U.S. Quitlines at a Crossroads: Utilization, Budget, and Service Trends 2005–2010

The North American Quitline Consortium (NAQC) is providing these talking points to make the case for sustained and enhanced funding of state-run quitlines. Use these discussion points when communicating the important messages contained in the report to legislators, stakeholders, and other relevant audiences. The full report is available online at: www.naquitline.org/report.

Q: How serious is a decrease in the total funding for U.S. quitlines of 7% from Fiscal Year (FY) 2009 to FY 2010?

A: A seven percent decrease represents $8.6 million nationally, and means far fewer smokers will have evidence-based services available to them. It is important to remember that prior to 2010, quitline budgets were increasing to better keep pace with record levels of demand for help in quitting.

Since the data were collected in October 2009, tobacco control program budgets, including quitline budgets, have been dramatically reduced by many legislatures. For example, the State of New Jersey is facing the complete elimination of their tobacco control program, including the quitline. The State of Maryland is also considering cuts of more than 70% to its tobacco control program, including the quitline.

Q: Is preserving and enhancing the investments already made in quitlines (by both federal and state government) a prudent, cost-effective, and cost-saving approach to health care?

A: Yes. The Centers for Disease Control and Prevention (CDC) states, "quitlines are effective in increasing successful quitting and have the potential to reach large numbers of smokers."[1] Further, the U.S. Public Health Service states, "quitlines significantly increase abstinence rates compared to minimal or no counseling interventions," and, "the addition of quitline counseling to medication significantly improves abstinence rates compared to medication alone."[2]

In addition, a study on priorities among effective clinical preventive services found that the three highest-ranking services (each with a score of 10) are: tobacco use screening and brief intervention; immunizing children; and discussing aspirin use with high-risk adults.[6]

Q: What has been the impact of budget cuts on the types of services that smokers may receive from quitlines?

A: As a result of budget cuts, quitlines have reported: delays to speak to intake staff or counselors; reducing or eliminating quitline promotions or advertising; reducing or eliminating nicotine replacement therapy (NRT) provisions; restricting eligibility criteria for counseling or NRT; and reducing the number of counseling sessions (e.g., from a multi-call protocol to a single-call protocol).

Q: Have quitlines received new funding through the American Recovery and Reinvestment Act (ARRA)?

A: Yes. In February, states and territories received a total of $44.4 million in ARRA awards for tobacco cessation activities for quitlines and media; this funding was awarded for a 24-month period. If we assume states will divide the funds evenly over the next 24 months, it will increase total funding for all quitlines in the FY 2010 budget by about $11.1 million, the FY 2011 budget by $22.2 million, and the FY 2012 budget by $11.1 million. The total funding decrease experienced by U.S. quitlines between FY 2009 and

FY 2010 was $8.6 million. There are three points to keep in mind: 1) The ARRA funding is being used for more than quitline services (e.g., media expenditures); 2) Based on this data, the ARRA funds may make up for the decrease in total funding that U.S. quitlines experienced, but with budgets continuing to diminish, we will have to assess the final impact at the end of the fiscal year—we anticipate the final assessment will show an overall decrease in total U.S. quitline budgets; and 3) the ARRA funding will only be available to states through mid FY 2012 so this will only result in a short-term solution to budget reductions.

Q: Given current budget shortfalls, do the resources really exist to fully fund quitlines and comprehensive tobacco control programs consistent with CDC's recommended best practices?[3]

A: Yes. According to a recent report on how states are spending the money collected each year from the Master Settlement Agreement and other tobacco tax revenues, in "Fiscal Year 2010, the states will collect $25.1 billion from the tobacco settlement and tobacco taxes. They will spend just 2.3 percent of it—$567.5 million—on tobacco prevention and cessation programs."[4] CDC recommends states invest $15-20 per capita for comprehensive tobacco control programs, including $2.19 per capita for quitlines.[1]

In [your state here], quitlines are currently funded at $[your state data here]* annually. To meet the CDC's recommended best practices, we would need to increase funding to $[your state data here]* annually. This funding could be raised through a dedicated tax on tobacco.

** Please contact NAQC at 602-279-2719 if you need your state-specific data.*

Q: Does Medicaid help pay for quitline services?

A: No. Unfortunately, Medicaid currently prohibits reimbursement to quitlines or the states for services to Medicaid beneficiaries who smoke. This is a real tragedy because the prevalence of tobacco use is very high among Medicaid beneficiaries and they represent a large proportion of the calls to quitlines—estimated at about 20% of all calls. If Medicaid reimbursed quitlines, they would have additional resources to provide services to smokers who want to quit.

We are disappointed to see that Medicaid coverage for tobacco cessation is being rolled back under Health Care Reform. Medicaid needs to enhance, not diminish, its coverage. *NOTE: Under the new Health Care Reform plan, only pregnant smokers will be covered for cessation under Medicaid.*

Q: Will funding comprehensive tobacco control programs, to levels recommended by the CDC, help quitlines increase reach?

A: Yes. In fact, states that have made the necessary investments have reached or exceeded the CDC's recommended level of reach.[5] Examples include Colorado, Maine, Montana, and South Dakota. *NOTE: Reach is defined as the number of unique tobacco users calling divided by the estimated number of smokers in the state.*

REFERENCES

[1] Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs—2007. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; October 2007. Reprinted with corrections.

[2] Fiore MC, Jaen CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

[3] The Fiscal Survey of States: December 2009, National Governors Association/National Association of State Budget Officers, http://www.nasbo.org/LinkClick.aspx?fileticket=5HIBWprlKhw%3d&tabid=106&mid=566&forcedownload=true (accessed 2/12/2010).

[4] Campaign for Tobacco Free Kids, "A Broken Promise to Our Children: The 1998 State Tobacco Settlement 11 Years Later," December 9, 2009. See http://www.tobaccofreekids.org/reports/settlements/FY2010/State%20Settlement%20Full%20Report%20FY%202010.pdf (accessed 12/11/2009).

[5] North American Quitline Consortium, 2009 NAQC Annual Survey Data, Phoenix, AZ.

[6] Maciosek MV, Coffield AB, Edwards NM et al. Priorities among effective clinical preventive services. Am J Prev Med 2006; 31(1) 52-61. http://www.prevent.org/images/stories/clinicalprevention/article%201669p.pdf (accessed 04/06/2010).