthcare laws and the overall federal landscape as well as the workings of private health plans. To address this need, some states chose to hire consultants to spearhead the projects.

### **“Why should anyone pay for services, when the Quitline is free?”**

Since the inception of the BTPP, Florida has been committed to providing free cessation services to all residents, which is a commendable strategy from a public health perspective. However, this provides no incentive for private health plans or employer groups to fund services. Some states have enacted legislation requiring private health plans to cover cessation benefits or have crafted legal agreements preventing tobacco settlement funds from being used to provide services to insured members. Still other state health departments, especially those which have experienced a reduction in funding, have established policies specifying that the state quitline will not serve or will provide limited services to insured residents. However, in the absence of a mandate for private payers to cover cessation treatment costs, it is only through voluntary agreements that this can be accomplished.

## Additional issues to consider

### The Patient Protection and Affordable Care Act

A new federal law expands insurance coverage to cover tobacco cessation services. Under the 2010 Patient Protection and Affordable Care Act (ACA), private insurance plans as well as Medicaid must now cover tobacco cessation services with little to no cost sharing for patients. The law states that private health insurance plans must cover all U.S. Public Health Service (USPHS) “A” and “B” recommendations, which include the provision of tobacco cessation services for adults (U.S. Preventive Services Task Force, 2010). This specific requirement of the ACA went into effect September 23, 2010. However, at the time of the writing of this report the legality of ACA is being challenged and its implementation in Florida and elsewhere is uncertain. Florida has halted implementation of the ACA as a result of a 2011 federal court ruling declaring the act to be unconstitutional, and trial and appellate court litigation continues. In Florida, the opposition to the ACA stems not from the requirement to provide “A” and “B” recommended preventive services but primarily from the mandate for individuals to purchase health insurance and concerns about the resulting impact on Medicaid costs. Still, the Florida ruling did not sever the individual mandate from the ACA, but instead struck down the entire Act.

Should the ACA be implemented in Florida, it would open the door to develop quitline cost sharing relationships with private payers including health insurance plans and employers. The ACA does not mandate that health plans cover quitline costs specifically, as the ACA requirements regarding cessation services are open to interpretation and could be met in many different ways (i.e., health plans could provide their own cessation services, cover physician visits in which cessation is discussed, or provide a prescription benefit for cessation medications). However, section 2502 of the ACA requires that beginning in 2014, Medicaid programs may no longer exclude tobacco cessation medications from coverage.

In addition, section 4107 of the ACA provides for Medicaid coverage of comprehensive tobacco cessation services for pregnant women, including both counseling and pharmacotherapy. States may cover counseling, including evidence-based quitline services, for all other Medicaid beneficiaries. States may claim the 50 percent administrative match rate for comprehensive quitline services provided to Medicaid beneficiaries.<sup>6</sup> In order to receive match, states must apply to the Centers for Medicare & Medicaid Services (CMS) and demonstrate that the costs should not have been duplicative and covered through another source.<sup>7</sup>

## Cost Sharing In Practice – State Case Studies

Several states have initiated cost sharing agreements with health plans to fund their tobacco cessation quitlines. Each state varies in terms of existing funding, state policies and political will, buy-in from health plans, vendor selection, helpline effectiveness, smoking rates, and more. However, the examination of individual state experiences provides some lessons for implementation in Florida.

## Health plan internal services model

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<sup>7</sup> CMS letter to State Medicaid Directors, June 24, 2011. <http://www.cms.gov/smdl/downloads/SMD11-007.pdf>

Some health plans and employers offer tobacco cessation services independent of the state. They vary in shape and form and may include quitlines, wellness coaching with a cessation component, and in-person clinician counseling. Additionally, health plans may offer pay-for-performance (P4P) incentives to clinics for tobacco cessation counseling or quitline referrals to increase the number of their members who receive cessation services of some type (Agency for Healthcare Research and Quality, 2006).

### **Lessons for Florida**

This is essentially the status quo in Florida. Some private payer cessation services likely exist, but the BTPP does not have access to any information about them. The benefit of this model is that it requires little work or time from the BTPP. The state bears no responsibility for advertising or administration; health plans take full responsibility to serve their members on their own. Unfortunately, the BTPP would also have no information about the number of people being served, no control over the quality of services provided, and no data on whether costs are truly being offset. Additionally, since the Florida Quitline has no connection to or information regarding other companies or health plans that provide services, they have no way of knowing whether callers to the Quitline should be diverted to their appropriate health plan program. In other words, the BTPP may unknowingly be paying for callers to receive services that they could be receiving someplace else. This is likely scenario in Florida because of the strength of the BTPP media campaign and Florida Quitline branding.

### **Triage and Transfer Model**

The states of Hawaii and Minnesota each established a triage-and-transfer protocol designed to share quitline costs with health insurance providers. However, each state was working within a very different set of environmental circumstances which either supported or hindered the effort. In the end, Hawaii eliminated their cost sharing protocol, while Minnesota has maintained theirs. The contrast of these two experiences provides valuable direction for Florida and other states who intend to pursue triage-and-transfer arrangements.

### **The Hawai'i Experience**

In the state of Hawaii, the Hawaii Tobacco Quitline is funded with a portion of tobacco settlement funds, administered by the Hawaii Tobacco Prevention and Control Trust Fund, and overseen by the Hawaii Department of Health. When the Quitline was first established in 2005, the Trust Fund sought to direct settlement dollars to residents most in need of services, namely tobacco users who are Medicaid recipients and those who are without health insurance. At the same time, the Trust Fund sought to ensure at least minimal service to all residents seeking tobacco cessation help while maximizing the number of tobacco users that could be served with available funds. The two largest insurers operating in the state already offered their own cessation services; several smaller insurers did not. The Trust Fund set up a triage-and-transfer protocol based on insurance status.

- The Quitline completed the registration and intake process with all callers, and during this process identified callers' health insurance provider. Medicaid, uninsured and pregnant callers were served directly by the Quitline and were eligible for a multiple counseling session program with free NRT as appropriate (the “4-Call Program”).

- Callers insured by the two largest health plans operating in Hawaii were warm transferred to the health plan to receive services (if warm transfer was unavailable or unsuccessful, callers were given referral information). Their benefits varied by health plan and policy level. Most callers were eligible for intensive counseling and some were eligible for cessation medications.
- Callers insured by the smaller plans were served by the Quitline using Trust Fund dollars, but were eligible for a lesser benefit: a program consisting of a single counseling session with no NRT (the “1-Call Program”). Callers were referred to their health plan for benefit information on NRT and prescription cessation aids.

A one-year evaluation of the transfer model revealed that approximately 25% of Quitline callers received the 1-Call services and 21% were transferred out of the state-funded system to health plan services. This led to significant financial savings for the state, but the value of those savings soon came into question.

As Hawaii evaluated their model, it became apparent that Quitline callers transferred to their health plan or enrolled in the 1-Call program were experiencing far lower levels of satisfaction and poorer outcomes as compared to those served by the 4-Call program. In fact, the 30-day abstinence rate for the 1-Call program (callers who had insurance but no substantive tobacco cessation benefit) was half that of the 4-Call participants. After monitoring the situation for some time, the Trust Fund elected to provide the higher level of cessation services to all tobacco users, regardless of health plan enrollment, for as long as it was financially feasible to do so. In September of 2011, Hawaii reopened the full Quitline service package to all callers regardless of insurance status. Currently, all callers are offered the 4-Call program along with a tiered NRT benefit: uninsured and Medicaid callers receive an 8-week supply, underinsured callers receive a 4-week supply, and those with private insurance receive a 2-week supply. Among insured callers, satisfaction levels rose significantly after the transfer protocol was abandoned and are now comparable to those of other caller groups. Going forward, the Trust Fund plans to continue to explore the feasibility of establishing cost sharing models with health plans.

Source: Poster presentation: *Hawaii's cost sharing model: Outcomes and reflections on administration*. June 10, 2009. National Conference on Tobacco or Health Conference. Betzner, A., Goto, C., Kokstis, M., Subialka, E. Additional information provided by Hawaii Tobacco Prevention and Control Trust Fund Project Team.

## The Minnesota Experience

Founded as a non-profit organization with the tobacco industry lawsuit settlement dollars, ClearWay Minnesota<sup>SM</sup> began offering tobacco cessation helpline services, the QUITPLAN<sup>®</sup> Helpline, to Minnesota residents in 2001<sup>8</sup>. When the tobacco settlement dollars were allotted, a court directive mandated that ClearWay Minnesota not duplicate or supplant existing programs. As a result, the Helpline was designed with a triage system from the beginning. Several Minnesota health plans had tobacco cessation services in place at this time. A partnership between ClearWay and seven major Minnesota health plans, the Call-It-Quits Collaborative, was established at the inception of the Helpline and callers to the Helpline could be easily transferred to their health plans if they were insured. Then in 2002, a change in service options upset the balance. The QUITPLAN Helpline added an eight-week NRT benefit to their services, and use of the Helpline skyrocketed, even without advertising the free NRT. Insured callers began resisting transfer to their health plan-sponsored quitlines because those services did not offer NRT. Although the primary purpose of

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<sup>8</sup> ClearWay Minnesota was first established under the name Minnesota Partnership for Action Against Tobacco (MPAAT).

the Helpline was and is to serve uninsured callers, analyses demonstrated that the QUITPLAN Helpline's cost to serve insured callers immediately increased from about \$13,000/month to \$344,056/month.

At this point, ClearWay met with the health plans who participate in the partnership and presented them with the utilization data. In response, the health plans gradually began adding NRT offerings to their members through their independent quitlines. The Helpline still warm transfers callers to their insurance plan's quitline. ClearWay maintains the active and strong partnership with Minnesota health plans and those relationships will continue for the foreseeable future.

Source: Schillo, B., Wendling, A., Saul, J., Luxenberg, MG, Lachter, R., Christenson, M., & An, LC. "Expanding access to nicotine replacement therapy through Minnesota's QUITPLAN Partnership." *Tobacco Control*, 16 (Suppl. 1): i37-i41. 2007.

### **Lessons for Florida**

The contrast between these two states' experiences highlights three distinct advantages that support a triage and transfer protocol. First, in Minnesota the court mandated that tobacco settlement dollars could not be used to reduce or substitute for existing programs, including those provided by health insurance companies. Neither Hawaii nor Florida have such a mandate.

Second, most of the major Minnesota health plans voluntarily provided high-quality, evidence-based cessation treatments for their insured members. This is a critical component. The lower-quality health plan cessation services proved to be a major barrier for Hawaii, and became the main reason why Hawaii elected to abandon the transfer protocol. Should Florida pursue similar transfer agreements, an important first step would be to survey the major health plans about their current cessation service benefits. A preliminary investigation by PDA suggests that most major insurers in Florida do not provide evidence-based cessation treatment without co-pay. Most Florida insurers provide self-help materials, referral to resources such as [www.WebMD.com](http://www.WebMD.com), or nurse lines. Some offer pharmacotherapy benefits, although such benefits are often available only to a portion of insured members. Some Florida insurers refer members to the Florida Quitline.

Third, Minnesota has the advantage of the Call-It-Quits Collaborative, of which most major health plans and ClearWay Minnesota are members. This is a long-standing group working toward a shared goal: to improve and ensure access to high-quality cessation services for all state residents. The Collaborative has been in existence for many years, and over time the health plans have built trusting and cooperative relationships, despite being business competitors. The members of the Collaborative now share data on the number of tobacco users served, and there is an ongoing project to document statewide quitline reach across all Collaborative partners, and to work toward establishing a statewide quit rate.

It is also important to note that the insurance landscape in Florida differs from both Minnesota and Hawaii. Florida has approximately 40 insurance companies operating in the state, as compared to fewer than fifteen operating in Hawaii and fewer than ten major health plans operating in Minnesota. Establishing warm transfer services with even half of Florida's insurers would be extremely complex.

## Independent contract model

In a variation on the triage and transfer model, quitline vendors may also initiate commercial contracts directly with employer groups, and in some cases, with health plans. These agreements exist independently of any state involvement, yet the end result is the same: private payers bear the costs of cessation services for their members or employees.

Currently Florida's Quitline vendor, Alere Wellbeing, Inc., uses this practice to expand the reach of the Florida Quitline using private payer funds. As part of the standard registration process, Florida Quitline callers are asked the name of their employer and their health insurance provider. Callers identified as eligible for services under one of Alere's commercial contracts will be served under that contract rather than the state Quitline contract. To the caller, the transition is imperceptible. Alere has more than 120 commercial contracts with employer groups which collectively have paid for 4,239 Quitline enrollments<sup>9</sup> in Florida during FY11, in addition to the 55,849 enrollments funded by the BTPP. The contribution of private payers represents an additional 7% of enrollments above and beyond those funded by the BTPP. These commercial contracts include Florida-based businesses and businesses operating in other states, but all have had at least one Florida-resident employee served by the Quitline under a commercial contract with Alere.

## Lessons for Florida

One main advantage to the independent contract model is that it requires no effort on the part of the state Quitline management staff. The Quitline vendor initiates and manages the contracts and the billing. There are some potential disadvantages; it may be more difficult for states to obtain data about callers served under independent contracts, or to calculate a statewide reach figure across multiple contracts. In addition, employer groups may pay higher rates for services under a commercial contract than if they were served under a state contract. Finally, due to the complexities of the 1-800-QUIT NOW telephone transfer system, it may be difficult for vendors to manage commercial contracts with "mega-employers," or large regional and national companies whose employees reside in several states. When employees dial 1-800-QUIT-NOW, they will be connected to the state quitline operating in their state of residence. The mega-employer may have a contract with a different vendor than the one serving that state.

Nonetheless, most states that PDA interviewed indicated they prefer employer groups to contract directly with vendors, but states were mixed on their preference for structuring contracts with health plans. Some states are prohibited by law to enter into such agreements, and others do not see an advantage to doing so. States who did prefer direct contracts with health plans cite the benefit of building or maintaining relationships with health plans. Contracting directly with health plans also gave states the opportunity to ensure that adequate service levels are provided to callers. The experience of some states has taught them that it is important to contractually require, or at least to encourage, health plans to promote the quitline benefits to their members. Without such requirements, once a cost sharing agreement is in place health plans may assume that their work is done. One state reported that utilization of the quitline by insured members actually declined after establishing cost sharing, because the health plans did not promote the services.

*Source: Performance Dashboard report and information about Florida commercial contracts provided by Alere Wellbeing, Inc.*

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<sup>9</sup> This refers to enrollments, not unique individuals. The BTPP is billed on a per-enrollment basis, and is also billed actual costs for NRT shipments. Floridians may re-enroll in the Quitline once every six months. Individual callers may be counted more than once in the total number of enrollments.

## Single Vendor Reimbursement Model

### The Colorado Experience

The model used in Colorado is one in which the state establishes contracts directly with health plans to cover services for their members through the state QuitLine. Colorado succeeded in setting up nine such contracts, involving all major health plans operating in the state. All QuitLine services are provided by the state-contracted vendor and the health plans reimburse the QuitLine for some or all of those services. The QuitLine vendor bills participating health plans under two different cost structures: some private payers reimburse the QuitLine on a per-participant basis, while some utilize a per-call pricing model. In addition, all private payers are billed for the actual costs of NRT shipments for their members each month. This model offsets approximately 13% of QuitLine costs.

Colorado also uses different methods to verify eligibility of callers, depending on the health plan contract. Some health plans allow the QuitLine to access their secure website and to log in and confirm callers' coverage. Some provide the QuitLine with member lists weekly or monthly, while others provide the QuitLine with a list of member-number prefixes which indicate eligibility for QuitLine services depending on policy-level coverage.

Colorado Department of Public Health and Environment, which administers the QuitLine, used several effective strategies to establish these public-private partnerships, and accomplished them with relative speed. After operating an effective and well-utilized service for many years, the QuitLine was facing major reductions in funding. In 2008, Colorado enlisted the services of a consultant and proactively began working with key stakeholders including health plans, state agencies, clinicians and public health advocates to address QuitLine's sustainability in the light of the anticipated funding cuts. The group of stakeholders known as the "Tobacco Cessation and Sustainability Partnership" (TCSP) was collaborative, inclusive, and responsible for developing the framework to guide the continuation of cessation services for Colorado's smokers.

While these partnership efforts were in progress, the Colorado legislature passed a bill mandating that health plans provide the prevention benefits outlined in the USPSTF "A" and "B" recommendations, including those that pertain to tobacco cessation, with limited ability to require cost sharing from their plan members for these benefits. The legislation went into effect in 2010, and although it predated the federal PPACA it is similar in its preventive service requirements. At the time the Colorado law was enacted, however, few stakeholders were in agreement regarding how the recommendations should be interpreted and what level of service they would have to provide. The TCSP developed "The Partnership Plan," a proposal for full cost sharing with the state and private insurers that allowed for health plans to reimburse the QuitLine for the services that their members receive. The state health department approached health plans as partners in this effort, and provided them with education about the QuitLine and the new law. Still, the state set a deadline to impose restrictions to QuitLine services for callers with a health plan membership. The Governor spoke about the importance of cost sharing, and the media began to pay attention to the issue. The publicity changed public perception of the issue and put additional pressure on health plans to comply. Within the year, the state's nine major health plans were participating in The Partnership Plan.

Additionally, the State of Colorado realized that as the largest employer in the state, they needed an evidence-based tobacco cessation program in place for their employees that met their own recommendations for others

and set a positive example, and until this point they had only offered minimum cessation benefits. They altered their own benefit structure to provide a fully evidence-based tobacco cessation wellness program.

*Source: Colorado Tobacco Cessation & Sustainability Partnership: A Case Study.* Retrieved from [http://www.actiontoquit.org/uploads/documents/Colorado Tobacco Cessation and Sustainability Partnership Case Study 5-6-11.pdf](http://www.actiontoquit.org/uploads/documents/Colorado_Tobacco_Cessation_and_Sustainability_Partnership_Case_Study_5-6-11.pdf)

## **The Ohio Experience**

Like Colorado, Ohio also has successfully established a reimbursement cost sharing model. The Ohio Tobacco Quit Line is operated by the Ohio Department of Health (ODH). Originally the Quit Line was funded through Ohio's master settlement agreement, until the Ohio State Supreme Court ruled that lawmakers could divert settlement funds to non-tobacco purposes. The state legislature did so, first reducing and then completely eliminating state funding for the Quit Line. The service now operates solely through a modest grant from the Centers for Disease Control and Prevention (CDC). The current grant funds Quit Line services only for uninsured, pregnant women and Medicaid callers.

As this funding history illustrates, Ohio sought cost sharing agreements out of necessity. The model they selected was one in which services are provided by the state-contracted Quit Line vendor and private payers reimburse the vendor's costs. Ohio developed a baseline package of Quit Line services and costs which they offer to health insurance plans and to employers. Private payers who agree to partner with the Quit Line negotiate a separate subcontract with the Quit Line vendor. The vendor bills the private payer for actual services provided to their members or employees. The agreement allows private payers to take advantage of the state's lower billing rates; if private payers contracted with the vendor on their own, they would pay a higher commercial rate. Private payers may elect to include more services than those offered in the standard benefit package; for example, some payers contract and pay for more intensive services or for additional reporting on their members' or employees' Quit Line use. The subcontracts specify that should the ODH change vendors in the future, all subcontracts would be assigned to the state's new vendor along with the main state contract.

At this time, Ohio has established contractual relationships with six major health plans and thirteen employers, resulting in the availability of tobacco cessation Quit Line coverage for 2.1 million people. Not enough time has passed to determine how these changes have affected actual utilization of the Quit Line, but the cost sharing agreements are estimated to offset only a very small proportion of Quit Line costs. However, the ODH sees the new partnerships as a major success and is continuing to work to expand cost sharing further.

ODH established these nineteen cost sharing agreements in less than one year's time. Part of the reason for this quick success is that ODH dedicated significant staff time and the services of a consulting firm to the partnership-building effort. Knowing that they would soon be losing the last of the tobacco settlement money allotted to run the Quit Line, ODH initiated discussions with their major health plans in January of 2011. Early on in the process, Ohio brought a consultant on board and spoke to several key players including the Department of Insurance (DOI), Governor's office, and the Ohio Association of Health Plans. After engaging in discussions with these stakeholders and surveying the state landscape, ODH focused their energy on working directly with a core group of large health plans. They hosted a meeting of health plan medical directors and demonstrated the clear return on investment (ROI) of tobacco cessation Quit Lines, particularly

in terms of how tobacco use worsens a multitude of chronic diseases that are particularly costly to health plans including diabetes and heart disease. ODH strategically negotiated with their Quit Line vendor to develop a cost sharing structure that would appeal to private payers. By offering subcontracts to business and health plans, ODH was able to extend their less expensive state pricing to health plans that then pay the Quit Line vendor for each participant served. While the Quit Line vendor could independently negotiate commercial contracts with these same payers and charge a higher commercial rate, the ODH arrangement provides the vendor with the advantage of new business without the development costs.

Source: Information about the Ohio cost sharing model was gathered through interviews with Ohio Department of Health personnel and Segue Consulting.

### **Lessons for Florida**

Using the reimbursement model ensures that all callers have access to at least a basic level of quality, evidence-based treatment. Yet the model allows health plans some flexibility in that they have the option to purchase a higher level of services for their members, and may choose to require verification of eligibility. Health plans may also purchase data reports on their members' utilization of services.

Colorado and Ohio succeeded in implementing their cost sharing model for several reasons. Both states were facing drastic cuts in quitline funding, which made cost sharing a necessity if the state quitline were to continue to serve insured tobacco users. Individuals in each state were proactive in their effort to obtain buy-in from major stakeholders, including policy makers, the public, and health plans. In each case a consultant was utilized early in the process, as it was clear the state did not have sufficient staff hours available to spearhead such a large effort.

Ohio provided a cost sharing incentive to health plans by allowing them to subcontract with the vendor through the state at a lower rate than they would receive if they were to contract directly with the vendor. This is a significant incentive for health plans and a strength of the reimbursement model. Despite the lower rate, quitline vendors can be incented to enter into this type of cost sharing agreement because it guarantees them the business of health plans that might otherwise contract with other vendors. This provides states with increased leverage as they work with both the health plans and quitline vendors.

Should Florida seek a reimbursement arrangement with health plans, careful consideration of the approach is warranted. In a way, Colorado used both a "carrot" and "stick" approach to cost sharing in that the quitline administration sought out the willing cooperation and partnership of health plans yet they did set a cutoff dated beyond which insured callers would no longer be served. Ohio simply stopped serving insured callers out of financial necessity. While the BTTP is not facing a similar level of fiscal crisis, the option to deny services to members of private health plans may motivate the health plans to take action. The risk in doing so is that health plans may perceive this as an aggressive stance which could impede negotiations. In the case of Colorado, they were already on the path to cooperative cost sharing and the legislation reinforced and accelerated the process and brought the remaining health plans on board. The cessation coverage change for Colorado state employees was also an important step that demonstrated the state's willingness to lead the way on providing cessation benefits.

## Cooperative fax referral model

PDA has learned of two different yet very successful models in which states and major health insurance plans cooperate to provide a single statewide fax referral program. One state uses a transfer model. There is one standard quitline fax referral form which includes a space to check the name of the patient's health insurance plan (if insured). All referrals are faxed to a triage agency, which in turn faxes the referrals for insured patients to the appropriate health plan quitline service and faxes referrals for uninsured patients to the state quitline. Each health plan pays for a share of the overall administration and for data reports, and pays a per-patient fee to cover the transfer process. This model is an excellent addition to other models and enhances both their performance and the potential for more cost sharing revenue. It is easy to use for health care providers and agencies when utilizing only one referral form and a single fax number.

A second state uses a fee model. Major health plans have an agreement to pay an annual fee to participate in the quitline fax referral program. The health plans support the fax referral to the quitline and in turn the quitline provides cessation services and provides health plans with quarterly aggregate reports regarding services received by members. Although this is not a cost sharing service agreement, it does offset costs and is beneficial to the state. This state has no funding for media promotion of their quitline. Yet the extensive fax referral program, supported by the health plans, has allowed the quitline to maintain and even increase its reach among tobacco users.

## Lessons for Florida

The Florida Quitline currently operates a statewide fax referral program which is supported solely by the BTPP. Alere's contract to provide the BTPP with quitline services includes support for the fax referral system. However, use of the fax referral system is low; currently, only about 3% of all Florida Quitline callers were initiated as fax referrals rather than inbound callers made by tobacco users. Fax referral is a sustainable way to increase and maintain quitline utilization without the need for statewide media promotion. Should Florida set up cost sharing agreements with health plans, these agreements could include financial support for fax referral systems as well as for individual cessation services. Cooperative fax referral systems can be used alone or in conjunction with any of the other cost sharing models presented above.

## Cost Sharing with Medicaid

With regard to covering cessation services for Medicaid recipients, some states have successfully expanded coverage for cessation services prior to the ACA. As of 2009, the CDC reports that 45 of the 51 state Medicaid programs (88 percent) covered some tobacco cessation services for both pregnant and non-pregnant individuals, and 51% of the 45 state Medicaid programs covered individual and/or group tobacco cessation counseling for all Medicaid beneficiaries. For example, Oregon and Massachusetts have successfully implemented the PHS recommended coverage guidelines for all Medicaid populations. Since 1998, Oregon Medicaid has provided a comprehensive tobacco cessation benefit, and in 2009 the state eliminated co-pays on tobacco cessation products and services for all Medicaid fee-for-service beneficiaries.

## The Massachusetts experience

The state of Massachusetts provides an excellent example of the significant ROI realized by offering comprehensive tobacco cessation programming and medications to Medicaid recipients. In 2006,

Massachusetts passed legislation requiring the coverage of cessation counseling services and all cessation treatments approved by the Food and Drug Administration including both prescription medications and NRT (Ku, 2012). The coverage is robust and aligned with CDC best practices including up to two annual 90-day courses of cessation medications per year (Centers for Disease Control and Prevention, 2003). Copayments are \$3 or less when prescribed by a Medicaid provider. Medicaid recipients may access all of these services through the state quitline or any of the state MCOs. Recent studies have reported that the Massachusetts program has resulted in an ROI of approximately \$3.12 in Medicaid expenditures for every dollar spent on tobacco cessation costs including medications, counseling, promotion and outreach (Richard P, 2012). Although this type of programming may require more funding to initiate, the cost savings can be realized within the first three years.

Although Massachusetts developed this program independent of the ACA, it did require legislation to implement. Although pursuing a legislative mandate is not a firm recommendation for Florida, it is an option, and the Massachusetts example provides strong evidence in the case for Medicaid tobacco cessation coverage.

### Lessons for Florida

According to the American Lung Association, the multiple Medical Care Organizations (MCO) responsible for administering Medicaid benefits in Florida offer varying levels of tobacco cessation coverage to Medicaid beneficiaries (American Lung Association). In-person cessation coverage is the only benefit that is consistent across the MCOs. As such, it is difficult to ascertain whether or not Medicaid-covered callers to the Quitline are eligible for more or less NRT and counseling through their plan than is available through the Quitline, and conversely whether or not they should be referred to other sources of assistance. Approaching the MCOs directly regarding tobacco cessation coverage of Medicaid members is a viable option to pursue cost sharing that is unrelated to the ACA. Just as with any of the private health plans, making the case for tobacco cessation and quitlines with well documented ROI is a convincing argument.

## Conclusions and Recommendations

Sharing the costs of tobacco cessation treatment between government and private payers is a best practice recommended by the CDC. For the Florida Quitline specifically, cost sharing would provide a mechanism to expand Quitline reach without increasing the state's share of financial support.

There is no single course of action that the BTPP could or should pursue to establish cost sharing agreements for the Florida Quitline. Instead, we present a combination of options which have been used successfully by other states, and appear to be the most feasible to implement in Florida.

*First, we recommend that Florida pursue public-private partnerships with commercial health insurance companies.*

***Focus efforts on the five largest health plans in Florida.*** Due to the large number of carriers operating in Florida, initial efforts should focus on the largest companies whose members have high utilization of the Quitline. These include Blue Cross Blue Shield of Florida, United Health Care, Aetna Health, Cigna

Healthcare and Humana Health. Establishing cost sharing agreements with the five largest insurance plans would cover about two-thirds of the insured callers currently utilizing the Florida Quitline. Once agreements are in place with some of these major health plans, they can serve as models to expand the practice with smaller health plans.

***Start with a partnership strategy rather than a mandate.*** We recommend using a collaborative, partnership approach to encourage health plans to support cessation services. This approach is preferable to seeking legislative mandates or establishing quitline policies that reduce or eliminate services for insured tobacco users. Partnership is recommended for several reasons:

- Unlike other states which have successfully established cost sharing after restricting benefits, Florida Quitline is not experiencing a funding crisis. The constitutionally mandated allocation of a portion of tobacco settlement funds provides a sizeable budget for the Quitline (although it is funded at substantially less than the funding level recommended by the CDC).
- Since the Quitline began, the BTPP has focused on providing effective and accessible cessation services to all Floridians who are interested in quitting; to refuse service to insured callers would be a major change in approach.
- The experience of other states suggests that a partnership approach is valued by both the state and the health plans.

The partnership approach can take time, as health plans often need to be educated about the effectiveness of the Quitline, the expected return on investment, and the advantages of using the Quitline vs. providing their own services. However, the experiences of Ohio and Colorado show that agreements can be established quickly if there is a will to do so. Responsibility and return on investment are convincing arguments to present to health plans, as is the potential marketing advantage that cost sharing partners might experience.

***Pursue policy changes should partnerships prove difficult to establish.*** Should the partnership approach result in little or no progress, then we recommend moving to a policy change. The BTPP can elect to reduce or eliminate benefits for insured callers, and use this as leverage to bring health plans to the table. Likewise, the BTPP should consider this strategy if the Quitline loses funding or experiences sharp increases in demand for services.

***Use a reimbursement model rather than a transfer model.*** The current Florida Quitline provides evidence-based, effective and cost-effective services so serving all tobacco users by the Quitline is a possibility. Several years of media promotion have produced high levels of awareness and brand recognition for the Quitline. The current Quitline vendor has the capacity to serve large numbers of callers, can handle increases in call volume, and has systems in place to identify callers' insurance coverage and invoice private payers. Insured callers would continue to receive quality services through the Quitline under a reimbursement model. In addition, the BTPP would have access to data on the numbers of callers served under private payer contracts. Finally, there is cost-savings to plans and employers through a reimbursement model.

The concern with implementing a transfer model is that Should insured callers be transferred out to health plan cessation programs they may receive services of lesser quality that are not evidence-based. Early investigations suggest that the major health plans in Florida do not offer cessation services that are comparable to those of the Quitline. The Hawaii case suggests that triage and transfer models are most successful if the participating health plans provide high-quality, evidence-based cessation services. Even if high quality services were offered by health plans, the transfer model is complex and costly to operate.

Establishing and operating a transfer model could potentially increase the costs BTPP pays to the Quitline vendor due to the ongoing costs to identify and transfer callers.

*Second, we recommend that BTPP work to improve and standardize cessation benefits for state employees.*

**Lead by example.** Other states have found that in order to successfully negotiate with private payers, the state needed to demonstrate that state employee health plans provide adequate tobacco cessation benefits. Currently, benefits are not standard across several state employee health insurance options. Standardizing and strengthening benefits for state employees could be done by working to establish partnerships with state employee insurance providers in the same ways as recommended for the commercial plans. This could also be achieved through legislation. The Florida Tobacco Cessation Alliance recommends a strategy that includes educating policy makers about the benefits of providing comprehensive tobacco cessation services for state (and other) government employees.

*Third, we recommend that the BTPP focus on increasing the number of employers who provide comprehensive cessation services for their employees.*

Even if the BTPP were to successfully establish cost sharing agreements with all major health insurance plans in Florida, there would still be self-insured employer groups which would be exempt. It is important to have another pathway to cost sharing for these groups. Cost sharing agreements with large employers can serve as that pathway. Return on investment is a very compelling argument for employers, who would benefit from reduced absenteeism, improved productivity, lower insurance premiums, and lower health care costs. In addition, employer groups can advocate to health plans to improve insurance coverage for cessation. Employer groups are in a position to request such coverage, and even to pressure health plans to provide it in order to secure or maintain contracts with employer groups. However, it is not feasible for the BTPP to take on the role of educating and negotiating with individual businesses throughout the state. We recommend four strategies to increase the number of businesses and employers who share costs with the Quitline.

**Consider ways to encourage Alere to increase their commercial contracts in Florida.** Alere is currently serving thousands of Floridians through its commercial contracts with employers. Increasing this effort would boost reach without time or expense on the part of the BTPP.

**Capitalize on the BTPP community cessation grants.** The grants are funded to promote, establish and strengthen tobacco control policies, including smokefree and cessation policies within businesses. These efforts may tend to be locally-focused, especially in the near future. However, the BTPP could develop and promote coordinated statewide strategies in order to concentrate grantee efforts on larger employer groups and therefore get a bigger payback on their efforts.

**Work closely with the Florida Tobacco Cessation Alliance.** The Alliance already has private sector businesses involved, and has developed ROI materials demonstrating the return employers can expect, and is actively working to encourage businesses to support cessation. The BTPP could develop a standard package of benefits available through the Quitline (and possibly the AHEC cessation initiative), and the Alliance could distribute and promote the service package as an option for businesses.

***Leverage the Florida AHEC programs' connections with businesses and chamber groups.*** The AHEC program offices and centers are involved (to a limited extent) in activities designed to promote cessation policy and coverage for cessation with businesses. AHEC personnel give presentations and meet with businesses to educate them on the role of employers in promoting and supporting cessation, although currently in most cases the AHECs provide their cessation classes to employers for no cost, although some employers do provide free NRT with their own funds. The BTTP should consider ways to expand these efforts which could increase both the reach of the Quitline and the reach of the AHEC tobacco cessation programs. In addition, the BTTP should encourage the AHECs to develop models in which employers share in costs for providing group cessation programs at their workplaces.

***Fourth, we recommend the BTTP and others work to improve access to and coverage for tobacco cessation for Medicaid recipients.***

The recent Massachusetts study provides compelling evidence of the return on investment for supporting cessation services for tobacco users in Medicaid. Not only did the study show a return of more than \$3 for every \$1 spent, most gains were realized within three years. Currently, the Quitline uses tobacco settlement funds to provide cessation counseling and a 2-week supply of NRT for Medicaid members.

Medicaid administration differs greatly from state to state, making it difficult to recommend a single course of action for the state of Florida. We present three possible approaches for improving Medicaid cessation coverage which have successfully been used in other states to increased quitline reach.

***Obtain the 50% federal match for tobacco cessation.*** The 2011 CMS decision to provide the 50% federal match for tobacco quitline administrative costs provides an opportunity to obtain funds to expand the reach of the Florida Quitline. States which have done this successfully report that that it has an added benefit in helping to further negotiations with private health plans: “Where CMS goes, the private health plans will follow.”

***Work to establish individual agreements with Medicaid managed care organizations.*** Here we suggest applying the same strategies described above in working with private health plans, or working directly with the state Medicaid office.

***Stakeholders outside the BTTP may advocate for legislative action.*** Groups such as the Florida Tobacco Cessation Alliance can be a powerful influence in calling for legislative changes to the Florida Medicaid system.

## Appendix 1

Insurance coverage for Florida Quitline callers vs. all Florida tobacco users

	Quitline Callers FY11		Florida Tobacco Users	
	N	%	N	%
None	19,526	48.1	520,568	22.3
Private insurance coverage	10,086	<b>24.8</b>	1,089,797	46.7
Medicare	4,288	10.6	372,726	16.0
Medicaid or Medical Assistance	6,732	<b>16.6</b>	248,091	10.6
Other	n/a	n/a	101,886	4.4
<b>Total</b>	<b>40,632</b>	<b>100.0</b>	<b>2,333,068</b>	<b>100.0</b>
Don't know/ missing/ refused	2,523	--	72,214	--

## Appendix 2

### Frequency and percent of insured FY11 Florida Quitline callers by commercial insurance carrier

<b>Commercial Insurance Carrier</b>	<b>N</b>	<b>%</b>	<b>Cumulative %</b>
Blue Cross Blue Shield	3,300	30.3%	30.30%
United Health Care	1,471	13.5%	43.80%
Aetna Health	1,233	11.3%	55.10%
Cigna Healthcare	851	7.8%	62.90%
Humana Health	476	4.4%	67.30%
Av-Med	256	2.4%	69.70%
Coventry Health Care	189	1.7%	71.40%
CHP	95	0.9%	72.30%
Florida Health Care	70	0.6%	72.90%
Health First	60	0.6%	73.50%
Healthcare District Opt 1	51	0.5%	74.00%
Universal Health Care	45	0.4%	74.40%
Neighborhood Health	27	0.2%	74.60%
Vista Healthplan	22	0.2%	74.80%
Medica HP	19	0.2%	75.00%
Health Options	17	0.2%	75.20%
Preferred Medical Plan	15	0.1%	75.30%
Citrus Health Care	10	0.1%	75.40%
JMH Health Plan	10	0.1%	75.50%
Total Health Choice	2	0.0%	75.50%
Trustmark Life	2	0.0%	75.50%
Connecticut General	1	0.0%	75.50%
John Alden Life	1	0.0%	75.50%
Other	2,661	24.4%	99.90%
<b>Commercially insured callers</b>			
<b>Total:</b>	<b>10,884</b>	<b>100.0%</b>	

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