Implementing the Affordable Care Act: A Report on Sustainability Activities Among State Quitlines

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Background

As the Affordable Care Act (ACA) is implemented in the U.S., cessation services are likely to become more available and their cost will be borne by health care payers. Under the ACA, tobacco cessation is included as a required preventive service and the financial responsibility for providing these services is placed on the insurer/health plan. Given the recent economic climate and enactment of ACA, states have reconsidered their role as the sole funder of state quitlines. Many states are developing innovative cost-sharing partnerships with Medicaid, health plans and employers to support the growing demand for quitline services and to align payment for services with the appropriate health care payers.

In 2012, state and territorial quitlines received over 1.3 million calls from about half a million callers. In addition, they received 171,379 referrals from a variety of sources (97,170 fax referrals from physicians; 45,288 web referrals; 1,509 electronic referrals; and 27,412 referrals from other sources). On average, state quitlines provide cessation treatment for less than 2% of tobacco users each year. The total budget for quitlines was $120.8 million in 2012. While the majority of revenues were provided by state government (77%), about 18% were provided by the CDC and 2% came from noteworthy new sources, federal Medicaid "FFP match" funds and cost-sharing agreements with third parties.

Methods

Data from the FY2012 North American Quitline Consortium (NAQC) Annual Survey of Quitlines were analyzed. The survey requested data on FY2012 budget and activities. Data were collected according to how each quitline defined its own fiscal year (beginning July 1, April 1 or October 1). 52 of 53 state quitlines completed the survey. The survey contained new questions on quitline sustainability activities, including whether the state quitline intended to claim (or already claimed) the newly allowed 50% Federal financial participation (FFP match) for quitline administrative expenditures for Medicaid enrollees, whether a cost-sharing arrangement currently existed (or is being pursued) with an entity other than Medicaid, and whether other cost-sharing strategies are being pursued.

Results

State Quitline Funding Sources

Table 1: State Quitline Funding Sources FY2012

Budget source FY2012	N (of 40)	Proportion of quitlines receiving funding	Total amount from each budget source	% of total
CDC (any type)	36	90%	$19,447,939	17.5%
Tobacco settlement funds (MSA or non-MSA)	18	45%	$53,699,328	48.4%
State/provincial dedicated tobacco tax funds	8	20%	$18,194,647	16.4%
State/provincial general funds	7	18%	$14,175,994	12.8%
Federal Medicaid Match	5	13%	$1,173,228	1.1%
Third party reimb. through employer	3	8%	$819,366	0.7%
Third party reimb. through insurance	3	8%	$366,471	0.3%
Non-gov. org.	2	5%	$38,709	0.0%
Charitable foundation	1	3%	$1,029,036	0.9%
Local government funds	1	3%	$600,000	0.5%
Federal Research grant	1	3%	$1,688,353	1.5%
State Medicaid Funds	0	0%	$-	0.0%
Health Canada	0	0%	$-	0.0%
Corporate charitable contribution	0	0%	$-	0.0%

Types of Cost-Sharing Activities Reported to Exist or Be In-Progress in State Quitlines, FY2012

- Building relationship with Medicaid agency
- Developing an MOU with state Medicaid agency for FFP
- Conducting state cessation coverage assessment
- Exploring cost-sharing agreements with private entities
- Implementing cost-sharing agreements with specific health plans (eg, state employees)
- Educating large employers and health plans about cessation coverage and quitline resources
- Educating regulators/policy makers about the importance of comprehensive cessation benefits in all insurance products
- Transferring insured callers from the state quitline to their health plan's quitline
- Training health care providers on cessation interventions and billing for treatment

Discussion

Given that 60% of quitline callers reported having some type of insurance, quitlines have an increased rationale to pursue cost-sharing strategies. As demand for quitline services continues to rise, cost-sharing strategies with appropriate health care payers will be critical for making available an adequate level of services to meet the growing demand. A large proportion of state quitlines are making innovative changes to their business practices to align payment for quitline services with appropriate payers such as Medicaid, health plans and employers. These practices include pursuing the newly allowed 50% Federal financial participation (FFP match) for quitline administrative expenditures for Medicaid enrollees, establishing cost-sharing agreements with entities other than Medicaid (eg, health plan, employer), and internal policies such as transferring callers directly to health plan/employer services they are eligible for or restricting quitline services for callers who have access to cessation coverage through an insurer or employer.

As implementation of the ACA moves forward, there are a number of critical questions to explore. The most important questions are:

- To what extent will state governments continue to fund state quitline and other cessation services?
- To what extent will state governments continue to pursue innovative cost-sharing agreements for state quitlines?
- To what extent will health plans engage in cost-sharing with the state quitlines, contract for their own quitline services or make other cessation services available to enrollees?
- Will more or less quitline and cessation treatment services be available to tobacco users after implementation of the ACA compared to before?

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